

**COMMUNITY FOLLOW-UP PROGRAM
SUPERVISORY QUALITY ASSURANCE REVIEW**

CLIENT NAME

CLIENT ID #

DATE OF BIRTH

REFERRAL DATE

REFERRAL SOURCE

CASE MANAGER ASSIGNED

OTHER TEAM MEMBERS ASSIGNED

INTAKE

DATE

| ITEM # | INTAKE INFORMATION | X * see note | DATE CORRECTED AND INITIALS |
|---|---|-----------------------|-----------------------------------|
| 1 | COMPLETED WITHIN 15 DAYS OF REFERRAL | | |
| 2 | CLIENT HIV DIAGNOSIS | | |
| 3 | MEETS AGENCY/PROGRAM ELIGIBILITY REQUIREMENTS | | |
| 4 | ALL DEMOGRAPHIC INFORMATION IS COMPLETE | | |
| 5 | PRELIMINARY EVALUATION OF CLIENT NEEDS IDENTIFIED | | |
| 6 | IDENTIFY INCOMPLETE SECTIONS: | | |
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| 7 | CONSENT FOR CFP/CMCM SIGNED | | |
| 8 | CMCM REGISTRATION COMPLETED | | |
| 9 | MEDICAID STATUS VERIFIED | | |
| 10 | MEDICAID PENDING | | |
| 11 | COPY OF MEDICAID CARD IN RECORD | | |
| 12 | ALL APPROPRIATE HIV RELEASE OF INFORMATION SIGNED | | |
| 13 | SIGNED AND DATED | | |
| <p>* MARK AN "X" ONLY IF ITEM NEEDS CORRECTION OR COMPLETION</p> | | | |

REFERENCE ITEM NUMBER AND/OR REVIEWER COMMENTS

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CASE RECORD REVIEWER

FOLLOW-UP REVIEWER

REVIEW DATE

FOLLOW-UP REVIEW DATE

CORRECTIVE ACTION *DUE* DATE

CLIENT ID #

CASE MANAGER

ASSESSMENT

DATE

| ITEM # | ASSESSMENT INFORMATION | X * see note | DATE CORRECTED AND INITIALS |
|--------|--|-----------------------|-----------------------------------|
| 1 | COMPLETED WITHIN 45 DAYS OF INTAKE | | |
| 2 | EXCEPTIONS DOCUMENTED IN CASE NARRATIVE | | |
| 3 | MINIMUM OF ONE HOME VISIT WITH CLIENT CONDUCTED DURING | | |
| 4 | ASSESSMENT PERIOD UNDER REVIEW | | |
| | IDENTIFY INCOMPLETE SECTIONS: | | |
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ASSESSMENT CONTENT INCLUDES THE FOLLOWING:

- 5 CLIENT STRENGTHS AND RESOURCES
- 6 FAMILY RELATIONSHIPS
- 7 FAMILY STRENGTHS AND RESOURCES
- 8 STATUS AND NEEDS OF EACH MINOR/DEPENDENT CHILD
- 9 SPECIAL NEEDS DUE TO GENDER, CULTURE, DISABILITY, ETHNICITY, LANGUAGE, ETC.
- 10 OTHER PROFESSIONAL/AGENCY INFORMATION
- 11 SIGNED AND DATED BY CASE MANAGER
- 12 SIGNED AND DATED BY SUPERVISOR

*** MARK AN "X" ONLY IF ITEM NEEDS CORRECTION OR COMPLETION**

REFERENCE ITEM NUMBER AND/OR REVIEWER COMMENTS

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CASE RECORD REVIEWER

FOLLOW-UP REVIEWER

REVIEW DATE

FOLLOW-UP REVIEW DATE

CORRECTIVE ACTION DUE DATE

CLIENT ID #

CASE MANAGER

INITIAL SERVICE PLAN

DATE

| ITEM # | INITIAL SERVICE PLAN INFORMATION | X * see note | DATE CORRECTED AND INITIALS |
|--|--|-----------------------|-----------------------------------|
| 1 | COMPLETED WITHIN 45 DAYS OF INTAKE IN CONJUNCTION WITH ASSESSMENT | | |
| 2 | EXCEPTIONS DOCUMENTED IN CASE NARRATIVE | | |
| 3 | CLIENT PARTICIPATED IN IDENTIFYING GOALS AND ACTIVITIES <i>INITIAL SERVICE PLAN CONTENT IDENTIFIES THE FOLLOWING:</i> | | |
| 4 | SHORT-TERM GOALS OF CLIENT | | |
| 5 | LONG-TERM GOALS OF CLIENT | | |
| 6 | GOALS OF DEPENDENT CHILDREN/COLLATERALS, AS INDICATED | | |
| 7 | GOALS ARE PRIORITIZED | | |
| 8 | CONCRETE ACTIVITIES TOWARDS GOALS | | |
| 9 | INDIVIDUALS OR AGENCIES TO PERFORM ACTIVITIES | | |
| 10 | ANTICIPATED TIME FRAMES TO COMPLETE ACTIVITIES | | |
| 11 | ANTICIPATED OUTCOMES OF ACTIVITIES | | |
| 12 | IDENTIFY MISSING GOALS: | | |
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| 13 | CRISIS/EMERGENCY CONTACT PLAN IS INCLUDED | | |
| 14 | SIGNED AND DATED BY CLIENT OR PARENT/GUARDIAN | | |
| 15 | SIGNED AND DATED BY CASE MANAGER/TEAM | | |
| 16 | SIGNED AND DATED BY SUPERVISOR | | |
| * MARK AN "X" ONLY IF ITEM NEEDS CORRECTION OR COMPLETION | | | |

REFERENCE ITEM NUMBER AND/OR REVIEWER COMMENTS

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CASE RECORD REVIEWER

FOLLOW-UP REVIEWER

REVIEW DATE

FOLLOW-UP REVIEW DATE

CORRECTIVE ACTION DUE DATE

CORRECTIVE ACTION *DUE* DATE

CORRECTIVE ACTION *DUE* DATE
