**Shared Living Home Visit Review Tool**

The Shared Living Home Visit Review Tool must be completed twice a year. Both the Administrative Oversight Agency and the Case Manager must each complete the tool at separate times during the year; ideally six months apart.

Completed by: Administrative Oversight Agency  Case Manager 

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| --- | --- | --- |
| **Consumer Name: ( Last, First M)** | | **EIS Number** |
|  | | |
| **Consumer Home Address: Street City Zip** | | |
|  |  | |
| **Shared Living Home Provider Name** | **Administrative Agency Name** | |
|  |  | |
| **Case Manager /Agency Reviewer Name** | **Reviewer’s Supervisor Name and Affiliation** | |
|  |  | |

Date of Home Visit: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Date of Last Home Visit: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

1. Reason for Home Visit:
   * Scheduled visit  Unscheduled visit
   * Change in residency Date of placement:\_\_\_\_\_**/\_\_\_\_\_/\_\_\_\_\_**
   * Reportable Event Follow-up Date of reportable event:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
   * Other:

\*If the Case Manager is completing the tool due to a change in residency, the home visit must be conducted and the tool completed

within the first 2 weeks of placement. The consumer must be present.

1. Is the consumer present at the time of the home visit? No Yes (The consumer must be present for at least two of the CM home

visits and two of the Administrative Oversight Agency visits per year).

1. Date of last contact with consumer: / /
2. Guardianship Status: No Yes, private guardian  Yes, public guardianship
3. Medication: Yes, takes prescription medication

Yes, takes non-prescription medication

No, does not take medication (go to question 7)

1. If taking medication, level of support needed for medication administration.

* Needs full assistance
* Needs some level of assistance
* Able to self-administer medication\*

\* Documentation from the medical provider verifying approval for the consumer to self-administer medication is required.

Provider verification must be in the consumer’s record.

1. Is the Provider certified as a CRMA, CNA-M, or RN? Y \_\_\_\_\_ N \_\_\_\_\_
2. Individual reports and documents reviewed in preparation for the visit and/or during the visit:

Written daily progress notes current to within 24 hours (dated & signed) Y \_\_\_\_\_ N\_\_\_\_\_

Reportable Events and Agency Incident Reports in file (**may be kept in Agency file**) Y \_\_\_\_\_ N \_\_\_\_\_ N/A \_\_\_\_\_

Permission from Guardian for medical treatment is updated annually Y \_\_\_\_\_ N \_\_\_\_\_ N/A \_\_\_\_\_

Informed Consent contact logs are current Y \_\_\_\_\_ N \_\_\_\_\_ N/A\_\_\_\_\_\_

Medication tracking sheets (MAR) are current Y \_\_\_\_\_ N \_\_\_\_\_ N/A \_\_\_\_\_\_

Medical visit forms Y \_\_\_\_\_ N \_\_\_\_\_ N/A \_\_\_\_\_\_

Annual Physical Form on file Y \_\_\_\_\_ N \_\_\_\_\_ Date of last annual physical \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Dental visits Y \_\_\_\_\_ N \_\_\_\_\_ Date of last dental appt. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Fire Drills Reviewed Y \_\_\_\_\_ N \_\_\_\_\_

Medicaid Attendance and/or Respite Need/Use Reviewed Y \_\_\_\_\_ N \_\_\_\_\_

Date of last Person Centered Plan: \_\_\_/\_\_\_/\_\_\_ Date Person Centered Plan was reviewed: \_\_\_/\_\_\_/\_\_\_

Unmet Needs Identified Y \_\_\_\_\_ N \_\_\_\_\_ N/A \_\_\_\_\_\_

If yes, Unmet Needs Identified as: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Shared Living Home Visit Review Tool**

