

SEDGWICK COUNTY  
COMMUNITY DEVELOPMENTAL DISABILITY ORGANIZATION

**Quality Assurance Review Cover Sheet**

<b>Name of Individual Reviewed:</b>	<b>Date of Birth:</b>
<b>Review Team Agency:</b>	<b>Name of Agency Representative/Designee</b>  _____
<b>Name of Agency Volunteer</b>	
<b>Date of Day site visit:        /        /</b>	
<b>Date of Residential site visit:    /        /</b>	
<b>Agency and Location of Day Site:</b>  _____	<b>Time of Day site visit:</b>  _____ <b>AM/PM</b>
<b>Agency and Location of Residential Site:</b>  _____	<b>Time of Residential site visit:</b>  _____ <b>AM/PM</b>
<b>Agency and Location of SHC/PAS Site:</b>  _____	<b>Time of SHC/PAS site visit:</b>  _____ <b>AM/PM</b>
<small>Please indicate SHC or PAS</small>	

**Instructions for completing reviews & forms:**

If completing this review with an individual who does not communicate verbally or has communication difficulties, the reviewer may also ask these questions to a staff person, guardian and/or family member. If completing the review in this manner, please indicate this in the appropriate box, which is located at the top of the review for all forms except children's services.

Reviews are to take place at both the residential and day sites, if both types of services are received.

If an adult attends two day programs, only the most attended program needs to be reviewed.

Complete on-site reviews *after* documentation reviews have been completed.

**Please answer all questions with as much detail as possible.**