CFCM
6-Month Monitoring Form

A thick boarder indicates a required field

Participant Name: **DOB:**

Review: 6-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)?
7. Has there been any changes to your emergency plans?

Section 4: Goals

1. Are you making progress towards goals?

Section 5: Continuity and Stability with Living Arrangement

1. Do you like where you live?
2. Can you have snacks/food when you like?
3. Do you need anything to stay in your home (e.g., equipment to get around)?

Section 6: Community Connections

1. What have you been doing outside the home/in the community in the past few months?
2. Do you like the things you are currently doing in the community?
3. Do you decide, or with necessary support decide, the community activities you do and with whom you do them (including people you do not live with)?
4. Are there things you are doing now that you would like to do more often, and/or things you are not doing now that you like to do?

Section 7: Employment

1. If you are not working now, are you interested in work?
2. If you are working now, would you like to explore ways to further your career goals, employment goals, or work more hours?
3. Have you had any changes to your employment status?

Section 8: Participant Satisfaction and Rights

1. Are your caregivers or providers treating you with dignity and respect?

2. Are providers listening to you and your needs?

3. Are you satisfied with your services?

4. Are you pleased with the way your life is going?

Section 9: Closing Question

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

Section 10: Questions to be Answered by the Case Manger

1. The participant's place of residence appears to be safe.

2. (For participants under self-direction): Will the current rate of budget expenditure allow services to continue as needed through the entire plan term?

Section 11: Contact Summary and Required Follow-up

Contact Comments / Additional Notes: