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:** ☐ 1-3 days ☐ 4-10 days ☐ 11–17 days ☐ 45-60 days

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		

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

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						

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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

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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:

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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

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Individual: