

MONITORING REPORT ADULT DAY CARE AND ADULT DAY HEALTH
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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:

Participant Records [10A NCAC 06R .0508 and 06S .0401] – <u>Standards</u> , Page 24-25

*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.

DAAS-6214 (7-07)

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.