SOUTHEASTERN VIRGINIA TRAINING CENTER
POST MOVE MONITORING REPORT

SECTION A:

Individual: Enter name **Monitoring Staff:** Enter name **Monitor Date:** Select date

Discharge Date: Select date **Time Frame:** ☐ 1-3days ☐ 4-10days ☐ 11–17days ☐ Post 30

CIM: Enter name **Social Worker:** Enter name **Residential Type:** Enter type

Residential Support: **Vocational/Day Program:**

Authorized Representative: **CSB Support Coordinator:**

SECTION B:

Source of Information and Name of Contact:	Contact Date	Method of Contact	Person Responsible	Others Involved
Individual		☐ Face-to-Face		
CSB Support Coordinator		☐ Phone/Email ☐ Face-to-Face		
Residential Provider/staff		☐ Phone/Email ☐ Face-to-Face		
Supported Employment/Day Provider		☐ Phone/Email ☐ Face-to-Face		
AR or Guardian		☐ Phone/Email ☐ Face-to-Face		

Contact Notes:

SECTION C:

1. Is the individual participating in a licensed employment/day program? Select one
2. If yes, what type of employment/day service is the individual receiving? (Check all that apply)

   ☐ Individual Supported Employment Enter date

   ☐ Group Supported Employment Enter date

   ☐ Workplace Assistance Services Enter date

   ☐ Community Engagement Enter date

   ☐ Community Coaching Enter date

   ☐ Group Day Services Enter date

   ☐ Receives day support services in an ICF Enter date

3. If no, why isn't the individual receiving employment/day services? Select one

4. If employment/day services will begin in the future, please provide the anticipated start date. Enter date

5. If “other” is selected in question #3 above, or if there is additional information to report regarding the reason the individual is not receiving day services, please provide details below.

   Enter reason/details

6. If the individual is participating in meaningful day or other non-licensed activity, please describe.

   Enter reason/details

SECTION D:

1. Are all of the Essential Supports identified in the Discharge Plan being provided?

Essential Supports	Document Observation and/or Evidence	Observed		Additional Training		
		YES	NO	Needed	Date Completed	Person Responsible
Staffing Supports						
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		
Employment/Day Options						
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		
Environment						
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		
Medical/Nursing						
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		
Mental Health (Psychological/psychiatric/substance abuse)						
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes		

Essential Supports	**Document Observation and/or Evidence**	**Observed**		**Additional Training**		
		YES	**NO**	**Needed**	**Date Completed**	**Person Responsible**
				☐No		
Behavioral						
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		
Nutritional						
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		
Physical Therapy						
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		
Occupational Therapy						
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		
Speech Language Therapy						
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		
Communication (Communication Dictionary and outcomes developed by others who are not SLT.)						
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		
Equipment						
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		
Transportation						

Essential Supports	Document Observation and/or Evidence	Observed		Additional Training		
		YES	NO	Needed	Date Completed	Person Responsible
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		
Social (family, friends, volunteers, church)						
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		
Recreational						
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		
Financial (management of funds)						
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		
Legal						
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		
Advocacy/AR Appointment						
		☐	☐	☐Yes ☐No		
		☐	☐	☐Yes ☐No		

Please describe any 1) outstanding issues or concerns under each question, 2) list evidence reviewed to verify information 3) request related documentation and attach:

2. Does the Individual and/or AR express satisfaction with his/her new life? ☐ Yes ☐ No

3. Are there any relationship or family concerns? ☐ Yes ☐ No

4. Has the individual remained free of injury/illness? ☐ Yes ☐ No
   (If no, request incident reports and/or ID Notes)

5. Were the medical and other provider appointments kept as stated in the discharge plan? ☐ Yes ☐ No
   Please provide written documentation verifying the appointment.

Medical Appointment	Date of Appointment	Medical Provider

Follow Training Center Protocol for reporting emergencies and health and safety concerns to ensure compliance with mandated reporting. **Individual:**

6. Have there been any medication changes? ☐ Yes ☐ No
   (If response is yes, list the medications changed, date of change and reason for changes; request copy of Physicians Orders, **regardless review individual's MAR)**

Medications Changed	Date of change	Reason for Change

7. Are there any medical needs that require further support? ☐ Yes ☐ No
   (If yes, list in #18 chart below)
8. Were there any behavioral incidents? ☐ Yes ☐ No
   (If yes, request incident reports and/or ID Notes)
9. If so, did staff feel equipped to manage them? ☐ N/A ☐ Yes ☐ No
10. Are there any behavioral needs that require further support? ☐ Yes ☐ No
    (If yes, list in #18 chart below)
11. Are there any concerns with communication between direct support partners and the individual? ☐ Yes ☐ No
    a. Did the PMM observe the communication plan in place? ☐ Yes ☐ No
    b. Was the individual responsive to direct support partners? ☐ Yes ☐ No
12. Additional Areas of concern: ☐ Yes ☐ No
13. Is the individual's community support plan:
    a. Current ☐ Yes ☐ No
    b. Have AR/LG signature ☐ Yes ☐ No
14. Has the individual been offered the opportunity to meet their neighbor? ☐ Yes ☐ No
15. Provider was reminded of their mandated responsibility to follow reporting guidelines regarding notification of serious incidents or other health concerns through CHRIS, Community Services Board, AR/LG, and Training Center PMM? ☐ Yes ☐ No
16. Were the current DBHDS Safety and Quality Alerts shared with the provider and what steps will the provider be taking to educate their staff? ☐ Yes ☐ No
17. Does the provider require a Community Resource Consultant Referral? ☐ Yes ☐ No
18. Are there additional supports that can be provided for the individual or provider? ☐ Yes ☐ No

Support requested/needed	Date requested	Target Date	Date completed	Person/s Responsible	Additional information

SECTION E:

Follow Training Center Protocol for reporting emergencies and health and safety concerns to ensure compliance with mandated reporting. **Individual:**

ACTION PLAN FOR AREAS OF CONTINUED MONITORING OR FOLLOW-UP

Action Item *Note: If this is an action item from previous monitoring report	Target Date	Date Completed	Person Responsible	Others Involved

Additional Comments:

Signature of Person Completing Monitor

Date

Signature of Reviewer

Date

Follow Training Center Protocol for reporting emergencies and health and safety concerns to ensure compliance with mandated reporting.

Individual: