Utah Department of Health & Human Services

UTAH DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF INTEGRATED HEALTHCARE
NEW CHOICES WAIVER PROGRAM

SELF-ADMINISTERED SERVICES
HEALTH AND SAFETY CHECKLIST

This checklist is to be completed at least quarterly during a face-to-face visit and should be saved to the participant's case management file.

Participant Name: _____ Designee/Representative: _____

Date of Visit: _____ CM/RN Conducting Visit: _____

LEVEL OF CARE

Has the participant experience a substantial change in health status in the past 90 days?

☐ Yes (please describe):

☐ No

Has the level of assistance required for ADLs changed within the past 90 days?

☐ Yes (please describe):

☐ No

Has the participant experienced new or change in disorientation to person, place and/or time in the past 90 days?

☐ Yes (please describe):

☐ No

Has the participant received any new medical diagnosis(es) in the past 90 days?

☐ Yes (please describe):

☐ No

EMOTIONAL WELLBEING

Using a standardized assessment, determine if the participant could benefit from support to improve emotional wellbeing. The Case Manager should discuss previous interventions and/or referrals and any impact that they had on the participant's wellbeing.

Previous Assessment:
Score: _____ Date: _____
Interventions/Referrals:

Discussion:

New Assessment:
Score: _____ Date: _____
Interventions/Referrals:

Discussion:

ENVIRONMENTAL RISKS

Examine/review the following to ensure in good working condition and/or possible risks

Smoke Detector: ☐ Working ☐ Not Working/Replaced ☐ N/A
Carbon Monoxide Detector: ☐ Working ☐ Not Working/Replaced ☐ N/A
Clutter in Living Areas Creating Fall Risk: ☐ N/A ☐ Intervention Planned
Mold (kitchen, laundry or bathroom): ☐ N/A ☐ Intervention Planned
Fire Extinguisher: ☐ Working ☐ Not Working/Replaced ☐ N/A
Medications Stored Appropriately: ☐ Yes ☐ No ☐ N/A
Escape Safety Plan: ☐ Yes ☐ No ☐ N/A
Flammable Objects Away from Stove: ☐ Yes ☐ No ☐ N/A
Other: _____

CRITICAL INCIDENTS

Did any critical incidents occur in the past 90 days?

☐ Yes (please describe):

☐ No

If yes, were incidents reported to NCW?

☐ Yes

☐ No (please explain):

Were appropriate safety measures or other interventions successfully implemented?

☐ Yes (please describe):

☐ No

SERVICES AND EMPLOYEES

Services

Were services provided in accordance with the current care plan (past 90 days)

☐ Yes

☐ No (please explain):

Are changes to the current care plan needed?

☐ Yes (please describe):

☐ No

Employees

Does the employee adhere to the agreed upon scheduled? ☐ Yes ☐ No

Does the employee treat you with respect and dignity? ☐ Yes ☐ No

Does the employee communicate changes to schedule in a timely manner? ☐ Yes ☐ No

Are there any concerns with the employee? ☐ Yes ☐ No

Additional comments: _____

_____

COMMUNITY ACCESS

Was participant able to access the community as described in the PCCP (past 90 days)?

☐ Yes

☐ No (please explain):

BACKUP PLAN

Was the backup plan reviewed with the participant/designee and changes made to the PCCP as needed?

☐ Yes

☐ No (please explain):