New Jersey Department of Human Services
Division of Developmental Disabilities

Support Coordinator Monitoring Tool Work Instructions

OVERVIEW

The Support Coordinator Monitoring Tool (MT) is a key document in the delivery of services and supports for Individuals with developmental disabilities. It helps ensure adherence to best practice standards and criteria established by the Centers for Medicare and Medicaid Services (CMS) Home and Community Based Services (HCBS), which emphasize the following:

- opportunities to engage in the life of communities
- respecting Individuals' rights, as well as ensuring safety
- developing and strengthening important relationships
- choice about where to live, work and the services to receive
- choice about personal goals and opportunities to realize those goals

The MT **documents** the **important** work of Support Coordinators. Completing the Monitoring Tool well helps accomplish the following:

- ensures health and safety, and shows whether Individuals' needs are being met
- identifies concerns or problems, which may require follow up or attention
- ensures satisfaction with services as approved in the Individualized Service Plan (ISP)
- ensures the ISP is updated as needed
- satisfies a necessary component for SCA reimbursement

The Division and Support Coordination Agencies (SCAs) are in **partnership** to support Individuals and families. Many Division units rely on MTs for necessary information, including updates related to:

- Justification for additional funding or transition to a different Medicaid waiver program
- Documentation about the history of a problem or concern
- Service concerns / Service Provider concerns
- Medicaid eligibility concerns

Quality documentation is vital to our work!

MINIMUM MONITORING REQUIREMENTS

Monthly monitoring may occur through phone / video contact or in person. Face-to-face monitoring is required by the third month from the date of initial ISP approval and at least every three months thereafter. At least one face-to-face visit each year (often referred to as the annual home visit) must take place in the Individual's home and at least one face-to-face visit to the location in which an Individual regularly receives a particular service for more than 16 hours per week. (See the SP and CCP Policies & Procedures Manuals, section 13.1 for further information.)

Two separate monitoring tools are used to fulfill monitoring requirements:

The Support Coordinator Monitoring Tool – Monthly is used to document monthly monitoring contact. This tool may be used with any Contact Type (Phone / Video Contact, Face-to-Face Visit or Home Visit) but **may not** be used more than two consecutive months.

The Support Coordinator Monitoring Tool – Quarterly is used to document monitoring contact with greater depth and detail than the Monthly tool to ensure best practice and HCBS requirements are met. This tool may be used with any Contact Type (Phone / Video Contact, Face-to-Face Visit or Home Visit) but **must** be used at least once every three months.

Monthly	Quarterly	Annually
• Contact may occur via Phone / Video Contact, Face-to-Face Visit or Home Visit. • The Monthly Monitoring Tool may be completed two consecutive months, but not three consecutive months.	• Every three-month period must include at least one face-to-face contact. • Every three-month period **must** include completion of a Quarterly Monitoring Tool, including contact with providers, if applicable. • Use of the Quarterly Monitoring Tool ***may***, but does not ***need,*** to coincide with face-to-face contact.	• At least once per year, monitoring must occur in person, within the home. • It is Best Practice to use the Quarterly Monitoring Tool during the annual home visit.

ICON UPDATE

When uploading Support Coordinator (SC) Monitoring Tools, the Contact Type icons remain unchanged. iRecord continues to require a face-to-face visit or annual home visit at least every third month. The exception feature allowing phone contact for three (or more) consecutive months needs to be enabled by the SC Supervisor when the Individual is not seen in person. Clear documentation is necessary explaining why the face-to-face requirement was not met. iRecord continues to prompt the Face-to-Face or Home Visit icons until the requirement is met. Compliance issues with face-to-face monitoring requirements require the submission of a Seeking Out Support (SOS) Form. See "Areas Requiring Division Assistance" below for additional information.