**II. Consumer Status:** Consumer must be present for at least two of the Case Manager home visits and two of the Administrative Oversight Agency visits per year. Report all pertinent observations.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **I. Physical Site:** Indicate areas that have been assessed during the home visit. Additionally, if the area warrants follow-up, mark the appropriate column. Identify the concern/need in the comment section to discuss and plan for remediation. | | | | | | | |
| **Observations** | **Assessed** | | | **Additional Follow-Up** | | | **Guidelines** *(In addition to MaineCare requirements, the following prompts may be used as points to consider while assessing for health, safety, compliance and good practice)* |
| * Cleanliness |  | | |  | | | Home is clean (dirt, trash, unusual odors etc.). Note any recent issues with pest control.  Temperature in the home is appropriate (consider how the consumer and home provider are dressed).  Water temperature is appropriate (hot/cold water temperature).  Personal hygiene is addressed appropriately. Consider specific arrangements for and needs of the consumer such as necessary personal care items (soap, towels, deodorant, sanitation, etc.).  Dietary needs are addressed appropriately. How and where food is stored. Consider specific arrangements for and needs of the consumer such as mealtime, etc. |
| * Odors |  | | |  | | |
| * Temperature/home |  | | |  | | |
| * Temperature/water |  | | |  | | |
| * Personal Hygiene |  | | |  | | |
| * Dietary Needs |  | | |  | | |
| **Comments:** Note details of concerns or issues to review for follow-up. ***Include all steps taken for follow-up on page 7 of tool.*** | | | | | | | |
| * Maintenance of home   (exterior & interior) | |  | |  | | Home is in good repair (working appliances, paint & furniture in good condition, no broken windows, doors etc.).  Interior and exterior of the home is free of potential hazards of falls, bodily harm, etc.  Considerations to consumer or situation posing risk to consumer (elopement, abuse). Note anything posing risk/harm to consumer’s health or safety.  Adequate space and lighting.  Fire safety includes escape plans, fire extinguishers and smoke alarms. Fire extinguishers and smoke alarms are in good working order and the expiration date valid.  The prescribed or necessary equipment and/or modification are present, used properly and in good repair (including handrails, ramps, wheelchair, and communication device). Note if they are approved & do not unduly restrict consumer.  Consumer has the ability to move safely throughout the home; in/out during an emergency. | |
| * Fire Precautions | |  | |  | |
| * Environmental Modification | |  | |  | |
| * Adaptive Equipment | |  | |  | |
| * Access/Mobility   (private/common areas) | |  | |  | |
| **Comments:** Note details of concerns or issues to review for follow-up. ***Include all steps taken for follow-up on page 7 of tool.*** | | | | | | | |
| * Personal Rights | | |  | |  | Appropriate interaction with home provider (respectful, attentive, responsive to consumer’s needs).  Observations of consumer’s opportunity for connections to community life including work and personal support networks. Consumer is able to express choice in decisions (including budgeting, wardrobe, food, activity, and visitation).  Any undue restrictions to consumer’s rights, including privacy, mobility, access to money, food, and personal belongings. | |
| * Choice | | |  | |  |
| * Money, personal belongings | | |  | |  |
| **Comments:** Note details of concerns or issues to review for follow-up. ***Include all steps taken for follow-up on page 7 of tool.*** | | | | | | | |

