Office of Long-Term Living Participant Review Tool

Participant Review Tool - Section 1 - General Information	
Date of Interview: (Enter in XX/XX/XXXX format)	
Start time you began interviewing the participant for this survey: (Enter in XX:XX AM/PM Standard Time format)	
Enter Service Coordination Entity Name:	
Service Coordinator (Enter First and Last Name):	
Participant (Enter First and Last Name):	
Enter 9-Digit (Participant) MCI Number:	

Section 2 - All Participants Service Coordinators must review all of the questions in this Section with the participant and document the participant's responses to each question.

Question Number	Question Description	Response Number	Response Description
q_1	Please select the participant's program:	1	Act 150 Program
		2	OBRA Waiver
q_2	Which model of service do you use?	1	Agency Model
		2	Participant-Directed Model
		3	Both Agency and Participant-Directed Models
		4	Resides in Provider Owned and Operated Setting

q_3	Please select who is answering the interview questions?	1	Participant
		2	Participant's Chosen Representative
		3	Both Participant and Representative
q_4	How many direct care workers provide services for you?	1	0
		2	1
		3	2
		4	3
		5	4
		6	5
		7	6
		8	7 or more
q_5	What is their relationship to you? (Select all that apply)	1	No Relation
		2	Parent
		3	Son
		4	Daughter
		5	Brother
		6	Sister
		7	Other relative
q_6	Do you have a power of attorney (POA)?	1	Yes
		2	No (If "NO" is selected go to q_9)

q_7	What is your POA's relationship to you?	1	Not Related
		2	Spouse
		3	Parent
		4	Son
		5	Daughter
		6	Brother
		7	Sister
		8	Other relative
q_8	How satisfied are you with your POA?	1	Very Unsatisfied
		2	Unsatisfied
		3	Neutral
		4	Satisfied
		5	Very Satisfied
q_9	Do you have a legal guardian?	1	Yes
		2	No (If "NO" is selected go to q_12)

q_10	What is your legal guardian's relationship to you?	1	Not Related
		2	Parent
		3	Son
		4	Daughter
		5	Brother
		6	Sister
		7	Other relative
q_11	How satisfied are you with your legal guardian?	1	Very Unsatisfied
		2	Unsatisfied
		3	Neutral
		4	Satisfied
		5	Very Satisfied

q_12	Describe a typical day. What activities do your workers and staff help you with?	1	Managing Finances
		2	Managing Transportation
		3	Shopping
		4	Meal Preparation
		5	House Cleaning
		6	House Maintenance
		7	Managing Communication
		8	Managing Medications
		9	Walking
		10	Feeding
		11	Dressing and grooming
		12	Toileting
		13	Bathing
		14	Laundry
		15	Transferring (which means being able to move from one body position to another. This includes being able to move from a bed to a chair, or into a wheelchair. This can also include the ability to stand up from a bed or chair in order to grasp a walker or other assistive device.)

q_13	What services are on your Individual Service Plan (ISP)? (Check all that apply)	1	Adult Daily Living Services
		2	Assistive Technology
		3	Community Integration
		4	Community Transition Services
		5	Financial Management Services
		6	Home Adaptation
		7	Home Delivered Meals
		8	Home Health Aide
		9	Home Health Nursing
		10	Home Health Occupational Therapy
		11	Home Health Physical Therapy
		12	Home Health Speech and Language Therapy
		13	Non-Medical Transportation Services
		14	Participant-Directed Community Supports
		15	Participant-Directed Goods and Services
		16	Personal Assistance Services
		17	Personal Emergency Response System (PERS)
		18	Prevocational Services/Employment Skills Development
		19	Residential Habilitation Services
		20	Respite