An additional field has been added to iRecord following selection of the Contact Type icon. When uploading completed Monitoring Tools, SCs will be prompted to indicate which tool was used, "M" for Monthly, "Q" for Quarterly. Each three-month period must include completion of a Quarterly Monitoring Tool. After any two consecutive months of selecting "M" to indicate use of the Monthly Monitoring Tool, only "Q" will be offered indicating that use of the Quarterly Monitoring is due. iRecord will not offer an exception to this rule.

GENERAL INSTRUCTIONS

The Support Coordinator Monitoring Tool is not meant to be a script read question by question. Rather, it is intended to generate and guide conversation. Through the course of the conversation, Support Coordinators gather information needed to complete the form.

Questions on the monitoring tools do not need to be read word for word. Support Coordinators will become familiar with the forms and may often need to rephrase questions to make them more readily understood by the person they are speaking with and/or to fit the flow of the conversation.

The questions on the MT are to be answered from the Individual's perspective, even if the Individual is not the primary contact. If a caregiver participating in the conversation has a differing perspective, this input should be included. Good conversations build rapport and relationship. Better relationships and partnerships promote better outcomes.

Familiarity with the monitoring tools will result in a more natural flow in conversations.

Answers *without* an asterisk (*)

Answers not marked with an asterisk (*) generally indicate things are going well in that area and the Individual/caregiver is satisfied with services or the status of the current circumstances. Support Coordinators are encouraged to pursue conversation with Individuals and caregivers about things that are going well. This helps Support Coordinators and Individuals/families to get to know each other and enjoy the working relationship. Having a greater understanding of an Individual's strengths and interests will result in better ISPs and Person Centered Planning Tools (PCPTs).

Answers *with* an asterisk (*)

To complete monthly monitoring well, pay careful attention to answers on the forms marked with an asterisk (*). Nearly all Yes/No questions on the forms have an answer marked with an asterisk. These answers may indicate a concern for which further action or follow up is needed. Each answer marked with an asterisk requires additional information in the space for Comments / Follow Up Items.

For answers with an asterisk (*) in particular, Support Coordinators should pursue a conversation asking **open-ended questions** to understand the Individual's perspective regarding a concern, a barrier, a preference, etc.

Open-ended questions

Open-ended questions nearly always begins with one of the following: Who, What, When, Where, Why, How. Open-ended questions are objective and do not lead the person being asked. These questions require a full answer, using the person's own knowledge or feelings. Asking good open-ended questions will give the Support Coordinator a much better understanding about a concern.

Asking open-ended questions may require curiosity, thoughtfulness and creativity. Because each Individual/family is different, follow up questions may also be different in different situations. Having good conversations with open-ended questions contributes greatly to the quality of service and at times may help identify a problem before it becomes an emergency.

Examples:

- **What**'s happening with your services or outcomes that you're not happy with?
- **How** would you like things to be different?
- **What** are your goals for housing in the future?
- **When** did this happen?
- **How** are you feeling now?
- **Who** do you think would be a good person to talk to about that?

Closed-ended questions

Closed-ended questions generally require only a single word answer, often Yes or No. They don't give much information and don't necessarily result in a greater understanding. Depending on the question, the person may simply respond to the strongest word in the question. Be aware that people are often prone to try to answer questions in a way that they believe the interviewer wants to hear.

Examples:

- Were you upset when that happened?
- Are you staying home for the holidays?
- Are you happy with your current homemaker?

Achieve a good understanding

Continue the conversation with thoughtful open-ended questions until there is a good understanding of the concern. Then summarize in the space named "Comment / Follow Up Items" at the end of each section. The explanation may be brief but should provide enough information that a third party reviewer would understand.

Follow Up Items

Discuss and consider carefully what follow up steps may be appropriate and include in the space for Comments / Follow Up Items. (Not every asterisk question will necessarily generate a follow up item.)

Follow up items should state clearly and concisely **who** will do **what** and **when**. Case notes will contain more detail documenting the Support Coordinator's efforts.

