



## QUARTERLY SERVICE DELIVERY MONITORING AND RISK ASSESSMENT

OAAS Support Coordination Documentation

**Monthly Progress Note/Fax/Mail**

Case No: \_\_\_\_\_

Ticket No. \_\_\_\_\_

Participant: \_\_\_\_\_

Activity: \_\_\_\_\_

SC ID: \_\_\_\_\_

Procedure Code: \_\_\_\_\_

Date: \_\_\_\_\_

Other Code: \_\_\_\_\_

Begin Time: \_\_: \_\_ (hh: mm)

Service Participants: \_\_\_\_\_

End Time: \_\_: \_\_ (hh: mm)

\_\_\_\_\_

Place of Service: \_\_\_\_\_

\_\_\_\_\_

Type of Contact: \_\_\_\_\_

\_\_\_\_\_

Entered: \_\_/\_\_/\_\_\_\_\_

Travel Log

Modified: \_\_/\_\_/\_\_\_\_\_

Begin Mileage: \_\_\_\_\_

Sent: \_\_/\_\_/\_\_\_\_\_

End Mileage: \_\_\_\_\_

**I. GENERAL QUESTIONS:**

- Answer all questions below for each service that the participant receives.
- For all "NO" answers, please describe in the narrative section how it was addressed.

<b>Review in the home:</b>	YES	NO
1. Plan of Care (current & approved) in the binder?		
2. OAAS Participant's Rights & Responsibilities Form (OAAS-RF-08- 003) in the binder?		
3. Blank Critical Incident Forms in the binder?		
4. Did the PAS provider keep required service logs/time sheets according to requirements?		
5. Is the Support Coordination Agency's toll free number available?		
6. Is the Provider's toll free number available?		
7. Is the OAAS Waiver Help Line toll free number available?		
<b>Ask the Participant or Responsible Representative (RR):</b>		
8. Does the worker arrive/leave according to the service log/time sheets?		
9. Are all assistive devices identified in the POC working properly? (Support coordinator may test device, if applicable.)		
<b>POC Renewal During This Quarter</b>		
If the POC was renewed during this quarter, enter date(s) sent to the Provider: Date: _____ and Participant: Date: _____ and attach supporting documentation.		
<b>I. Narrative Section:</b>		



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<b>II. QUARTERLY RISK ASSESSMENT</b>	<b>YES</b>	<b>NO</b>
25. According to the participant or RR is the Emergency Plan and Agreement Form is effective and up-to-date? (Effective means that if the plan was executed, it worked) Name the person who verified below.		
26. Was the Emergency Plan and Agreement Form revised? Date _____ Summarize revisions below.		
27. According to the participant or RR is the Individualized Back-Up Staffing and Agreement Form effective and up-to-date? (Effective means that if the plan was executed, it worked) Name the person who verified below.		
28. Was the Individualized Back-Up Staffing and Agreement Form revised? Date _____ Summarize revisions below.		
29. Risk factors for the quarter were reassessed and <b><u>a summary of how present risks were mitigated during this quarter including all risk factors identified</u></b> through the CAPs and otherwise is documented below (reference CAPs as appropriate).		

**RISK ASSESSMENT NARRATIVE:**

(Refer to Section II. instructions above)



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### III. MONITORING OF ONGOING SERVICES:

- During each quarterly visit, the SC evaluates delivery of ongoing services for the previous quarter. **This section applies only to PAS and ADHC.**

**Instructions:**

1. Review service delivery documentation for the previous quarter.
2. Discuss last quarter's service delivery with the participant or responsible representative.
3. Determine whether all ongoing services in the POC were delivered in the amount, frequency, and duration specified in the service plan. If so select code 01 and proceed to III.
4. For any ongoing service **NOT** delivered according to the POC for the quarter, check applicable code below and enter supporting details in the narrative section.
5. Enter Codes in CMIS. (Codes must be entered for payment).

***At least one service monitoring code must be checked (√) for each applicable service:***

#### III.A. Service Monitoring Codes:

- Check all that apply

	PAS	ADHC
01 All ongoing services were delivered in the amount frequency and duration specified in the POC.		
02 Participant was temporarily admitted to an institutional care facility.		
03 Scheduled PAS services were <u>voluntarily</u> declined because family or other caregivers were able to temporarily offer additional unpaid supports. (Excluding Back-up Staffing plan)		
04 ADHC Unable to attend due to unscheduled closures or weather.		
05 PAS hours not received due to unplanned worker absence and <b>family or other natural support assumed responsibility as specified in the back-up staffing plan.</b>		
06 PAS hours not received due to participant refusing relief worker.		
<b>07*</b> PAS hours not received due to unplanned worker absence and <b>PAS provider did not assume coverage as specified in the back-up staffing plan.</b>		
<b>08*</b> Participating in Self-Direction Program and PAS hours not received due to unplanned worker absence and <b>coverage was not assumed according to backup staffing plan.</b>		
<b>III.B. Remediation Activity Code: Check any that apply</b>	<b>PAS</b>	<b>ADHC</b>
<b>*MUST ENTER AT LEAST ONE REMEDIATION CODE WHEN 07 or 08 HAS BEEN SELECTED</b>		
<i>09R Remediation in Progress</i>		
<i>10R Assisted participant in locating other providers who could best meet their needs</i>		
<i>11R Change to Back up Staffing Plan</i>		
<i>12R POC Revision for Provider Change</i>		
<i>13R New worker in place by PAS provider</i>		