		21	Service Coordination
		22	Specialized Medical Equipment and Supplies
		23	Structured Day Habilitation Services
		24	Supported Employment/Job Coaching
		25	TeleCare
		26	Therapeutic and Counseling Services
		27	Vehicle Modification
		28	Job Finding
		29	Careers Assessment
		30	Benefits Counseling
q_14	Do you know the amount of services you should receive (items or hours, etc.)?	1	Yes
		2	No
q_15	Overall, how satisfied are you that your Individual Service Plan (ISP) meets your needs?	1	Very Unsatisfied (If "Very Unsatisfied" is selected go to q_16)
		2	Unsatisfied (If "Unsatisfied" is selected go to q_16)
		3	Neutral
		4	Satisfied
		5	Very Satisfied
q_16	If you are not satisfied please explain why:	Enter Text	

q_17	Do you have a copy of your Individual Service Plan (ISP)?	1	Yes
		2	No
q_18	Do you receive all of the services in your Individual Service Plan (ISP)?	1	I Don't Know
		2	Yes, 100%
		3	No, about 75% or more
		4	No, about 50% or more
		5	No, about 25% or more
		6	No, less than 25%
		7	No services received at all
q_19	Can you describe your EMERGENCY (Disaster Preparedness) backup plan?	1	Yes (If "Yes" is selected go to q_20)
		2	No (If "No" is selected go to q_21)
q_20	If the answer is Yes, how well is it working?	1	Not at all (If "Not at all" is selected go to q_22)
		2	Not Well (If "Not Well" is selected go to q_22)
		3	Neutral (If "Neutral" is selected go to q_22)
		4	Well (If "Well" is selected go to q_22)
		5	Very Well (If "Very Well" is selected go to q_22)
q_21	If the answer is No, the Service Coordinator must review the emergency backup plan with the participant and ensure it is complete and fully understood by the participant. Describe actions taken to update or complete the emergency backup plan and ensure it is fully understood by the participant:	Enter Text	

q_22	Can you describe your INDIVIDUALIZED backup plan?	1	Yes (If "Yes" is selected go to q_23)
		2	No (If "No" is selected go to q_24)
q_23	If the answer is Yes, how well is it working?	1	Not at all (If "Not at all" is selected go to q_25)
		2	Not Well (If "Not Well" is selected go to q_25)
		3	Neutral (If "Neutral" is selected go to q_25)
		4	Well (If "Well" is selected go to q_25)
		5	Very Well (If "Very Well" is selected go to q_25)
q_24	If the answer is No, the Service Coordinator must review the individualized backup plan with the participant and ensure it is complete and fully understood by the participant. Describe actions taken to update or complete the individualized backup plan and ensure it is fully understood by the participant:	Enter Text	
q_25	Do you always feel safe?	1	Yes (If "Yes" is selected go to q_28)
		2	No (If "No" is selected go to q_26)
q_26	If no, please explain:	Enter Text	
q_27	If you do not feel safe would you feel comfortable talking with someone?	1	Yes
		2	No

q_28	Do you know you can call me (your service coordinator) if you need anything?	1	Yes
		2	No
q_29	Is your service coordinator's phone number in a place where you can easily find it?	1	Yes
		2	No
q_30	How many times have you been hospitalized (inpatient, ER, NF, rehab) in the last six months?	0	0 (If "0" is selected go to q_33)
		1	1
		2	2
		3	3
		4	4
		5	5 or More

q_31	What were the reasons for your hospitalization(s)?	1	Circulatory system diseases such as Congestive Heart Failure , arrythmias, and Coronary Atherosclerosis (Angina , Heart Attacks , Strokes)
		2	Respiratory system diseases such as Chronic Obstructive Pulmonary Disease (Emphysema) , Pneumonia , Asthma
		3	Infectious processes (septicemia , viral infections such as Flu and COVID)
		4	Endocrine issues (Diabetes related issues, Thyroid issues)
		5	Orthopedic Issues (HIP and Knee fractures, replacements , etc.)
		6	Other (If "Other" is selected go to q_32)
q_32	Please describe other reasons for your hospitalization(s):	Enter Text	
q_33	Are all of your appointment(s) scheduled and kept?	1	Yes (If "Yes" is selected go to q_38)
		2	No (If "No" is selected go to q_34)
q_34	If No, what kinds of appointment(s) were missed, if any? (Select all that apply)	1	Routine medical appointments scheduled on a regular basis
		2	Unanticipated medical appointments for illnesses or injuries
		3	Personal affairs such as financial management
		4	Legal
		5	Meetings with your service coordinator
		6	Other (If "Other" is selected go to q_35)