Examples of Follow Up Items:

- Support Coordinator will provide information to the Individual/family about day programs in their area by next week.
- The parent will contact the County Board of Social Services to follow up about Medicaid concerns by Friday.
- The SC will update the ISP for changes in Community Based Supports and submit to SCS for approval within 3 days.
- The SC will coordinate an IDT meeting within the next 2 weeks.
- The SC will email the DDD Assessment Requests helpdesk by tomorrow to request a status update about the NJCAT reassessment request.

Note: A critical piece of Support Coordination is recognizing follow up that should occur, then completing and documenting the follow up.

In Summary

Having a good understanding of these three steps, and practicing them, are key to completing this form well.

1. Ask open-ended follow up questions.
2. Understand and explain the concern.
3. Identify follow up items as appropriate.

Tip!

When there is difficulty completing a Monitoring Tool in full:

Use your **judgment**. Use your **resources**.

- If a critical piece of information is missing, especially if related to health/safety, pursue conversation with someone who could help until the need for information is satisfied.
- If your Supervisor, a Division reviewer or a Medicaid auditor would have significant concerns about seeing certain questions unanswered, or answered incompletely, seek follow up conversation with an additional informant.
- If a small amount of information is missing, which is not connected to one's health/safety and does not seem critical, answer to the best of your ability based on the conversation and your understanding, and include explanation in the space for Comments / Follow up Items as needed.
- Consider whether there is someone nearby or easy to contact who could conveniently assist, and if so make the effort to contact others as needed.
- Use a different informant the following month. Including different informants over time reduces risk of the same sections/questions lacking information from month to month.

FORM INSTRUCTIONS

Identifying Information (Section 1, Quarterly MT; Section 1, Monthly MT)

Contact is to be with the Individual, and information gained through completion of the MT is to be from the Individual's perspective. An Individual may choose someone who supports them to elaborate or provide responses for them. Contact with the Individual should be consistent to the degree possible and should **not** be neglected by using other informants for the sake of convenience.

If caregivers participate in monthly monitoring conversations, it is recommended to include different caregivers over time to gain a broader perspective. If an Individual has a Legal Guardian assigned, include them in the rotation of caregiver contact.

If an Individual resides in a provider managed setting and attends a day program, and if staff participate in monitoring conversations, staff involvement should alternate between residential and day program staff.

Specific Entries in Section 1

Who is the primary contact for this Monitoring Tool? If the Individual is not the primary contact for the MT, there should be an effort to include them in the conversation. Space is provided to **describe** their participation or to **explain** why they were not involved.

Contact Type: When contact occurs by Phone / Video Contact, **Contact Location** will be the location of the person with whom the SC is speaking.

Completing a quarterly face-to-face visit or annual home visit ahead of schedule is always permitted. The face-to-face visit and/or annual home visit requirement will reset starting from that month. (A Support Coordinator may always do more than the minimum requirement, but not less.)

Follow Up Items from Previous Months' Contact (Section 2, Quarterly MT; Section 2, Monthly MT)

To complete this section, list each follow up item **not** resolved at the time of last month's monitoring contact. This includes follow up items identified during the previous monitoring contact and also longer term items identified in prior Monitoring Tools, which were not resolved at the time of last month's contact.

Once a follow up item is identified, it should continue to be listed on each following MT until an entry shows it is completed/resolved. After a specific follow up item has been resolved, it does not ***need*** to be included in subsequent Monitoring Tools. Reviewing a series of MTs will show follow up items as they are identified and when they have been completed or resolved.

Specific Entries in Section 2

Follow Up Item: Be brief. State concisely what was identified for follow up.
Completed / Resolved? Check the appropriate box, yes or no.
If Yes, no further information is required here. Including a statement to summarize the resolution is optional.*
If No, briefly state what has occurred so far regarding this action, and describe the next steps.

*Information in Section 2 is not meant to duplicate case notes, but rather to simply list follow up items and the status. Ensure case notes contain complete documentation showing your efforts.

