CSB THERAPY SERVICES ON-SITE QUALITY ASSURANCE REVIEW

Name:	**City of Residence/Region:**	**Check if JCM** ☐
Therapy Service Reviewed: **PT ☐ OT ☐ SLP ☐**	**Date(s) of Review:**	
Reviewer:	**Reviewer E-mail/Phone:**	
Therapy Agency and Agency Contact Name:	**Therapy Agency E-mail/Phone:**	
Therapist:	**Therapist E-mail/Phone:**	
Current ISP Budget: Begin Date – End Date:	**Date of Last Annual ISP Meeting:**	
Approx. how long has the therapist worked with this person? < 1 year ☐ 1 – 3 years ☐ > 3 years ☐		

Standards Ref. #	REVIEW TOPIC or QUESTION	Yes	No	Partial	NA
Fill in EITHER Section 12.4.7.12.2 OR Section 12.4.7.12.3, dependent on evaluation cycle.					
12.4.7.12.2	INITIAL THERAPY EVALUATION *date on report reviewed:*				
12.4.7.12.2	Assessment is individualized and functionally based.				
12.4.7.12.2.1	Contains all relevant content required by the standards.				
COMMENTS:					
12.4.7.12.3	ANNUAL THERAPY RE-EVALUATION REPORT *date on report reviewed:*				
12.4.7.12.3.1. c	The functional status of the person in all (major) areas of therapy intervention during the prior year is addressed.				
12.4.7.12.3.1. d	Addresses the status of current therapy objectives as compared to baseline data.				
12.4.7.12.3.1. d	Indicate % of Therapy Objectives that have been met to closest 10%.	_____ **%**			
12.4.7.12.3.2	The report is dated at least 14 calendar days prior to the Annual IDT meeting.				
COMMENTS: (Include # of Therapy Objectives met/Total # of Therapy Objectives)					
12.4.7.12.5.1	THERAPY DOCUMENTATION FORM (TDF). *Date on TDF reviewed:*				
	The header, footer, and signature sections are completed correctly.				
	The therapist filled out the request for initial, ongoing and/or revised units correctly.				

Standards Ref. #	REVIEW TOPIC or QUESTION	Yes	No	Partial	NA
COMMENTS:					
12.4.7.12.5.1	THERAPY INTERVENTION PLAN (TIP)	Y	N	P	NA
	Therapy objectives are measurable.				
	Baseline information is identified for therapy objectives OR additional objective states that baseline will be obtained.				
	The TIP signature is dated within 14 days following Annual ISP meeting.				
COMMENTS:					
12.4.7.12.5.1	" DELIVERABLES" SECTION of the TIP	Y	N	P	NA
	Information for "deliverables" section of the TIP is completed correctly. (WDSI, daily routines, AT, CARMP, etc.)				
COMMENTS:					
12.4.7.12.5.1	BUDGET DEVELOPMENT WORKSHEET for THERAPISTS	Y	N	P	NA
	Indications for "core" units OR "fading" units are marked.				
COMMENTS:					
12.4.7.12.5.1	SEMI-ANNUAL REVIEW	Y	N	P	NA
	Indicates status of therapy objectives.				
	Indicates status of intervention related to "deliverables".				
	Semi-Annual Signature date is dated before or at 190 days following ISP effective date.				
COMMENTS:					
12.4.7.12.6	WRITTEN DIRECT SUPPORT INSTRUCTIONS (WDSI)	Y	N	P	NA
	At least one WDSI is developed (unless within the first 6 months of the initial therapy budget).				
	WDSI(s) contain required elements.				
	Ongoing WDSIs have a revised or reviewed date that is at least 3 weeks prior to new ISP effective date.				
	SLP ONLY: If there is an indication that the individual is functionally non-verbal, the individual has a Communication Dictionary AND a 24-hour Communication System created or planned.				

Standards Ref. #	REVIEW TOPIC or QUESTION	Yes	No	Partial	NA
COMMENTS:					
12.4.1	PARTICIPATORY APPROACH (PA)	Y	N	P	NA
	Therapy intervention (WDSIs, therapy objectives, etc.) focuses on functional participation in life activities.				
	WDSIs reflect prioritized areas of therapy intervention needs that consider health, safety, and function.				
COMMENTS:					
12.4.2	COLLABORATIVE – CONSULTATIVE MODEL (CC Model)	Y	N	P	NA
	TDF and/or other documents indicate plan for collaboration with IDT members.				
COMMENTS:					
12.4.3	DELIVERY OF THERAPY SERVICES	Y	N	P	NA
	Services are delivered in both home and community settings.				
COMMENTS:					
12.4.7.2	IDT PARTICIPATION	Y	N	P	NA
	TIP and other documentation indicate that the therapist is supporting achievement of ISP Visions/Outcomes.				
COMMENTS:					
12.4.7.3	SUPPORT ACCESS AND UTILIZATION OF AT, PST, ENVIRONMENTAL MODIFICATIONS				
	Therapist is supporting the individual's access and utilization of AT, PST, and/or Environmental Modifications to promote functional activity and/or health and safety.				
	Current copy of AT inventory is present.				
COMMENTS:					
12.4.7.7	TRAINING	Y	N	P	NA
	WDSIs are trained at least annually.				
	Training rosters are present.				

Standards Ref. #	REVIEW TOPIC or QUESTION	Yes	No	Partial	NA

COMMENTS:					
OTHER	BUDGET	Y	N	P	NA
	If JCM budget exceeds ☐ 232 units (Clinical Exception) or exceeds ☐ 288 units (Super Exception) is a Clinical Exception Request present?				
ADDITIONAL GENERAL COMMENTS or FEEDBACK BY THE REVIEWER (if applicable)					
REVIEWER RECOMMENDATIONS:					
☐ No specific follow-up is needed.					
☐ Technical Assistance related to the following topics was provided:					
☐ The following Clinical Resources were provided:					
☐Agency will follow-up with the therapist to re-train the therapist regarding the following: ☐TA topics noted above. ☐Other:					
☐ Additional Comments:					
Reviewer Signature:	Date:				
Agency Representative Signature:	Date:				

Note: Agency or therapist should feel free to contact the reviewer with additional questions or comments.

Thank you so much for all you do for the individuals you support. Your assistance with this QA Review is very much appreciated!