Kansas
Department of Aging and Disability Services

Shared Living Home Visit Review Tool

Obtain completed REQUEST FOR SHARED LIVING form & information from residential licensed provider prior to home visit.

Section I: Participant Information

Consumer Name _____

Guardian Name _____ Phone: _____

Section 2: Provider Information

Shared Living Contractor Name: _____ Phone: _____

Residential Licensed Provider (RLP): _____

Provider Contact Name: _____ Phone: _____

Section 3: Residential Provider Information – use REQUEST FOR SHARED LIVING form

Residential Provider Shared Living Policy		Y ☐	N ☐
Provider's Shared Living Plan meets KDADS policies/requirements?		Y ☐	N ☐
Residential Provider Organizational Chart		Y ☐	N ☐
Shared Living Contractor (SLC) Application		Y ☐	N ☐
SLC background checks		Y ☐	N ☐
SLC Training (CPR/1st Aid, R&R, ANE, Med. Admin)		Y ☐	N ☐
SLC proof of insurance – home and auto		Y ☐	N ☐
RLP and SLC agreement		Y ☐	N ☐
Pool Safety Plan (if applicable)	N/A ☐	Y ☐	N ☐
Gun Safety Plan (if applicable)	N/A ☐	Y ☐	N ☐
Pet Immunizations (if applicable)	N/A ☐	Y ☐	N ☐
Shared Living Personal Preference Agreement between SLC and each consumer		Y ☐	N ☐
Written lease agreement with tenant/landlord protections		Y ☐	N ☐
Choice documentation		Y ☐	N ☐
Person Centered Support Plan: ____/____/_____	PCSP Reviewed?	Y ☐	N ☐
MCO Integrated Service Plan: ____/____/_____	ISP Reviewed?	Y ☐	N ☐
Behavior Management Plan: ____/____/_____	BMP Reviewed?	Y ☐	N ☐
Behavior Management Committee / HRC reviewed BMP? ____/____/_____		Y ☐	N ☐
BASIS ____/____/_____		Y ☐	N ☐
Risk Assessment	N/A ☐	Y ☐	N ☐
Backup Plan		Y ☐	N ☐
Protocol to address provider compliance 65-1124 (Nurse Practice Act)		Y ☐	N ☐

Section 4: Home Visit Information

Date of Home Visit: _____/_____/_____

Reason for Home Visit Tool:

☐ New Shared Living Arrangement (Complete Shared Living Notice of Compliance following review)

☐ Sample or scheduled visit ☐ Unscheduled visit

☐ Change in residency **Date of Move: _____/_____/_____**

☐ Reportable Event Follow-up **Date of reportable event: _____/_____/_____**

☐ Other: _____

Is the consumer present at the time of the home visit? ❑ No ❑ Yes

If consumer not present at visit, Date of contact by QMS: ___/___/____

Record Review: skip this section on Initial visit to Shared Living homes not yet providing services.

Progress notes/behavior data? Y ☐ N ☐

Informed Consent current? N/A ☐ Y ☐ N ☐

Critical Incident/AIR Report: ____/____/____ ____/____/_____AIR Reviewed? N/A ☐ Y ☐ N ☐

Other: ____/____/____ ____/____/_____ Y ☐ N ☐

Consent for Emergency Medical treatment? Y ☐ N ☐

Release of Information? Y ☐ N ☐

Health Profile: skip this section on Initial visit to Shared living homes not yet providing services.

Medication Regimen

☐ Consumer has no prescribed medication ☐ Consumer does not take medication

☐ Consumer is prescribed medication ☐ Consumer has OTC/PRN Medication

Medication tracking sheets (MAR), Medication Error Reports? Y ☐ N ☐

Health Profile to include health status, special medical and health conditions, medication list? Y ☐ N ☐ 30-63-29(4)(A-C)

Doctor's visits on file? Y ☐ N ☐ Date of Physical/Visit(s)? ____/____/____ ____/____/____

Dental visits on file? Y ☐ N ☐ Date of Dental Visit(s)? ____/____/____ ____/____/____

Comments:

Section 4: Review of Minimum Assurances

Who Lives in the Home?	Relationship to Consumer	Age	Cleared Background Checks	HCBS
Name:	Consumer			X
Name:				
Name:				
Name:				
Name:				
Name:				
Informal Supports/Respite Supports				
Name:				
Name:				

Section 5:

Following home visit, are there any issues, concerns or needs that warrant additional follow-up?
Y ☐ N ☐
Please specify in the table below:

Issue Concern	Action	Responsible Person

Supervisory Comments:

❑ **Attach Residential Services Visit Checklist**

❑ **Complete <u>Shared Living Notice of Compliance</u> on New Shared Living Request**

A copy of this review has been received by: (Check all that apply)

❑ *Supervisor* ❑ Targeted *Case Manager* ❑ Administrative Agency
❑ Home Provider

_____ _____/_____/_____
Reviewer's Supervisor Signature Date of Supervisory Review