CFCM
Monthly Monitoring Form

A thick boarder indicates a required field

Participant Name:

DOB:

Review: 1-Month

Worker:

Review Date:

Assessment/Form Status:

Open/Close: LTSS

State Agency/Program: BHDDH/IDD/HCBS

Contact Form

Attempted Contact Outcome:

Type of Contact:

Opt Out of Monthly Contacts:

Section 1: General Information

1. Date of Contact:
2. Person(s) Contacted Type:
3. Person Contacted Name:
4. Duration of contact:
5. If completed by someone other than the assigned case manager, please explain:

Section 2: Person-Centered Plan

1. Are services, supports, and resources being delivered according to your person-centered plan?

2. Are services, supports, and resources meeting your needs and wants?

3. Are you satisfied with your service providers?

4. Are there services you would like to change, add or remove from your person-centered plan?

Section 3: Health and Safety

1. Have there been any changes to your health, functional capacity, social or physical environment, or support system since our last contact?

2. Have you visited a physician, urgent care, emergency room or been hospitalized since our last discussion?

3. Has anything happened that has made you feel unsafe at home, in your neighborhood, at work/day program, or during a community activity?

4. Have you felt down or lost interest in doing things?

5. Have you encountered any additional difficulties or improvements in your daily activities?

6. Do you have access to food and resources in needed (i.e., are you eating regularly)?

Section 4: Closing Question

1. Is there anything else you would like me to know right now, or anything else you need assistance with?

Section 5: Contact Summary and Required Follow-up

Contact Comments / Additional Notes: