

<b>MONITORING REPORT</b> <b>ADULT DAY CARE AND ADULT DAY HEALTH</b>
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DATE OF VISIT: \_\_\_\_\_

I. PROGRAM: \_\_\_\_\_ COUNTY: \_\_\_\_\_

II. TYPE OF VISIT: ( ) Announced ( ) Unannounced TIME OF VISIT: \_\_\_\_\_

 III. ENROLLMENT: # Full-time \_\_\_\_ # Part-Time \_\_\_\_ Month Reviewed \_\_\_\_\_  
 ATTENDANCE: # Participants at time of visit \_\_\_\_\_ # of Staff \_\_\_\_\_

 IV. CONCERNS FROM PREVIOUS VISIT: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have these concerns been resolved? ( ) YES ( ) NO (If no, complete DSS Form 6215)

V. AREA REVIEWED:

<b>Participant Records</b> [10A NCAC 06R .0508 and 06S .0401] – <u>Standards</u> , Page 24-25
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*It is recommended that you review several participant records.*Yes   No

- ( ) ( ) Individual folder is established and maintained for each participant
- ( ) ( ) Folder includes, signed application, recording:
- Participant's full name;
  - Address and telephone number;
  - Date of birth, marital status and living arrangement of participant;
  - Time of day participant will arrive and time of day client will leave the program;
  - Travel arrangements to and from the program for the participant;
  - Name, address and telephone number of at least two family members or friends who are responsible for the participant and can be contacted in emergencies;
  - Name, address and telephone number of a licensed medical service provider who will see the participant on request; and
  - Personal concerns and knowledge of the caregiver that may have an impact on the participants' care plan.
- ( ) ( ) Copies of all current and former signed authorizations to receive and give out confidential information, obtained each time request for information is made from a different party and dated within the prior 12 months
- ( ) ( ) Signed authorization for the participant to receive emergency medical care from any licensed medical practitioner, if such emergency is needed;  
Suggested but not required to have allergies noted (drugs, environmental, topical, food) highlighted or in red.

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Make copies for DSS file; Program Director, and State Adult Day Services Consultant.

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Check Yes or No. If no, provide explanation.

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**Participant Records (Continued)**

*Included in participants individual folder (continued)*

Yes      No     

- ( ) ( ) A medical examination report conducted within the past three months of enrollment and updated annually, signed by a licensed physician, physician's assistant or nurse practitioner. The report shall include information on:
  - Current diseases and chronic conditions and degree these require observation by day care staff and restriction of normal activities;
  - Presence and degree of psychiatric problems;
  - Amount of direct supervision required;
  - Any limitations on physical activities;
  - Listing of all medications with dosages and times to be administered;
  - Most recent date participant was seen by doctor.
- ( ) ( ) Assessment forms;
- ( ) ( ) Progress notes (written report of staff discussions, conferences, consultation with family or other interested parties, evaluation of a participant's progress and other information regarding a participant's situation), updated a minimum of once every three months.
- ( ) ( ) All service plans for the participant, including scheduled days of attendance, for the preceding 12 months;
- ( ) ( ) Signed authorizations for photographs, video or audio recordings;
- ( ) ( ) Statement signed by participant, family member or other responsible person reflecting agreement to abide by policies.

VI. COMMENTS/CONCERNS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Attach an additional sheet if needed*

VII. PROGRAM DIRECTOR'S COMMENTS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

VIII. Continued by ( ) DSS-6215 ( \_\_\_\_\_ # of forms)

IX. Signatures:

Coordinator and/or Specialist	Date	Program Director	Date

Make copies for DSS file; Program Director, and State Adult Day Services Consultant.