q_35	Please describe what kinds of appointment(s) were missed:	Enter Text	
q_36	Reasons for missing appointment(s):	1	Transportation
		2	Unavailability of Parking area
		3	Weather Condition
		4	Service Cost
		5	Insurance Type and Coverage
		6	Improved Health Condition
		7	Fear and Anxiety
		8	Childcare
		9	Language Barrier
		10	Oversleeping and forgetfulness
		11	Other (If "Other" is selected go to q_37)
q_37	Other reason for missing appointment(s):	Enter Text	

q_38	How helpful are your direct care worker(s)/employee(s) with Assistance while at appointments:	1	Very Unhelpful
		2	Not Helpful
		3	Neutral
		4	Helpful
		5	Very Helpful
		6	N/A
q_39	How helpful are your direct care worker(s)/employee(s) with Providing your medications:	1	Very Unhelpful
		2	Not Helpful
		3	Neutral
		4	Helpful
		5	Very Helpful
		6	N/A
q_40	Do you take all of your medications?	1	Yes
		2	No
		3	I have no medications (If "I have no medications" is selected go to q_43)
q_41	Do you take your medications at the proper times?	1	Yes
		2	No
q_42	Do your direct care workers know where to find information related to your medications side effects?	1	Yes
		2	No

q_43	How many times did you remain in bed for more than 1 day in the last 6 months (do not include hospitalization)?	0	0 (If "0" is selected go to q_47)
		1	1
		2	2
		3	3
		4	4
		5	5 or More
q_44	Was it your decision to remain in bed?	1	Yes (If "Yes" is selected go to q_45)
		2	No (If "No" is selected go to q_46)
q_45	If Yes, please describe if/how this has affected your health.	Enter Text	
q_46	If No, please describe the circumstances.	Enter Text	
q_47	Are you alone often?	1	Yes (If "Yes" is selected go to q_48)
		2	No (If "No" is selected go to q_50)
q_48	Is this your choice?	1	Yes (If "Yes" is selected go to q_51)
		2	No (If "No" is selected go to q_49)
q_49	Please describe the details if you are alone and it is NOT your choice.	Enter Text	
q_50	Are you never alone but would like to be?	1	Yes
		2	No

q_51	Do you have access to and control of your personal resources, for example, a bank account?	1	Yes
		2	No
q_52	Do you have the opportunity to participate in community activities of your choice such as religious services, movies, and dining out.	1	Yes (If "Yes" is selected go to q_54)
		2	No (If "No" is selected go to q_53)
q_53	If you feel you cannot participate in community activities, what are the activities and why do you feel you cannot participate?	Enter Text	
q_54	If you would like to work, do you have the opportunity to work?	1	Yes - I am working (If " Yes - I am working " is selected go to q_55)
		2	No - I am unable to work (If "No - I am unable to work " is selected go to q_57)
		3	No - I do not want to work (If "No - I do not want to work" is selected go to q_58)
		4	No - but I DO want to work and I am job ready now (If "No - but I DO want to work and I am job ready now" is selected
		5	go to q_57) No - but I DO want to work but I am NOT job ready now (If "No" is selected go to q_57)
q_55	How many hours do you work in a typical work week?	1	10 or less
		2	More than 10 but less than 20
		3	More than 20 but less than 30
		4	More than 30 but less than 40
		5	40 hours or more
		6	N/A

q_56	Is the individual working in a competitive integrated job? PLEASE NOTE: Competitive integrated employment (job) is defined as - earning minimum wage or better and working in a setting where the majority of workers do not have a disability. The individual is paid directly by the employer and not by the service provider. Transitional work or prevocational work, where the individual is paid minimum wage or above minimum wage is not considered competitive integrated employment.	1	Yes
		2	No
q_57	If you would like to work but feel you don't have the opportunity, what are the reasons?	Enter Text	
q_58	Do you get to choose what you do each day in your home and in the community, or does someone else choose for you?	1	I choose (If "I choose" is selected go to q_60)
		2	Someone else chooses for me (If "Someone else chooses for me" is selected go to q_59)
q_59	If someone else chooses, please describe how that occurs.	Enter Text	
q_60	Do you know that you have a choice of service providers?	1	Yes
		2	No
q_61	Are you satisfied with the staff or workers who assist you?	1	Yes
		2	No
q_62	Do the people who assist you respect your preferences concerning your needs?	1	Yes
		2	No

