**Ohio Department of Developmental Disabilities**

**Discharge Review Summary – Exit or Conversion Waiver and ICF/IID Downsize**

 \_\_\_90-day \_\_\_180-day \_\_\_1-yr \_\_\_Special

##

### **Date of Interview:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Discharge from** (\_\_\_\_\_DC):

### **Name of Individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Provider/Address:** **Provider County:**\_\_\_\_\_\_\_\_\_\_\_

**Type of Interview:** In Person: \_\_\_\_\_ Phone: \_\_\_\_\_\_ Other: \_\_\_\_\_\_ **Funding:** \_\_ICF; \_\_Waiver; \_\_Other

**Person Conducting Follow-Up:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Person(s)/Phone #(s) contacted if not a personal visit:**

|  |  |
| --- | --- |
|  | **COMMENTS** |
|  Environmental  |   |
| Is home clean and well kept?**Yes** or **No** |  |
| Are personal affects in individual’s bedroom?**Yes** or **No** |  |
| Are there any noticeable safety issues?**Yes** or **No** |  |
|  Personal Appearance |  |
| Is individual’s personal appearance clean and neat?**Yes** or **No** |  |
| **III. Individuals Affect** |  |
| Did individual interact or respond during visit?**Yes** or **No** |  |
| Did staff interact with individual during visit?**Yes** or **No** |  |
| Was staff present & able to share information about individual?**Yes** or **No** |  |
|  **IV. Medical** |  |
| Have there been any significant medication changes?**Yes** or **No** |  |
| Any apparent aversive effects of medication changes?**Yes** or **No** |  |
| Have there been any significant changes in weight?**Yes** or **No** |   |
| Have there been any health related issues or problems?**Yes** or **No** |  |
| Has person been able to access necessary consultants (medical, dental. psych)**Yes** or **No** |  |
|  **V. Program Services** |  |
| Are staff aware of individual needs?**Yes** or **No** |  |
| Is individual involved in activities at home?**Yes** or **No** |  |
| Is individual involved in activities away from home?**Yes** or **No** |  |
| Have there been any behavior support concerns?**Yes** or **No** |  |
| Is individual currently attending Day Services or working?**Yes** or **No** |  |
| **VI. Health and Safety:** |   |
| Have there been any noteworthy incidents (if so describe)?**Yes** or **No** |  |
| Have there been any MUIs (if so describe)?**Yes** or **No** |  |
| Does individual have all recommended adaptive equipment/devices?**Yes** or **No** |  |
| Is individual’s current diet order being followed?**Yes** or **No** |  |
| Current supervision level being maintained?**Yes** or **No** |  |
| **VII Individual Satisfaction:** |  |
| Are you happy living in your home? Does the person appear to be happy? (Please describe).**Yes** or **No** |  |
| Do you feel safe in your home? Does the person appear to feel safe? (Please describe).**Yes** or **No** |  |

**Additional Comments/Information:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_