**Shared Living Quality Assurance Checklist**

Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Date of Contract: \_\_\_\_\_\_\_\_\_\_\_\_

Individual’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Individual Completing this Form** | **Document** | **Date listed on Document (if applies)** | **Check off if found in Record** |
|  | Shared Living Contract |  |  |
|  | Shared Living Questionnaire |  |  |
|  | Copy of DSP Certificate   |  |  |
|  | Copy Driver's License (every driver) |  |  |
|  | Copy of HS Diploma or GED |  |  |
|  | Copy of Automobile Registration   |  |  |
|  | Copyof Automobile Insurance |  |  |
|  | Copy of Home Owner/Renter's Insurance   |  |  |
|  | Proof of Vaccinations for Pets  |  |  |
|  | Copy of Member’s Current PCP   |  |  |
|  | Copy of CNA-M/CRMA Certificate or RN License  |  |  |
| **Name of Individual Completing this Form** | **Document** | **Date listed on Document (if applies)** | **Check off if found in Record** |
|  | Member Information (MaineCare Manual 21.09 Member Records)  |  |  |
|  | Progress Notes that identify progress toward goals outlined in the PCP (includes signature) |  |  |
|  | Progress Notes that document the level of services per the PCP |  |  |
|  | Collected requisite daily documentation |  |  |
|  | Collected Medication Administration Reports (MAR’s) |  |  |
|  | Confirmation that the licensee (if applicable) is in good standing with the licensing board |  |  |
|  | Cert Certified as a CRMA, CNA-M, or RN  |  |  |
|  | Agency conducted home visits *every other month (member present for at least 2 per yr.)* |  |  |
|  | Agency conducted phone contact *every other month* (month the home is not visited) |  |  |

--------------------------------------------------Administrative Use Only----------------------------------------------------

*Annotate date of enrollment or completion of training*

*Include Name of Individual completing this form if different from name listed above*

**Date of Contract: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Completed:**

\_\_\_\_\_\_\_\_\_\_\_\_ Adult Protective Check. Check must be completed *prior to entering contract*.

\_\_\_\_\_\_\_\_\_\_\_\_ Criminal Background Check completed *prior to entering contract* on:

* Provider
* Everyone living in the home on a full or part time basis
* Everyone providing support to the individual

\_\_\_\_\_\_\_\_\_\_\_\_ Criminal Background Check must be completed *at least every 2 years* after the

 initial check.

\_\_\_\_\_\_\_\_\_\_\_\_ Driver Record Check.

\_\_\_\_\_\_\_\_\_\_\_\_ Exclusion Check through Program Integrity (OIG)

\_\_\_\_\_\_\_\_\_\_\_\_ Medication Administration Training prior to administering medications to Member.

\_\_\_\_\_\_\_\_\_\_\_\_ Reportable Events Training prior to working with member or at least *within 30*

 *days of entering contract.*

\_\_\_\_\_\_\_\_\_\_\_\_ Completed the Four (4) Modules from the College of Direct Support. Required

 to complete ***prior*** *to providing services to the member alone*.

1. Introduction to Developmental Disabilities
2. Professionalism
3. Individual Rights and Choice
4. Maltreatment

\_\_\_\_\_\_\_\_\_\_\_\_ Completed the Direct Support Professional (DSP) curriculum, *or* demonstrated

 proficiency through DHHS’s approved Assessment of Prior Leaning, *or* has

 successfully completed the curriculum form the Maine College of Direct Support

 w*ithin 6 months of date of entering contract*.

\_\_\_\_\_\_\_\_\_\_\_\_ Agency completed the DHHS-OADS Shared Living Home Visit Review Tool *yearly*.

\_\_\_\_\_\_\_\_\_\_\_\_ Case Manager completed the DHHS-OADS Shared Living Home Visit Review Tool

 *yearly*.