q_63	Do those who assist you know how to help you with your services?	1	Yes
		2	No
q_64	Do you know how to report a concern or complaint?	1	Yes
		2	No (If "No" is selected go to q_65)
q_65	If the answer is No, the Service Coordinator must review how to report a concern or complaint with the participant and ensure it is complete and fully understood by the participant. Describe the specific actions implemented to ensure the information was communicated clearly and effectively to the participant.	Enter Text	
q_66	Do you know how to report abuse, neglect, and exploitation, and what to do?	1	Yes
		2	No (If "No" is selected go to q_67)
q_67	If the answer is No, the Service Coordinator must review how to report abuse, neglect, and exploitation, and what to do with the participant and ensure it is complete and fully understood by the participant. Describe the specific actions implemented to ensure the information was communicated clearly and effectively to the participant.	Enter Text	
q_68	Are there any other topics/concerns you would like to discuss?	1	Yes (If "Yes" is selected go to q_69)
		2	No (If "No" is selected go to q_70)

q_69	Please describe what else you would like to talk about?	Enter Text	
Section 3 - Participant-Directed Model or Agency and Participant-Directed Models			
Question Number	**Question Description**	**Response Number**	**Response Description**
Q_70	Participant receives services through a Participant-Directed Model or Agency and Participant-Directed Models.	1	Yes (If "Yes" is selected go to q_71)
		2	No (If "No" is selected go to q_78)
q_71	How do you verify your direct care worker's timesheets?	Enter Text	
q_72	Do your direct care workers need additional training?	1	Yes (If "Yes" is selected go to q_73)
		2	No (If "No" is selected go to q_74)
q_73	Please identify the area of training needed:	Enter Text	
q_74	Do you need additional training?	1	Yes (If "Yes" is selected go to q_75)
		2	No (If "No" is selected go to q_76)
q_75	Please identify the area of training needed:	Enter Text	

q_76	How do your direct care workers help you with managing your money?	1	No Help is Needed
		2	Pay bills
		3	Family Member Pays Bills
		4	Mail Bills
		5	Take Monies/Checks to the Bank
		6	Budget finances
		7	Purchase Supplies
		8	Other (If "Other" is selected go to q_77)
q_77	Please describe how do your direct care workers help you with managing your money?	Enter Text	

Section 4 - Provider Owned and Operated Residential Settings			
Question Number	**Question Description**	**Response Number**	**Response Description**
q_78	Participant lives in Provider Owned and Operated Residential Setting.	1	Yes (If "Yes" is selected go to q_79)
		2	No (If "No" is selected go to q_104)
q_79	SC enter name of provider:	Enter Text	
q_80	Enter the Participant's Address:	Enter Text	

q_81	Did you have a choice when providers were presented?	1	Yes
		2	No
q_82	Did you have a choice of where your services are provided?	1	Yes (If "Yes" is selected go to q_83)
		2	No (If "No" is selected go to q_85)
q_83	Were your choices adequate?	1	Yes (If "Yes" is selected go to q_85)
		2	No (If "No" is selected go to q_84)
q_84	If no, please describe:	Enter Text	
q_85	Did you have a choice of where you will live?	1	Yes (If "Yes" is selected go to q_86)
		2	No (If "No" is selected go to q_88)
q_86	Were your choices adequate?	1	Yes (If "Yes" is selected go to q_88)
		2	No (If "No" is selected go to q_87)
q_87	If no, please describe:	Enter Text	
q_88	Did you have a choice of a private bedroom?	1	Yes (If "Yes" is selected go to q_90)
		2	No (If "No" is selected go to q_89)
q_89	If no, please explain how your bedroom was determined:	Enter Text	
q_90	Do you have a bedroom roommate?	1	Yes (If "Yes" is selected go to q_91)
		2	No (If "No" is selected go to q_93)

