Wyoming Department of Health

Case Management Monthly Review Form

Participant's Name: _____ Plan Start Date: _____ Month/Year of Service: _____

DOCUMENTATION OF BILLABLE SERVICES

Case Managers must have two (2) hours of documented service each month to bill for case management, which includes a required monthly home visit with the participant present. Please check the type of service provided, the time in and out of service, and provide a summary of your activities for each category checked. Case management notes should be detailed and specific each month. Use these discussions and notes for planning services and changing the plan as needed.

Date	Time Start/ Time Stop	Total Time in minutes	Type of Service
__/__/___	_____ am/pm _____ am/pm		☐ Home Visit (Required)

Home Visit: *Describe the overall condition of the participant, including any health concerns noted on the day of the home visit; the general condition of the home environment and the participant's bedroom; and summarize your discussion and concerns noted on the day of the home visit. Use additional boxes, if needed. Use the discussion topics in the next section to capture notes on those items.*

_____

_____

_____

_____

__/__/___	_____ am/pm _____ am/pm		☐ Plan Development ☐ Monitoring/Follow up ☐ Service Observation ☐ Team Meetings ☐ Participant Specific Training ☐ Face to face meeting with participants, guardian, family ☐ Advocacy and Referral ☐ Crisis Intervention ☐ Coordination of Natural Supports

Service Summary:

_____

_____

_____

_____

__/__/___	_____ am/pm _____ am/pm		☐ Plan Development ☐ Monitoring/Follow up ☐ Service Observation ☐ Team Meetings ☐ Participant Specific Training ☐ Face to face meeting with participants, guardian, family ☐ Advocacy and Referral ☐ Crisis Intervention ☐ Coordination of Natural Supports

Service Summary:

_____

_____

_____

_____

__/__/___	_____ am/pm _____ am/pm		☐ Plan Development ☐ Monitoring/Follow up ☐ Service Observation ☐ Team Meetings ☐ Participant Specific Training ☐ Face to face meeting with participants, guardian, family ☐ Advocacy and Referral ☐Crisis Intervention ☐ Coordination of Natural Supports

Service Summary:

_____

_____

_____

_____

Total Minutes (Must total at least 120 minutes) **NOTE: Please print extra copies of this form as needed to document your service time for the month.**	

Follow up completed from prior month(s):	Resolution notes:

DISCUSSION TOPICS

The home visit is required to ensure you, as the case manager, are receiving feedback and input from the participant and/or guardian regarding the delivery and satisfaction of waiver services as they fit into the other activities of their life. The discussion topics and suggested questions below shall be asked in a conversational format as you build and maintain your relationship with the participant or guardian, but can be asked in different settings other than the home visit.

You may need to explain the topic a few ways and provide information on the topic in a printed format, so the person understands what you mean. Some of the questions may not be directly related to waiver services or to all ages of participants, but it will help the person's team and Division understand how the waiver is helping the person to have an active, healthy, involved life in the community. You will use this information in the quarterly report you submit to the Division online in the EMWS. If a question isn't applicable to the person, just skip it.

Community Involvement What did you do with providers in the community the past month? About how often? Did you go out with providers as often as you wanted?	**LEISURE**: ☐ restaurant ☐ vacation ☐park ☐ movie ☐mall **CHURCH/CULTURAL EVENT**: ☐ church ☐ cultural event **ERRANDS**: ☐ bank ☐ store ☐ pay bills ☐ Other: _____ ☐ Yes ☐ No Notes:
Desired Accomplishments Are you working on things (i.e. objectives, skills) with your providers that support your desired accomplishments for the year?	☐ Yes ☐ No Notes:

Health/Medical Have there been changes in your health? Any new medications changes or new medical needs? Also, ask about PRN medication usage, if applicable.	☐ Yes ☐ No Notes:
Provider Satisfaction & Concerns Are you having any issues with providers or staff who work with you or other people around you? How are things going?	☐ Yes ☐ No Notes:
Friendships/Social Interactions Ask about friendships. Are you talking to your friends, able to hang out with them, need help making some, etc.?	Notes:
School Attendance & Satisfaction *For school age persons:* How is school going? Any extended absences or barriers to school involvement?	_____ # of Absences this month ☐ N/A ☐ Summer Vacation Notes:
Self-Determination quarterly topic Are you making your own choices, choosing places to go? Are people listening to you? Ask about interest in self-directing some of their waiver services. *Or, if they are self-directing,* how satisfied are they with that service?	Notes:
Employment quarterly topic Do you want to look for a job? Or if working, how is your job going? Is it a job you like to do? Any issues? Do you want to look for a different job or doing something else at work?	Notes:

SERVICE OBSERVATION AND OBJECTIVE PROGRESS

Objective progress shall be submitted to you monthly by the provider. You need to observe the person in their habilitation services each quarter, and other direct care services every six (6) months, to see if the services and support levels are being provided as specified in the plan of care and see if the person is receiving the appropriate services based upon their needs and preferences. You should also try to observe objectives being practiced by the provider and participant.

Service Name	**Training Objective**	**Quantify** monthly progress on objectives	**Observation Notes**	**Support Level** provided during visit	**List any action or IPC changes needed**
				:	
				:	
				:	
				:	
				:	

BILLING DOCUMENTATION – Monthly Review from Prior Month

Units should be checked on the Electronic Medicaid Waiver System each month. Providers are required to submit copies of service documentation to the case manager by the 10th business day of the following month, and billing documentation by the 10th business day after billing is submitted for payment.

Service	Provider	Billing Received?	Billing/documentation concerns?	Unit Usage Concerns?

INCIDENT REPORTS – Areas of Concern

Number of **internal** incidents reports: _____ Number of **Division reportable critical** incidents: _____

Incident Report trends and/or concerns this month needing follow-up: None ☐

Behavior trends, changes in type/frequency, and/or concerns this month needing follow-up: None ☐

PRN Usage trends or concerns with Psychoactive Medication(s): None ☐

FOLLOW UP

Follow-up I need to do: *(objectives, provider issues, documentation, IRs, etc.)*	**With Whom?**	**By When?**