CDC+ MONTHLY CONSUMER REVIEW FORM

Consumer Name: _____ Consultant Name: _____

Consumer ID #: _____ Consultant Agency: _____

Start Date: _____ Date of Monthly Review: _____

AREA TO BE REVIEWED	CONSULTANT TO INITIAL
1. Services and supports are in place and being purchased in accordance with approved Purchasing Plan.	YES _____ NO _____
• If no, Corrective Action Plan initiated, if required – attached.	YES _____ NO _____
2. Reviewed Monthly Budget Report with consumer/rep and noted no problems for which consumer/rep is responsible.	YES _____ NO _____
• If no, Corrective Action Plan initiated, if required – attached.	YES _____ NO _____
3. Consumer has all receipts for cash purchases made during month.	YES _____ NO _____
• If no, Corrective Action Plan initiated, if required – attached.	YES _____ NO _____
4. All cash purchases were for items identified on the approved Purchasing Plan.	YES _____ NO _____
• If no, Corrective Action Plan initiated, if required – attached.	YES _____ NO _____
5. Consumer is receiving all medically necessary supports and services to ensure his/her health, safety, and welfare needs are met.	YES _____ NO _____
• If no, Corrective Action Plan initiated, if required – attached.	YES _____ NO _____
6. Prior to pursuing a one-time expenditure or an increase in the monthly budget, all community resources have been explored. If not, explain below.	YES _____ NO _____

Detail all Problems/Concerns and follow-up needed:	**Date and How Addressed:**