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| **Client Name** |  | **Medicaid ID** |  | **Waiver/Program** |  |
| **Current CM** |  | **CM during Cert Period being reviewed** | |  | QIS assigned to: |

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| **ULTC Assessment (100.2)** | **Event #** |  | **LTC Certification Span Start Date** | | |  | **LTC End Date** |  | |
| **Conducted in the client residence?** | | | Yes / No | | **Was the client present?** | | Yes / No | |
| **ADLs** | | **Score** | **Comments Justify Score** | **Needs Identified** | | | **Contains HOW info obtained** | **Need addressed in SP?** |
| Bathing | |  |  |  | | |  |  |
| Dressing | |  |  |  | | |  |  |
| Toileting | |  |  |  | | |  |  |
| Mobility | |  |  |  | | |  |  |
| Transfers | |  |  |  | | |  |  |
| Eating | |  |  |  | | |  |  |
| Sup. Behavioral | |  |  |  | | |  |  |
| Sup. Memory | |  |  |  | | |  |  |
| Mental Health Diagnosis: | | | | | | | |  |

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| **Service Plan** | **Service Plan**  **Event #** |  | **Guardian Identified** | Yes / No | **Name of Guardian** | |  |
| **Natural Supports** | Yes / No | | **Third Party Resources** | | Yes / No | |
| **State Plan Benefits** | Yes / No | | **Home Health Benefits** | | Yes / No | |
| **Service Goals:**  Individual services include service goals that are individualized and commensurate with ULTC Assessment | | |  | | | |
| **Client’s personal goal:**  Individualized and completed? | | |  | | | |
| **Contingency plan:**  Individualized and addresses client’s health and welfare when services are not available? | | |  | | | |

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| **Service Plan Revisions** | **Event #** | **Revisions are justified by client record** | **Service Goals include documentation to justify the need for a revision** | **Delivered to client/guardian** | **Signed by correct legal party** |
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| **Log Notes** | **Indicates SP revisions needed?** |  | **All SP revisions in the BUS/Bridge?** |  |
| **Indicates Critical Incidents occurred?** |  | **All Critical Incidents completed in the database?** |  |