Examples of Follow Up Items

Example 1

April Comments / Follow Up Items	**May**, Section 2
John's behavioral incidents seem to be getting more frequent and more intense in recent months. The SC and Parent agree that an IDT meeting is needed. SC will schedule IDT in next two weeks.	Follow Up Item: SC scheduled an IDT meeting. Completed/Resolved? Yes☐ No☐

- Case note entries will show details about the IDT meeting being scheduled and held. Case notes may summarize the outcome. IDT notes should be uploaded in iRecord.

Example 2

June Comments / Follow Up Items	**July,** Section 2	**August,** Section 2	**September,** Section 2
Dante and his parents/guardians are interested in a new residential placement. SC to complete the Residential Referral Coversheet and begin making referrals.	Follow Up Item: SC is following up on residential referrals. Completed/Resolved? Yes☐ No☒ If no, briefly describe the status **and** planned action: SC has made multiple residential referrals. Two Meet and Greet meetings are scheduled. SC will continue follow up.	Follow Up Item: SC is following up on residential referrals. Completed/Resolved? Yes☐ No☒ If no, briefly describe the status **and** planned action: Meet and Greet with "Preferred Provider" went well. Pre-Placement meeting will be scheduled.	Follow Up Item: SC completed follow up on residential referrals. Residential placement has been identified. Completed/Resolved? Yes☒ No☐

- Case note entries will reflect the following:
  - dates and details about each residential referral
  - details about SC's follow up efforts and scheduling Meet and Greet meetings
  - details about outcomes of Meet and Greet meetings, pre-placement meeting and all efforts related to coordinating residential placement

Community Connections (Section 3, Quarterly MT)

Have a conversation about what the Individual has been doing in the community recently, who they've been doing things with, if they enjoy the activities or not, and if they decide, or help decide, activities they do and who with.

Example, Question *b.* **Do you like the things you are currently doing in the community?**

If the answer to this question is "No":

1. Ask open-ended questions such as: "**What** would you rather be doing?" "**How** are activities determined?" "**Who** decides who you do activities with?" "**What** do you think we can do about that?
2. Achieve a good understanding of the concern.
3. Discuss and consider how preferred activities might be arranged. Look for opportunities to help Individuals advocate for themselves, or for you to advocate for them. A likely follow up item would be to assist the Individual to express their preferences to a caregiver.

Example Continued:

Document in the space for comments and follow up items.

If the answer to this question is "Yes", pursue further conversation by asking the Individual/caregiver to elaborate on what is going well, what they are interested in or excited about. Discussions like this can lead to a new service, taking a class or employment opportunities.

Relationships (Section 4, Quarterly MT)

Discuss how the Individual is staying in touch with people who are important to them. Pay particular attention to how the Individual's social circle expands beyond the people they live with. Quarterly monitoring should help ensure the Individual is maintaining relationships and staying in touch with people important to them.

If the Individual is interested in opportunities to make new friends, explore with them what they may be interested in doing to improve their opportunities for developing friendships.

Example, Question *b.* **Are you able to have visitors when you want?**

If the answer to this question is "No":

1. Ask open-ended questions such as: "**Who** are the visitors you would like to have over? **When** would you like to have them over? **Why** doesn't it work to have visitors at these times?" "**When *are*** you able to visit with this person/these people?"
2. Once you understand the concerns, you may be able to help the Individual problem-solve or advocate for themselves. There may be a compromise solution.
3. Follow up items may include discussion with a parent or group home manager to explore available options. Follow up might be completed by you or someone else, like the Individual.

Document in the space for comments and follow up items.

Personal Rights and Autonomy (Section 5, Quarterly MT)

Questions in this section are a small sampling of potential questions pertaining to rights, respect, autonomy and opportunity for choice and decision making. If the Individual expresses concerns, ask open-ended questions to understand the issues.

Important! During discussion listen carefully and consider whether any information disclosed by the Individual may qualify as an allegation of abuse, neglect, exploitation, or another type of incident requiring completion of an Incident Report (IR) according to Division standards.

