

## Aged/Disabled Adult Waiver Case File Review Tool

PSA \_\_\_\_\_ County \_\_\_\_\_ Date \_\_\_\_\_

Case Management Agency \_\_\_\_\_

Initials											
LOC											
Freedom of Choice (available programs)											
Provider Choice											
Fair Hearing											
Legal guardianship											
Eligibility Documents											
Assessment is current											
Care Plan is current											
Dated and signed by Case manager											
Signed by client or representative											
Care Plan meets assessed needs											
Significant change Reassessments											
Legible and maintained in detail											
Annual Reassessment											
Face to Face visits											
Service Authorizations											
Documentation of receipt of services											
Justification for Medicare/Medicaid Covered Services to be paid using waiver funds											
Complaints											
Client Satisfaction											
Narratives											
Initials and Comments											

Note: Indicate Y for yes, N for no, or NA for not applicable in boxes.