01 All ongoing services were delivered in the amount frequency and duration specified in the POC.

02 Participant was temporarily admitted to an institutional care facility.

03 Scheduled PAS services were voluntarily declined because family or other caregivers were able to temporarily offer additional unpaid supports. (Excluding Back-up Staffing plan)

04 ADHC Unable to attend due to unscheduled closures or weather.

05 PAS hours not received due to unplanned worker absence and **family or other natural support assumed responsibility as specified in the back-up staffing plan.**

06 PAS hours not received due to participant refusing relief worker.

**07\*** PAS hours not received due to unplanned worker absence and **PAS provider did not assume coverage as specified in the back-up staffing plan.**

**08\*** Participating in Self-Direction Program and PAS hours not received due to unplanned worker absence and **coverage was not assumed according to backup staffing plan.**

#### III.B. Remediation Activity Code: Check any that apply

**\*MUST ENTER AT LEAST ONE REMEDIATION CODE WHEN 07 or 08 HAS BEEN SELECTED**

*09R Remediation in Progress*

*10R Assisted participant in locating other providers who could best meet their needs*

*11R Change to Back up Staffing Plan*

*12R POC Revision for Provider Change*

*13R New worker in place by PAS provider*



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**IV. MONITORING ALL TYPES OF SERVICES DELIVERED**

- The SC evaluates whether all types of services in the POC were received **during the final quarter of the POC year or quarter of discharge**, as applicable.

- Determine whether **all types** of services in the POC were delivered within the plan year. If yes, enter the appropriate CMIS code FOR EVERY SERVICE.
- For any service types specified in the POC which were **NOT** delivered during the POC year, check applicable code below and enter supporting details in the narrative section.
- If an undelivered service is due to any reason requiring remediation code as 18, and document the remediation activities which have occurred.
- Enter Codes in CMIS. (Codes must be entered for payment)

***At least one service monitoring code must be checked (√) for each applicable service:***

<b>IV.A Service Monitoring Codes: Check all that apply for each service in the POC</b>	<b>ADHC</b> Adult Day Health Care	<b>CTSS</b> Care-giver Temp. Support	<b>ADMS</b> Asst. Devices/ Medical Supplies	<b>EAA</b> Environ. Access. Adapt-ation	<b>HDM</b> Home Delivered Meals	<b>NMT</b> Non-Medical Transpor-tation	<b>Nurs-ing</b>	<b>PAS</b> Personal Assistance Services	<b>SMT</b> Skilled Maint. Therapy	<b>TS</b> Transition Services
<b>14</b> All types of services in the POC were delivered within the plan year.										
<b>15</b> Health decline after person admitted to waiver resulting in discharge prior to service delivery.										
<b>16</b> Participant changed his/her mind about service and POC was changed to remove service.										
<b>17</b> SC contacted all providers in the Provider Locator Tool and no enrolled service provider could be found to meet participant's needs.										
<b>18</b> Other reason: Enter Remediation Code ( Describe)										



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<b>IV.B Remediation</b> <b>Activity Codes:</b> Must enter a remediation code(s) below whenever code 18 has been selected  <b>Check all that apply:</b>	ADHC Adult Day Health Care	CTSS Care-giver Temp. Support	ADMS Asst. Devices/ Medical Supplies	EAA Environ. Access. Adapt -ation	HDM Home Delivered Meals	NMT Non-Medical Transpor -tation	Nurs- ing	PAS Personal Assistance Services	SMT Skilled Maint. Therapy	TS Transition Services
<b>19R</b> Remediation in progress (Explain in narrative)										
<b>20R</b> POC amended to accurately describe current situation and service needs										
<b>21R</b> Documentation that services were appropriately discontinued										
<b>22R</b> The participant began receiving the type of service specified in the plan										
<b>23R</b> No provider within a reasonable transport radius (Shows up only in the drop down for center-based services)										

**SERVICE DELIVERY MONITORING NARRATIVE**

(Refer to Sections III. & IV. instructions above)



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**SERVICE DELIVERY MONITORING NARRATIVE**

(Refer to Sections III. & IV. instructions above)

SC Signature \_\_\_\_\_ Date: \_\_\_\_\_