Ask clarifying questions to make sure you understand any concerns, but **do not investigate** by pursuing interviews with other parties. Doing so can taint a potential investigation. If/when uncertain about how to proceed, review with your SCS and do not hesitate to reach out to the Division with questions.

Feeling respected is abstract and it may be difficult for some Individuals to comment on whether they feel respected or whether they feel their personal space is respected. As needed, rephrase to ask if the Individual feels like people are nice to them and do a good job supporting/helping them. It might be appropriate to ask if the Individual feels like people listen to them and take them seriously when they express thoughts, feelings, preferences, etc.

Example, Question a: **Do you have access to your own money, and are you able to spend it on things you like?**

If the answer to this question is "No":

1. Ask follow up questions such as: "**Who** has your spending money?" "**How** do you normally get your spending money?" "**What** are the arrangements with your money?"
2. Get a good understanding of the situation and the concern, to help determine next steps.
3. a. If the Individual alleges their money is being misused by someone else, an Incident Report (IR) for exploitation would likely be needed. The Support Coordinator would explain in the space for comments and identify a follow up item to complete an Incident Report (IR).
   b. If an IDT has convened in the past and an arrangement is in place about how and when an Individual receives their spending money, consider whether the Individual may need assistance to discuss with a caregiver or staff person, or whether further the IDT needs to revisit the issue.
   c. If arrangements about the Individual's money are well established and no follow up actions are needed, explain in the space for comments.

Continuity and Stability with Living Arrangement (Section 6, Quarterly MT; Section 4, Monthly MT)

This section monitors the Individual's stability and satisfaction with the current living arrangement and conditions. Ask open-ended questions to explore and understand any concerns. Make sure to understand whether the Individual, family or legal guardian is requesting assistance with something and explain on the Monitoring Tool. If there are concerns, discuss whether an IDT meeting may be appropriate.

The Monthly MT also asks about Incident Reports in this section, which may be an indicator of stability in general.

Example Question about housing: **Do you like where you live?**

If the answer to this question is "No":

1. Ask open-ended questions such as: "**What** is it about your current housing you don't like?" "**How** would you like it to be different?" "**What** are your goals for housing in the future?"
2. Achieve a good understanding of the concern. Depending on what the Individual describes, the conversation could go in various directions. The Individual might describe concerns that require completion of an Incident Report and/or should be addressed immediately. Other concerns may be appropriately addressed by convening an IDT meeting. The Individual might be requesting a transfer from one residential program to another. (This requires involvement from the legal guardian if one has been appointed). The Individual might be interested in a long-term goal of moving to their own apartment.
3. In the space for Comments and Follow Up Items explain the concern and state the follow up items. In this example, follow up items might include any of the following:
   - Convene an IDT meeting
   - Request addition to the Waiting List for CCP services
   - Complete a Residential Transfer Coversheet

Employment and Day Services (Section 7, Quarterly MT)

This section monitors the Individual's satisfaction with how they spend their weekdays. Listen to ensure the Individual enjoys what they are doing during the day, and whether adjustments or changes are needed. If there are concerns, discuss whether an IDT may be needed.

Example, Question b. **Do you like what you do during the day?**

If the answer to this question is "No":

1. Ask open-ended questions such as, "Could you tell me more about **what** you do there?" "**How** long have you been doing this job/attending this program? "**What** is it that you don't like about what you are doing?" "Could you describe **what** you would rather be doing?"
2. Make sure you understand the Individual's concern and preferences.
3. Ensure the Individual/Legal Guardian is aware of service options and discuss whether they are requesting information about other services. Consider whether an IDT is needed to address a concern at a job or day program. Consider whether referrals are needed to a vocational rehabilitation agency (DVRS/CBVI) or to different service providers.

Document in the space for comments and follow up items.

Outcomes and Services (Section 8, Quarterly MT; Section 3, Monthly MT)

Outcomes should reflect what an Individual wants for their life and should be connected to the Hopes and Dreams section of the Person Centered Planning Tool (PCPT). **Services** should make sense in the way they support the outcomes under which they are entered in the ISP.

