

**E&D WAIVER
PCS-IHR SUPERVISORY VISIT CHECKLIST FORM**

Participant Information					
Participant's Name:			Medicaid ID:		
Service Frequency:	PCS		IHR		
Representative's Name:			Phone Number:		
Direct Care Worker's Name:			DCW Present During Visit?	YES ☐	NO ☐

Quality Survey Responses: Participant Observation						
Questions	Select One					Initial
Is the participant generally pleased with services?	YES ☐	NO ☐	N/A ☐			
Does the participant appear comfortable and cared for?	YES ☐	NO ☐	N/A ☐			
Are the common areas neat and clean (i.e. bedroom, bathroom, kitchen)?	YES ☐	NO ☐	N/A ☐			
Does the participant have any complaints?	YES ☐	NO ☐	N/A ☐			
Are the interactions between the DCW and participant friendly?	YES ☐	NO ☐	N/A ☐			

Quality Survey Responses: DCW Observation						
Questions	Select One					Initial
Does the DCW report observations to the representative and/or agency?	YES ☐	NO ☐	N/A ☐			
Does the DCW follow the PSS?	YES ☐	NO ☐	N/A ☐			
Does the DCW complete documentation and obtain the client/representative signature at the end of each visit?	YES ☐	NO ☐	N/A ☐			
Is the DCW neat in appearance?	YES ☐	NO ☐	N/A ☐			
Does the DCW arrive as scheduled?	YES ☐	NO ☐	N/A ☐			
Does the DCW demonstrate respect for the participant's belongings?	YES ☐	NO ☐	N/A ☐			
Does the DCW demonstrate proper body mechanics?	YES ☐	NO ☐	N/A ☐			
Does the DCW demonstrate use of infection control/universal precautions?	YES ☐	NO ☐	N/A ☐			

Purpose of Visit						
Required Documentation	Date	Time	Follow Up Needed?			Initial
Initial			YES ☐	NO ☐	N/A ☐	
Bi-Weekly Supervised (DCW Present)			YES ☐	NO ☐	N/A ☐	
Bi-Weekly Unsupervised (DCW Not Present)			YES ☐	NO ☐	N/A ☐	
Complaint Review			YES ☐	NO ☐	N/A ☐	

If Yes to "Follow Up Needed," Please Check The Individual(s) Below:	
DCW	☐
Client	☐
Family/Representative	☐
Case Manager	☐

Supervisor Signature/Date

Client or Representative Signature/Date