

## **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.