This section helps ensure that outcomes remain relevant and that services support the outcomes. This section helps assess satisfaction with services and prompts discussion about potential changes and new opportunities.

Example, Question b: **Are you receiving all services as entered in the ISP?**

If the answer to this question is "No":

1. Ask questions such as "**What** service(s) is not being received as expected according to the ISP?" "**Why** not?" Or, "**What** is the problem with that service at this time?" "**How** long has it been like this?" "**What** would you like to be different?"
2. Make sure you understand the circumstances and/or barriers and the Individual's preferences.
3. Follow Up Items may include the following:
   - Contact the Service Provider to discuss concerns and/or clarify expectations.
   - It may be appropriate to discontinue the service in the ISP if the Individual/Legal Guardian are no longer interested in the service.
   - If the Individual/Legal Guardian are interested in the service, a new provider may need to be sought.

Document in the space for comments and follow up items.

Tip!
Pay particular attention to question *e*. regarding the rate of budget expenditure. If the answer to this question is "No," further discussion is needed with the Individual/Planning Team. If an Individual's budget is fully used or allocated before the end of the ISP plan term, there may be no remedy. Once an Individual's budget is exhausted, they may be without Division funded supports until the start of the next plan term. Situations like this require case by case consideration.

If you are aware that an Individual's budget will not fund services as needed throughout the **entire** plan term, use the SOS process to proactively reach out to DDD for awareness and assistance.

Health and Safety (Section 9, Quarterly MT; Section 5, Monthly MT)

When completing quarterly monitoring with someone in a DDD funded, provider-managed residential or day program setting, speak with provider staff to complete questions *a.* through *j.* in this section. Be sure to note the staff member's title along with their name in the space provided. When completing quarterly monitoring with someone in a setting **other than** a DDD funded, provider managed setting, complete only questions *f.* through *l.* with the Individual/caregiver.

Annual Medical/Dental: For Individuals living in DDD licensed settings and/or attending a DDD day program, documentation of an annual physical **and** dental checkup is required. Enter the appropriate dates on the Quarterly/Annual MT for questions *a.* and *b.* If either/both dates are not current within the past year, include additional information in the space for Comments / Follow Up Items stating how updated medical/dental checkup(s) will occur.

For Individuals living in a non-provider managed setting (Aka "own home") and not attending a DDD day program, annual medical/dental checkups are not required. However, both are encouraged. Offer a reminder of the importance of routine/preventative medical/dental/specialist appointments and check the appropriate box on the Quarterly/Annual MT for question *k.*

Example, Question d: **Are there any restrictions in this setting affecting the rights of this Individual <u>not</u> supported by a specific assessed need and justified in the ISP? (For example: Access to sharp objects, food, common areas of the home, computer/internet; alarms on doors/windows, privacy locks, etc.)** (Be aware that if an Individual in a provider-managed setting has an approved restriction, it may potentially also impact the rights of others in that setting.)

If the answer to this question is "Yes":

Ask open-ended questions to achieve a good understanding of the restriction and how it may impact the Individual who does not have a need for the restriction. The Support Coordinator should understand the Individual's level of awareness about the restriction and how it is handled in that setting. For example, if a setting has restricted access to food because direct access to food may be unsafe for a housemate, ask questions about the Individual's awareness of the restriction being for someone else's safety. Ask about their awareness that they may ask staff for food at any time and whether they are comfortable doing so.

Consider whether discussion is needed with the planning team to ensure accommodations are in place respecting the Individual's rights. Document in the space for comments and follow up items.

Medicaid Status (Section 10, Quarterly MT; Section 6 Monthly MT)

As Medicaid eligibility is required for DDD services, if there is a problem or a question about Medicaid eligibility, reach out for assistance promptly, either to the DDD SCHelpdesk or the DDD Medicaid Eligibility Helpdesk .