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| **III. Consumer Interview:** Review domain areas with the consumer, using the prompts to help assess the consumer’s overall satisfaction. Efforts should be made to talk with the consumer in areas including health, residence, work/day program, satisfaction with services and supports, quality of life etc. Include comments around assessment for safety, unmet needs, satisfaction etc. Indicate if the domain area was assessed, noting consumer’s satisfaction or dissatisfaction. If the consumer has expressed dissatisfaction in any of the domains, the CM will document and follow-up. The Case Manager will check areas in which to follow up. | | | | |
| * The consumer was not present at the time of visit. * The consumer chose not to participate in the interview. * The consumer’s ability to communicate was not sufficient for Case Manager to assess domain areas by interview. * Provider or *other:* was present during the interview for assistance, or safety. | | | | |
|  | **Domain Area** |  | **Comments** | **Assessment**  ***If follow-up is selected, include all steps taken for follow-up on page 7 of tool.*** |
|  | **General Health/Wellbeing**  *How have you been feeling? Have you been to the doctor, dentist? Any change to medications?* |  |  | * General satisfaction * Expressed dissatisfaction * **Follow-up** * Not assessed |
|  | **Home**  *How are things at home? Do you like living here? Do you feel safe?* |  |  | * General satisfaction * Expressed dissatisfaction * **Follow-up** * Not assessed |
|  | **Home Provider**  *Do you get along with your home provider? Do you feel you are treated fairly and respected?* |  |  | * General satisfaction * Expressed dissatisfaction * **Follow-up** * Not assessed |
|  | **Work/ Day Program**  *Do you like where you work/go during the day? Would you like to have a [different] job or other place to go? Do you feel safe there?* |  |  | * General satisfaction * Expressed dissatisfaction * **Follow-up** * Not assessed |
|  | **Work/ Day Program Staff**  *Do you get along with your work/day program staff? Do you feel you are treated fairly and respected?* |  |  | * General satisfaction * Expressed dissatisfaction * **Follow-up** * Not assessed |
|  | **Inclusion**  *Do you have things you like to do outside the house, like shopping, going out to eat, or someplace fun? Does the home provider help you get out into the community if you want to?* |  |  | * General satisfaction * Expressed dissatisfaction * **Follow-up** * Not assessed |
|  | **Relationships**  *Do you have someone you can talk to about personal things? Do you have help to plan to see friends/family when possible?* |  |  | * General satisfaction * Expressed dissatisfaction * **Follow-up** * Not assessed |
|  | **Planning/Services**  *Do you get the services you need? If you want to change something, do you have someone to talk to about it? Are there things that you want to talk about at PCP?*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |  |  | * General satisfaction * Expressed dissatisfaction * **Follow-up** * Not assessed |

**Shared Living Home Visit Review Tool**

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| **IV. Residential Record:** Indicate areas that have been assessed during the home visit. Additionally, if the area warrants follow-up, mark the appropriate column. Identify the concern/need in the comment section to discuss and plan for response. | | | | | |
| **Record Components** | **Assessed** | **Additional Follow Up** | | | **Guidelines** *(In addition to MaineCare requirements, the following prompts may be used as points to consider while assessing for health, safety and good practice)* |
| * Record Maintenance |  |  | | | Record is in order and documents can be located.  Documentation reflects provider is following written protocols, MaineCare requirements and best practices.  The most recent plan is contained in the record. Indication that the guardian is participating in planning (at the minimum signed off on the plan). The plan is individualized for the consumer. The plan identifies all services, unmet needs etc.  Notes document progress toward goals outlined in the PCP.  Notes document level of services provided according to the PCP.  All needs are identified and addressed appropriately.  Supporting documentation of current status, his/her goals, authorized services etc. Documentation reflects efforts to address that the consumer is involved in community life, is in contact with unpaid supports and participates in decision making etc.  Documentation supports that the Provider is in compliance with Behavior Plans. |
| * Current, approved PCP |  |  | | |
| * Routine documentation of progress notes |  |  | | |
| * Notes are meaningful, reflecting services |  |  | | |
| * Services/Supports |  |  | | |
| * Unmet needs |  |  | | |
| * Behavior Plans |  |  | | |
| Comments: Note details of concerns or issues to review for follow-up. ***Include all steps taken for follow-up on page 7 of tool.*** | | | | | |
| * Current medical exams   (physical, dental, vision) |  | |  | ****Documentation reflects at least an annual physical exam within the last year, timely dental and other exams. Recommendations are clearly noted & addressed.  If the consumer is under guardianship, the documentation clearly notes the guardian was contacted prior to the consumer’s appointment/treatment. Provider tracks documentation of consent.  Documentation reflects that Physician recommendations are being implemented and followed. | |
| * Physician recommendations |  | |  |
| * Prior consent for treatment |  | |  |
| Comments: Note details of concerns or issues to review for follow-up. ***Include all steps taken for follow-up on page 7 of tool.*** | | | | | |
| * Medication tracking system |  | |  | Medications are stored and tracked appropriately. MAR is used and up to date with current medication regime. Administration policies are in place.  Corresponding doctor’s order to prescription on file.  The provider is following reportable event procedure for missed and/or refused dosages.  If the consumer is under guardianship, the documentation clearly notes that the guardian was contacted prior to the changes in medications. Provider tracks documentation of consent. | |
| * Prior consent re:changes to medication regime |  | |  |
| Comments: Note details of concerns or issues to review for follow-up. ***Include all steps taken for follow-up on page 7 of tool.*** | | | | | |

