SELF-DIRECTED SERVICES

Housing Subsidy Quality Assurance Checklist

DEVELOPMENTAL DISABILITIES REGIONAL OFFICE 2

NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

Individual Name: _____

Individual Address: _____

_____

Fiscal Intermediary: _____

Fiscal Intermediary Reviewer: _____

Care Coordination Manager Name: _____

This checklist is to be completed at the time of enrollment in the program and is expected to be updated annually. A new checklist will be required if an individual moves prior to the annual update.

Indicate "Yes" or "No" after each of the following statements.

1. The home has smoke detectors in the corridors outside the sleeping areas.	☐ Yes ☐ No
2. The smoke detectors work.	☐ Yes ☐ No
3. An evacuation plan was developed and reviewed with the individual particular to his/her living situation.	☐ Yes ☐ No
4. The home has a working telephone.	☐ Yes ☐ No
5. Local emergency phone contact is available and appropriate to the individual.	☐ Yes ☐ No
6. The home is reasonably clean and well maintained.	☐ Yes ☐ No
7. The home is free from hazardous conditions.	☐ Yes ☐ No
8. The furnishings are adequate.	☐ Yes ☐ No
9. The home meets the individual's physical needs and requirements	☐ Yes ☐ No
10. The heat, water, electricity and air conditioning (if applicable) are in good working order.	☐ Yes ☐ No
11. The home has a working carbon monoxide detector.	☐ Yes ☐ No
12. The individual's health, safety and well-being are reasonably maintained in the home.	☐ Yes ☐ No
13. The residence covered by renter's insurance.	☐ Yes ☐ No

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If "No" is indicated for any of the above items, check either (a), (b), or (c) below and describe the needed action.

_____ (a) The reviewer has discussed with the individual any problems with the above item(s), and does not consider them to be a significant threat to the individual's health, safety, or well-being.

_____ (b) The reviewer has discussed with the individual any problems with the above item(s), and the individual has been encouraged to access available services to address behaviors or activities which jeopardize his/her health, safety, or well-being.

_____ (c) The individual has not engaged in activities necessary to ensure his/her health, safety, or well-being, and therefore and alternate living arrangement must be developed.

Needed Actions: _____

_____

_____

_____

_____

_____

_____

_____ _____ / _____ / _____

Individual / Advocate Signature Date

_____ _____ / _____ / _____

Care Coordination Manager Signature Date

_____ _____ / _____ / _____

Fiscal Intermediary Reviewer Signature Date