DDD-1431AFORPF (4-07)

Clear The Form

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

ATTENDANT CARE/HOUSEKEEPING SERVICE MONITORING/SUPERVISION

This form should be used to evaluate Attendant Care/Housekeeping service provided by an Independent Provider or Qualified Vendor employee. A Qualified Vendor may choose to use this form or one by their own agency.

INDIVIDUAL'S NAME *(Last, First, M.I.)*		I.D. NO.
SUPPORT COORDINATOR'S NAME	SERVICE START DATE	MONITORING VISIT DATE

SERVICE

1. OUTCOME *(Objective)*

☐ Attendant Care (ANC) ☐ Attendant Care Family (AFC) ☐ Housekeeping

☐ 5 days ☐ 30 days *(ANC/AFC/HSK in-home)* ☐ 60 days *(if required)* ☐ 90 days

Check the appropriate box. If 'NO' is checked, please enter a comment.	**YES**	**NO**	**N/A**
1. Does the individual appear to have their ANC/AFC or HSK needs met?	☐	☐	☐
2. Was activity observed or reported as consistent with the service agreement?	☐	☐	☐
3. Is the provider respectful of the consumer/family choices?	☐	☐	☐
4. If attendant care (non-family member) is being provided, is the individual/family satisfied with the service provided?	☐	☐	☐
5. Are other providers used for this service? If yes, are there any concerns with the other providers?	☐	☐	☐
6. Are there skin integrity issues?	☐	☐	☐
6a. If there are skin integrity issues, is the provider following the ISP for resolution?	☐	☐	☐
6b. Has a nursing assessment been completed?	☐	☐	☐
7. Does the family know who to call if a problem arises?	☐	☐	☐
8. Does the individual/responsible person know who to call if there is a service gap or their provider does not show up to provide a scheduled service?	☐	☐	☐

MONITOR'S NAME	TITLE	SIGNATURE	DATE
CONSUMER OR FAMILY MEMBER'S NAME		SIGNATURE	DATE
PROVIDER'S NAME	TITLE	SIGNATURE	DATE

Routing: Original - Employee's file; copy - Consumer case record; copy - Provider file.

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