**Shared Living Home Visit Review Tool**

**Additionally, if the**

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| **V. Supervision:** All Home Visit Review tools are to be reviewed with the assigned reviewer’s supervisor (when applicable). Reviewer (Administrative Oversight Agency and Case Manager) and supervisor will maintain copies of the tool. Following review of findings, the reviewer and their supervisor may discuss reasonable steps to address concerns. **Any person identified as the ‘Responsible Person’ will be notified, and at minimum, receive a copy of page 5 of the Home Visit Review tool.** Action steps will be documented in the EIS Action Note. DHHS will be made aware of ongoing concerns, action steps and resolutions. The PCP team will meet and plan whenever there are notable concerns. Note: The term ‘supervisor’ pertains to the Case Manager Supervisor. |

10. Following the home visit, are there any issues, concerns or needs that warrant follow-up?

Y \_\_\_\_\_ N \_\_\_\_\_ (If yes, please specify in the table listed below).

11. Has a Reportable Event been submitted based on the findings of this review? Y \_\_\_\_\_ N \_\_\_\_\_

12. Was the Case Management Record reviewed? Y \_\_\_\_\_ N \_\_\_\_\_ N/A \_\_\_\_\_

If yes, \_\_\_\_\_Hard Copy Record \_\_\_\_\_ EIS Electronic Record

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| --- |
| **VI. Other Related Documents: To be completed by the Administrative Oversight Agency ONLY.** |

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| --- | --- | --- | --- |
| **Document/Certificate** | **Found in Record** | **Not Found in Record** | **Date Completed** |
| Shared Living QA Checklist |  |  |  |
| Shared Living Member Record |  |  |  |
| Shared Living Background Check Statement |  |  |  |
| Shared Living Home Visit / Phone Contact Log |  |  |  |
| Shared Living Provider Questionnaire |  |  |  |
| Shared Living Home Visit Tool (Completed by Agency) |  |  |  |
| Shared Living Home Visit Tool (Completed by CM) |  |  |  |
| Personal Support Services Agreement (signed & renewed yearly) **Optional** |  |  |  |
| Adult Protective Check (to include provider and everyone living in the home or providing support) |  |  |  |
| Criminal Background Check- initial (to include provider and everyone living in the home or providing support) |  |  |  |
| Criminal Background Check - at least every 2 years after initial (to include provider and everyone living in the home or providing support) |  |  |  |
| Medication Administration Training (CNA-M, CRMA, or RN) |  |  |  |
| Medication Administration Training (8 hour) |  |  |  |
| Reportable Events Training |  |  |  |
| DSP Training |  |  |  |

**Shared Living Home Visit Review Tool**

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| **Issue/Concern** | **Action** | **Person Responsible for Follow-Up** | **Date Responsible Person was Notified** | **Date Action Note Entered in EIS by CM** |
|  |  |  |  |  |
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|  |  |  |  |  |
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|  |  |  |  |  |

***Please attach separate sheet if additional space is needed***

**Coordinator/Reviewer Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***A copy of this review has been received by: (Check all that apply)***

Case Manager Case Manager Supervisor Administrative Agency SL Provider

CM Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

CM Supervisor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Administrative Agency Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

*Shared Living Home Visit Tool / Revised September 2016 / BC / PCU*