If you are not sure who the representative payee is, make a note of this in the space for Comments / Follow Up Items and include a follow up item to find out.

Closing Question for the Individual/Caregiver (Section 11, Quarterly MT; Section 8, Monthly MT)

The final question asks, "Is there anything else you would like me to know right now, or anything else you need assistance with?

Tip!

- Be careful not to rush through this question.
- Occasionally, critical information may be disclosed here.
- This space may also be used to document any other topics of discussion, not included elsewhere on the form, such as ABLE accounts, burial planning, etc. Additional information learned here may need to be recorded in case notes or the ISP.

To be Answered by the Support Coordinator (Section 12, Quarterly MT)

The Support Coordinator completes this section based on the monitoring conversation that has taken place, information from other sources and their knowledge of the Individual and their situation. These questions do not need to be asked directly or discussed specifically during the monthly monitoring conversation, though it may be appropriate to do so. The Support Coordinator will use their judgement about when and how to weave these topics/questions into the discussion.

Tip! about Incident Reports (IRs)

Incident Reports can reveal important information about a person's physical health, mental health and/or circumstances in their environment. Being aware of incidents should prompt questions about appropriate follow up. For example: If an Individual has been hospitalized the SC will want to follow up to ensure the Individual is okay, and to see if any changes are needed in the ISP. If there is an increase or a pattern of IRs, an IDT may be needed.

Areas Requiring Division Assistance (Section 13, Quarterly MT; Section 7, Monthly MT)

After two consecutive months of phone contact, iRecord will only offer the Face-to-Face and Home Visit icons indicating face-to-face contact is due. If phone contact is the only possible way to make contact in the third month, iRecord allows for an icon exception so that the phone icon can be selected. (An asterisk [*] will appear to indicate the minimum monitoring requirement was not met.) If phone contact is the only possible way to complete monthly monitoring in a **fourth** consecutive month, complete an SOS form so the Division can determine how to assist.

Throughout the conversation listen for risk factors that may require Division assistance. Examples of risk factors include significant changes in support needs, behavioral/medical concerns, housing instability, long-term hospitalization, nursing home admission, etc.

Complete an SOS Form, upload in iRecord and notify the DDD SCHelpdesk. The SOS Form is used not only to report urgent situations or to request assistance, but also to troubleshoot involved situations.

If an SOS Form has already been completed for a situation, simply make a note of it in the space for comments and follow up items on the form. Do not complete more than one SOS Form for the same situation.

Contact Summary (Section 14, Quarterly MT; Section 9, Monthly MT)

The entry in this section should give a "flavor" of the Individual's past month and reflect the tone of the conversation. This section should record things like impressions about the Individual's mood, appearance and interactions, as well as observations about the environment. Summarize points of interest from the conversation, i.e., what the Individual is excited about or upset about, things they are interested in or feeling proud of, discussion about activities, travel plans, holiday plans, important relationships, etc. The entry does not need to repeat or summarize information already included on the MT, such as routine comments about Medicaid status, which is already noted on the form.

The Contact Summary section is a good place to record points to revisit in the future. For example, the Individual may say they are interested in exploring different opportunities for spending more time outdoors next summer, or they may say they would like to discuss different job or day habilitation options in a few months.

It is good practice to begin the contact summary by stating whom you spoke with and how the meeting took place, even though this information is noted in Section 1.

Completed by (Section 15, Quarterly MT; Section 10, Monthly MT)

This form should be consistently completed by the SC assigned in iRecord. Occasionally, due to illness, scheduling conflicts, etc. someone other than the SC might complete the MT. However, this should be the exception. If someone other than the assigned SC completes the MT, a brief explanation is needed in the space provided.

Reviewed by (Section 16, Quarterly MT; Section 11, Monthly MT)

According to the CCP and SP Policies and Procedures Manuals, SCS review is required for the first 60 days of any new Support Coordinator, when performance issues have been identified and for complicated or difficult situations.