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Support Coordination ECM Onsite Report		
This optional tool may be used to satisfy document requirements for Enhanced Case Management. When used consistently, three of these reports also satisfy the ID and DS Waivers requirement for a quarterly person-centered review. Any changes to the content of this form may impact compliance with Medicaid, Licensing or DOJ requirements.		
Section I: Demographics		
Individual's Name:		
Date of visit:		
Type of visit ☐ 30-day ☐ 90-day Location of visit ☐ home ☐ work ☐ day support ☐ other:	ECM criteria met (check all that apply): ☐ Provider has conditional or provisional license ☐ More intensive medical or behavioral needs as defined by the SIS ☐ Service interruption for more than 30 days ☐ Serious or multiple less serious crises in a 3 month period ☐ Moved from a Training Center in past 12 months ☐ Reside in a congregate setting of 5 or more	Status of ECM criteria: ☐ Continued ☐ Resolved (as evidenced by SIS risk assessment update, observation and/or report) ☐ Concluding ECM visit* *If all criteria are resolved and the individual has returned to a pre-criteria level of functioning, ECM may cease after one additional 30-day visit to confirm stability.
List others present during the visit and their relationship to the individual:		
Describe the type(s) of services/support observed during the visit and the individual's response:		
Section II: Current Status		
1.	**Describe the status of previously identified risks,** (such as at risk of losing current housing, at risk of losing placement due to challenging behavioral needs) **injuries, needs, or other changes in status; include a brief statement regarding the current plan for resolution or how the plan needs to be modified.**	
2.	**Describe physical, mental, behavioral health and well-being** (including preventative care and adequacy of supports), **as well as any unmet needs, risks, injuries or changes in status needing support at the time of this visit. Include a brief statement regarding the plan for resolving any identified risk** (e.g. Medical appointment is scheduled, schedule appointment with Behavior Specialist).	
3.	**Describe recent medical appointments, any changes in medications and any concerns with**	

Individual's Name: _____ Medicaid#: _____

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	physical health (such as weight, hygiene, physical marks, bruises, etc). **If there are no concerns or no changes have occurred, indicate in response.**	
4.	**If applicable, describe if the individual is following a special diet** (Include if it is prescribed by a physician or by individual's choice, observe that appropriate foods/equipment are available).	
5.	**Describe mental status considering changes in typically observed abilities**: o Attitude – such as cooperative, guarded, hostile, suspicious o Behavior – such as observation of eye contact, gait, level of activity and arousal o Mood – such as neutral, depressed, happy, angry, anxious or apathetic o Affect - for example emotion conveyed by person's non- verbal behavior o Speech – changes in production of speech, loudness, rhythm, intonation, pitch, quantity, and rate.	
6.	**List any assessments completed** (LOF, Risk Assessment, Fall Risk Assessment, Informed Sexual Consent Screening, UAI, etc.) **and provide a brief statement of results or refer to assessment** – e.g. "see fall risk assessment dated 6-24-2013.")	
7.	**Describe recent efforts to address crises as applicable** (e.g., use of crisis services, START, admissions to emergency rooms or hospitals, admissions to Training Centers or other congregate settings, contact with criminal justice system).	
8.	**Describe issues of safety and freedom from harm** (e.g., neglect and abuse allegations involving the individual, injuries, use of seclusion or restraints or deaths). **Be sure to document only the facts!**	
9.	**Describe how supports and services are consistent with the individual's choice/self-determination and preferences and are being provided in the most integrated setting**	

Individual's Name: _____ Medicaid#: _____

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	appropriate to the individual's needs.	
10.	**If a team meeting is needed, describe when it will occur, anticipated topics and who will be involved.**	
Section III: Services and Community Participation		
11.	**Describe how observations indicate (or do not indicate) that the paid supporters and other people are respectful toward the individual** (consider if access to the home/site was provided readily and if private discussions with the individual were accommodated).	
12.	**Review current services and describe satisfaction with each service. If dissatisfied, describe what is being done to resolve concerns** [e.g. consider satisfaction with living arrangements, concerns with conditions of home, stability of services, access to services (e.g., waitlists, outreach efforts, identified barriers, service gaps and delays, adaptive equipment, transportation, availability of services geographically, cultural and linguistic competency) as well as any adjustments that have occurred in services & supports].	
13.	**Describe the individual's interest in any additional services, supports or activities** (include what will be done to address these interests).	
14.	**List community activities, integrated work opportunities, integrated living options, educational opportunities, and/or why they have not accessed the community** (consider if the person likes the places that they go and if community involvement occurs on a regular basis and if involvement reflects the individual's desired lifestyle). **Describe plans over time to move to the most integrated settings and services.**	
15.	**Describe any financial concerns requiring additional support** (consider the amount of choice and control the individual has over the use of his or her own money).	

Individual's Name: _____ Medicaid#: _____

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16.	**Describe the natural supports present in the individual's life** (obtain understanding through observation and interview with individual, family, providers, etc).	
Section III: Additional information and Quarterly Review		
17.	**Describe any ISP outcome changes that have occurred or are needed** (consider if current outcomes and support activities address preferences and all health and safety support needs).	
19.	**Please describe any significant events not reported above** (good, bad or neutral).	
20.	**Please describe any needed referrals that will be made as a result of this visit.**	

Quarterly Update - The following questions must be completed <u>at least once during each quarter</u> following the SC obtaining and reviewing all provider completed quarterly reviews. Include a review of the full 90 day period. Provide any changes in condition or supports, and if the changes were implemented, during these 90 days. Describe how the individual participated in the summary.		
21.	**Have all person-centered reviews been received, reviewed and incorporated in this information for the current ISP quarterly review period?**	☐ **Yes** ☐ **No**
22.	**Provide a summary of current services, outcomes and supports as reflected in the ISP.**	
23.	**Please explain the reasons, in detail, this person continues to need high intensity supports (Day Support or Pre-vocational) and/or overnight safety supports (Residential) as indicated in the Plan for Supports, if applicable**	

Additional Comments:

Support Coordinator Signature and Credentials:_____ Date:_____

Individual's Name: _____ Medicaid#: _____