q_91	If yes, were you able to select who you wanted as a bedroom roommate?	1	Yes (If "Yes" is selected go to q_92)
		2	No (If "No" is selected go to q_93)
q_92	Please explain how this was done:	Enter Text	
q_93	Do you have the freedom to lock and/or unlock your bedroom door at any time?	1	Yes
		2	No
q_94	Do others have keys to your home?	1	Yes (If "Yes" is selected go to q_95)
		2	No (If "No" is selected go to q_96)
q_95	If yes, what is their relationship to you?	1	Relative
		2	Non-relative
q_96	Do you have access to food at any time?	1	Yes (If "Yes" is selected go to q_98)
		2	No (If "No" is selected go to q_97)
q_97	If no, please describe when food is available:	Enter Text	
q_98	Are you able to have visitors who you choose at any time?	1	Yes (If "Yes" is selected go to q_100)
		2	No (If "No" is selected go to q_99)

q_99	If no, please explain:	Enter Text	
q_100	Have you been restrained against your will at any time during your living arrangements here?	1	Yes (If "Yes" is selected go to q_101)
		2	No (If "No" is selected go to q_102)
q_101	If yes, how did that happen?	Enter Text	
q_102	Who owns or leases your home?	1	Participant
		2	Family member
		3	HCBS Provider
		4	Other (If "Other" is selected go to q_103)
q_103	If other, please identify who:	Enter Text	

Section 5 - Service Coordinator Observations The following questions are based upon the Service Coordinator's observations and are to be answered by the Service Coordinator only.			
Question Number	**Question Description**	**Response Number**	**Response Description**
q_104	Are any of the following concerns present? (Check all that apply)	1	Bruising
		2	Poor physical appearance
		3	Wounds/pressure sores
		4	Signs of abuse
		5	Malnourishment
		6	Signs of neglect
		7	Dementia/confusion
		8	Lack of family cooperation
		9	Possible fraud/financial mismanagement
		10	Non-compliance with service plan
		11	Depression
		12	Other (If "Other" is selected go to q_105)
		13	None
q_105	Please describe each concern (including severity):	Enter Text	

q_106	Are there any environmental conditions that jeopardize the health and welfare of the participant? (Check all that apply)	1	Lack of food
		2	Cleanliness
		3	Lack of electricity
		4	No phone
		5	No heat/air
		6	Trash accumulation posing fire hazard
		7	No running water
		8	Utility shutoff
		9	Unsafe food handling
		10	Pet problems
		11	Home not accessible to participant/provider
		12	Insect/rodent infestation
		13	Pending eviction or foreclosure
		14	Other (If "Other" is selected go to q_107)
		15	None
q_107	Please describe environmental conditions that jeopardize the health and welfare of the participant:	Enter Text	

q_108	Is necessary adaptive equipment available, in good condition, and being used?	1	Yes
		2	No (If "No" is selected go to q_109)
		3	Participant does not require adaptive equipment.
q_109	If no, please describe why the necessary adaptive equipment is not available, not in good condition, and/or not being used:	Enter Text	
q_110	If any significant concerns were raised in this survey, the SC supervisor must sign off on the completed review tool and mitigation plan. Are there additional actions needed:	1	Yes (If "Yes" is selected go to q_111)
		2	No (If "No" is selected go to q_116)
q_111	Observed significant concerns to address (Select all that apply)	1	Explore additional resources
		2	Increase SC monitoring
		3	Alter type of waiver
		4	Change in services
		5	Change in model of service
		6	File incident report
		7	File APS/PS report
		8	File report to BPI
		9	Change in waiver service provider
		10	Change in quantity of service
		11	Other (If "Other" is selected go to q_112)

q_112	Please describe significant concerns:	Enter Text	
q_113	Are steps to be taken to address the significant concern(s)?	1	Yes (If "Yes" is selected go to q_114)
		2	No (If "No" is selected go to q_115)
q_114	If yes what steps are to be taken:	Enter Text	
q_115	If no steps are to be taken for this participant, explain reasons why no additional action is necessary:	Enter Text	
q_116	Service Coordinator signature:		
q_117	Service Coordinator Supervisor signature required (if per q_110 monitoring tool reflects a significant concern):		
q_118	Enter the end time you finished interviewing the participant for this survey: (Enter in XX:XX AM/PM Standard Time format)		