UTAH DEPARTMENT OF HEALTH
DIVISION OF MEDICAID & HEALTH FINANCING
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

Determine if the participant could benefit from support to improve emotional wellbeing. Recommended assessments include: PHQ-9, Geriatric Depression Scale (short form) and Section E of MDS. The Case Manager should discuss previous interventions and/or referrals and any impact that they had on the participant's wellbeing.

Previous Assessment
Outcome: ________________ 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 Plan: ☐Yes ☐No ☐ N/A
Flammable Objects Away from Stove: ☐Yes ☐No ☐ N/A
Home is Cooled/Heated Appropriately: ☐Yes ☐No ☐ N/A
Flooring is Free from Fall/Trip Hazards:☐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

Any 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 as needed?

☐Yes

☐No (please explain)