



OMH HCBS Waiver Program Site Visit Review

Reviewer:	Provider Agency/ County:
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Date of Review:	
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Field Coordinator: Please send a copy of completed summary to The OMH HCBS Waiver Unit, Central Office within 30 days of date of site visit.

ICC Agency: Please Note: Remediation will be required for all identified deficiencies. A Performance Improvement Plan (PIP) will be required of any item on this tool that has been noted as a programmatic trend and/or areas from past reviews that continue to lack any significant improvement. In addition, areas in which additional staff training is needed may be identified. Your response to identified areas must be submitted to your Field Coordinator within 30 days of the agency's receipt of the Site Visit Summary.

Individualized Service Plan Review Section 400

Participant Name/ CIN#	DOB:	Enrollment Date:
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Mental Health Dx:

Initial LOC Date:	Notice of Decision Date(Acceptance):	Notice of Decision Date(Termination with discharge date):
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Loss of Waiver Date:	Annual Recertification Dates:
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Participant Enrollment Documentation In Accordance With The Guidance Document

*Insert Dates if yes otherwise "X" is no.	Dates	Comments
Freedom of Choice Application Signed		
Screening Letter Received		
Choice of Providers, updated as necessary		
Release of Information forms are completed in accordance with Guidance and are updated when necessary		
Flex Fund Letter received		

Service Plan Review Required Dates	Initial	30 Day SPR	90 Day SPR	2ND 90 Day SPR	3RD 90 Day SPR	If 4th 90 day is needed, please use comments box below
Date of Enrollment (30 & additional 90s scheduled from this date):		30 DAY DATE:	90 DAY DATE:	2ND 90 DATE:	3RD 90 DATE:	Please Note: The enrollment date is used to calculate the due date for the service plans. At no time, including signatures, can the plan be completed 5 days prior to the due date. For extenuating purposes, supervisors may extend the due date by no more than 3 days and this must be noted in the plan and progress notes (After 8/2016 no note needs to be made in the progress notes for supervisor signature 3 days past due date).

Signature Dates						
Participant Signed/Dated						If participant did not sign indicate why:
Parent Signed/Dated						
ICC signed and dated						
ICC supervisor signed and dated						
CANS-NY Completion Date						

Local Government Unit Review/Approval											Comments
Service Plan Approved (Yes or No)											
Service Plan Signed/Dated											
Choice of Provider Signed/Dated	*****										PENDING
Initial Budget Approved (Yes or No)											
Initial Budget Signed/Dated											
Service Plan <i>Date of Enrollment (30 & additional 90s scheduled from this date):</i>	Initial		30 Day SPR		90 Day SPR		2ND 90 Day SPR		3RD 90 Day SPR		If 4th 90 day is needed, please use comments box below
	Y	N	Y	N	Y	N	Y	N	Y	N	
Initial Service Plan (ISP) includes a comprehensive description of the child's life domains, child and family strengths, priorities as defined by the child and family, a discharge profile and initial measurable goals, objectives and methods.											If 4th 90 day is needed, please use comments box below
Includes Input From Treatment Provider											
Includes Input From All Waiver Service Providers											
Includes Significant Collateral Sources Input											
Goal Objectives Describe Frequency and Duration											
Progress in terms of each goal and objective is individually described.											
Reasons for changing, adding or ending goals or objectives are explained.											
Modifications with corresponding status/ target dates, are made to goals/ objectives.											
The family and participant were engaged in conversations periodically, as well as at service plan reviews, addressing the child's progression and probable services needed after discharge from the Waiver.											
The personal goals of participant and family are being addressed.											

	Initial		30 Day		90 Day		2nd 90 Day		3rd 90 Day		If 4th 90 day is needed, please use comments box below	
Please include most recent date of scheduled appointment at time of review												
Medical Doctor Visit (Date)												
Dental Visit (Date)												
Mental Health Prescriber (Date)												
Mental Health Counseling (Date)												
Other Specialist(s) (Date) and Type											Please indicate type of Specialist utilized (medical, dental, psych, etc.):	
Comments (include strengths, challenges, recommendations):												
Budget	Initial		30 Day SPR		90 Day SPR		2nd 90 Day SPR		3RD 90 Day SPR		If 4th 90 day is needed, please use comments box below	
	Y	N	Y	N	Y	N	Y	N	Y	N		
Services listed are in the Service Plan.												
The Budget is reviewed and modified as needed with each Service Plan Review.												
Participants' costs is monitored to assure that they stay within approved ceilings.												
Waiver services are reviewed to assure that they are being utilized as noted in the Service Plans and Budget. Changes to projections are made accordingly.												
Flex Funds	Initial		30 Day		90 Day		2nd 90 Day		3rd 90 Day		If 4th 90 day is needed, please use comments box below	
	Y	N	Y	N	Y	N	Y	N	Y	N		
Flex Fund adjustments are made to the methods as indicated.												
Flex Funds are used in accordance with OMH Guidelines.												
Flex Funds expenditures are tracked (e.g., Flex Fund spending Log).	<input type="checkbox"/> YES <input type="checkbox"/> NO						Comments:					

