

**Continuity of Care**

**Pre-Move Site Review Instrument for the Community Living Discharge Plan**

Individual Name		CARE No.
Potential Community Placement Site Address		Site Administrator/Manager Name
Provider Agency Name	State Supported Living Center (SSLC)	Date of On-site Review

Potential Setting Type:    HCS Residential    HCS Foster Care    HCS Supported Home Living    ICF/ID

Items/Issues to be Reviewed	Yes	No	NA
1. As of the week of the on-site review, is the contract with which services are provided at the residence in good standing with DADS, as verified by LA staff using the DADS Quality Reporting System (QRS) website? (Print and attach.) <a href="http://facilityquality.dads.state.tx.us/qrs/public/qrs.do">http://facilityquality.dads.state.tx.us/qrs/public/qrs.do</a> .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. When asked, did the site administrator/manager respond that DADS identified environmental or safety concerns at the time of its last visit to the residence? Attach a copy of the last residential review, if available. .... If yes, explain:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. When asked, did the site administrator/manager respond that the potential site presents an environmental concern that would impact the individual's identified needs? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. During the visit, did the LA staff observe any environmental concerns that would impact the individual's identified needs? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. In meeting with the site administrator/manager: <ul style="list-style-type: none"> <li>• Did the site administrator/manager have a copy of the individual's draft Community Living Discharge Plan and know of the outcomes important to the individual or legally authorized representative? .....</li> <li>• Did the site administrator/manager verify services and supports could be provided that are necessary to assist the individual in achieving the outcomes? .....</li> </ul> If no, explain:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I have visited the residential setting named at the top of this form, which is the choice of a location to receive  HCS or  ICF/ID services for \_\_\_\_\_, and believe that according to the rules governing Continuity of Services – State Mental Retardation Facilities, 40 TAC Chapter 2, Subchapter F, specifically §2.277(b) and (c), this setting:

- does** meet the criteria described in §2.277(b) and is recommended for interdisciplinary team (IDT) approval.
- does not** meet the criteria described in §2.277(b) and is not recommended for IDT approval. The reasons for this recommendation are:
- [state the criteria described in §2.277(b) that the provider setting did not meet]
  - [state the reasons why the LA determined the criteria was not met]

Additional people involved in this on-site review:

Printed name of LA staff who conducted on-site review		Date
Signature – LA Staff		Title
Name of LA	Signature – Site Administrator/Manager	Date
Date submitted to SSLC		