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| **DESIGNATED COORDINATOR REVIEW** | | |
| Name: Program site:    Date of review:    Name of the Designated Coordinator completing the review:  \*If the responsibilities of the Designated Coordinator (DC) and the Designated Manager (DM) are fulfilled by the same person in the company, both this form and the *Designated Manager Review* form may be completed by that person. If the responsibilities of both positions are filled by different persons in the company, each position will complete the applicable review form. | | |
| The Designated Coordinator is responsible for the delivery and evaluation of services provided by the license holder including the provision of supervision, support, and evaluation of activities that include:   * Oversight of the license holder’s responsibilities assigned in each person’s *Support Plan* and *Support Plan Addendum*. * Taking the action necessary to facilitate the accomplishment of the outcomes according to 245D.07. * Instruction and assistance to staff implementing the *Support Plan* and service outcomes, including direct observation of service delivery sufficient to assess staff competency (the DC may delegate the direct observation and competency assessment of service delivery activities of direct support staff to an individual whom the DC has previously deemed competent in those activities). * Evaluation of the effectiveness of service delivery, methodologies, and progress on each person’s outcomes based on the measurable and observable criteria for identifying when the desired outcome has been achieved according to 245D.07 | | |
| **Review area** | **Evaluation** | **Write correction action plan and recheck date, if necessary** |
| The *Support Plan* | *Support Plan* date:  Is the *Support Plan* consistent with the *Support Plan Addendum*?  Yes  No  If no, indicate what is not consistent:  Are health needs being met as assigned in the *Support Plan or Support Plan Addendum*?  Yes  No  Is any staff training/qualifications determined necessary in addition *Support Plan or Support Plan Addendum* requirements?  Yes  No  If yes, indicate what training or qualifications are necessary:  Service responsibilities assigned to the license holder are being met and staff are implementing the plan.  Yes  No  If no, indicate what is not being met: |  |
| *Support Plan Addendum* | *Support Plan Addendum* date:  Information contained in the *Support Plan Addendum* is accurate in all required areas for the person served:  Yes  No  If no, indicate what information needs to be corrected: |  |
| *Service Outcomes and Supports* and *Behavioral Outcome* | Service outcomes are consistent with the *Support Plan Addendum*.  Yes  No  Current outcome statements include measurable and observable criteria for outcome achievement.  Yes  No |  |
| Direct observation of service delivery and staff implementation of service outcomes and supports | Service outcomes observed during this review:  1.  2.  3.  Staff observed implementing the service outcomes:  1.  2.  Note any concern with staff implementation of the service outcomes:    Name of person who did the direct observation:  Based upon this direct observation, staff are deemed to be competent to perform their job functions and service delivery.  Yes  No |  |
| Progress towards accomplishment of service outcomes and progress reports and service plan review meetings | Data is being collected accurately for each service outcome to indicate level of progress.  Yes  No  Is progress being made towards accomplishment of service outcomes?  Yes  No  Progress report contains information on the person’s status and summary data, recommendations, and rationale for each service outcome.  Yes  No  Date of most recent team meeting:  Service plan review meetings frequency completed as specified in the *Support Plan*.  Yes  No Frequency:    *Progress Report and Recommendations* frequency completed as specified in the *Support Plan*.  Yes  No Frequency: |  |
| Assessments | The *Individual Abuse Prevention Plan* is current and accurately reflects the person’s vulnerabilities.  Yes  No Date of assessment:  *Program Abuse Prevention Plan* date:  The *Self-Management Assessment* is current, descriptive of the person’s overall strengths, functional skills and abilities, behaviors or symptoms, and accurately reflects the person’s ability to self-manage.  Yes  No Date of assessment: |  |
| Positive support strategies and person-centered principles:  9544.0030 | Have positive support strategies and person-centered principles been incorporated in writing into the person’s treatment, service or individual plans?  Yes  No If not, what is being done to address this:  Was an evaluation done with the person regarding their positive support strategies and person-centered principles?  Yes  No  \*Refer to 9544.0030, subpart 2 for positive support strategies and their standards.  Upon this evaluation, are changes needed to positive support strategies or to enhance person-centeredness for the person?  Yes  No If yes, what is being done to address this:  Date of review (completed every 6 months): |  |
| Service recipient record | All information and documentation related to service provision for this person is being maintained accurately and as directed by the *Policy and Procedure on Data Privacy*.  Yes  No  All documentation has been filed according to the *Service Recipient Record Index.*  Yes  No |  |
| Indicate any additional areas to be addressed through this review. | | |