CANS-NY	Initial		30 Day		90 Day		2nd 90 Day		3rd 90 Day		If 4th 90 day is needed, please use the comment box below
	Y	N	Y	N	Y	N	Y	N	Y	N	
ISP addresses Risk factors and strengths identified through the CANS-NY											Comments:
CANS NY Domain Scores of 2 and/or 3 addressed In The Service Plan											
Reasons for any deferrals with regard to Domain Scores of 2 and/or 3 have been documented											
Are changes in the CANS-NY ratings are integrated into the plan including ratings of 2 and 3.											
CANS-NY (List 2's and 3's Domains)	Indicate changes in domains listed over time (e.g., decrease, increase, new)		Initial	30 Day	90 Day	2nd 90 Day	3rd Day	Please attach CANS-NY Over Time Report. <i>This section is to be completed if CANS-NY Over Time Report is unavailable. Please utilize the below comments area to note observations from the CANS-NY Over Time Report.</i>			
								Comments:			

Date of Enrollment (30 & additional 90s scheduled from this date):		30 DAY DATE:	90 DAY DATE:	2ND 90 DATE:	3RD 90 DATE:	Please use the Date of Enrollment for a point of reference on the required date of completion when reviewing and recording the actual date of signatures/ completion (this date can be carried through from page 1).
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Safety Alert Plan Section 400.2

SAP	Initial	30 Day	90 Day	2ND 90 Day	3RD 90 Day	If 4th 90 day is needed, please use comment box below					
Participant Signed/Dated						If participant did not sign indicate why:					
Parent Signed/Dated											
ICC signed and dated											
ICC supervisor signed and dated											
	Y	N	Y	N	Y	N	Y	N	Y	N	
Copy of signed and dated Safety Alert Plan given to family											
The Safety Alert Plan is completed in accordance with the Guidance Document											
The Safety Alert Plan is updated to reflect the current needs and skills of the participant											
The Risks Issues are Being Addressed											

Comments (include strengths, challenges, recommendations):

Progress Notes Section 400.4

	Y	N	Y	N	Y	N	Y	N	Y	N	
ICC Contact Tracker Log utilized according to Guidance Document (effective 8/2016)											
Progress notes indicates service, date of service, duration, type of contact and use of flex funds, if applicable											
Progress notes indicate related goal and objectives											
Progress notes provide a narrative of contact. Purpose is clearly defined as indicated in Guidance Document											

Comments (include strengths, challenges, recommendations):

Discharge and Aftercare Plans												
Reason for Discharge:												
Signature Dates:	Discharge Plan		2- Week Follow-Up		4-Week Follow-Up		Month 2- Follow-Up		Month 3- Follow-Up		Comments:	
Participant Signed/Dated												If no follow-up was completed, please indicate here:
Parent Signed/Dated												
ICC signed and dated												
ICC supervisor signed and dated												
	Y	N	Y	N	Y	N	Y	N	Y	N	Comments:	
CANS-NY completed within 30 days of discharge date (include date in comments).												
Discharge Planning completed in accordance with Guidance Document												
Discharge Summary (within Plan) describes progress toward each goal and objective as well as the services used.												
Discharge services to be provided upon disenrollment are indicated (list under comments).												
After Care Plan: Was it determined that discharge services were implemented, and if not, what actions were taken?												

***CANS-NY							
CANS-NY Ratings	Initial (30 days prior to enrollment)	30 Day	1st 180 Day	2ND 180 Day	3RD 180 Day	4TH 180 Day	DISC HAR GE (within 30 days)
Completed Dates							
Child/Youth Behavioral Health Domain	Score	Score	Score	Score	Score	Score	Score
Psychosis							
Impulsive/ Hyper							
Depression							
Anxiety							
Oppositional							
Conduct							
Anger Control							
Attachment							
Child/Youth Risk Behaviors Domain							
Suicide Risk							
Self-Injurious							
Other Self Harm							
Other Self Harm							
Sexual Aggression							
Delinquent							
Exploitation							
Fire Setting							
Runaway							
Intent Misbehavior							
Decision Making							
Child/Youth Life Functioning Domain							
Primary Caregiver							
Family							
Acculturation: Language							
Living Situation							
Sleep							
Sexuality							
Knowledge of Sexuality							
Social Functioning							
School Achievement							
School Attendance							
JJ/ Legal							
Developmental							
Medical Helath							
Behavioral Health							
Adj. to Trauma							
Substance Exposure							
Substance Use							
Child/Youth Developmental Domain							
Cognitive							
Agitation							
Self-Stimulation							
Self-Care/ Daily Living							
Communication							
Developmental Delay							
Motor							
Sensory							

Child/Youth Adjustment To Trauma								
Sexual Abuse								
Physical Abuse								
Emotional/ Verbal Abuse								
Medical Trauma								
Natural Disaster								
Witness to Family Violence								
Witness to Community Violence								
Witness or Victim of Criminal Activity								
Affect Dysregulation								
Re-Experiencing								
Avoidance								
Numbing								
Dissociation								
Somatization								



Comments (include strengths, challenges, recommendations):

Family Interviews:			
Number of families interviewed:	Y/N	Agency Comments (If any)	Family Comments
Families are aware of the complaint/grievance procedures			
Families are aware of the incident reporting procedures			
Families are aware of the contact information for the parent advisor and the OMH field office			
Family interviews reflect overall satisfaction with Waiver services and service delivery			
Family interviews indicate that families feel their child's needs are identified and addressed			
Is there a goal/objective in the services plan where the method or intervention is carried out by family support service?			
Additional Comments:			