ISS INDEPENDENT SUPPORT SERVICES INC.
Make your Own Path

HOUSING SUBSIDY QUALITY ASSURANCE CHECKLIST

PARTICIPANT'S NAME:
PARTICIPANT'S ADDRESS:
FORM COMPLETED BY:
REVIEWER CONTACT INFO:
CARE MANAGER'S NAME:
BROKER'S NAME:

DATE: ______________________

DIRECTIONS: 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. Yes / No

1. The home has smoke detectors in the corridors outside the sleeping areas.
2. The smoke detectors work.
3. An evacuation plan was developed and reviewed with the individual particular to his/ her living situation.
4. The home has a working telephone.
5. Local emergency phone contact is available and appropriate to the individual.
6. The home is reasonably clean and well maintained.
7. The home is free from hazardous conditions.
8. The furnishings are adequate.
9. The home meets the individual's physical needs and requirements.
10. The heat, water, electricity and air conditioning (if applicable) are in good working order
11. The home has a working carbon monoxide detector.

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Yes / No

12. The individual's health, safety and well-being are reasonably maintained in the home.

13. The residence covered by renter's insurance.

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:

____ ____________

Housing Subsidy Participant/Advocate Signature Date

____ ____________

Care Manager's Signature Date

____ ____________

Broker's Signature Date

The above information was reported to ISS, Inc. by the COS and will be maintained with the housing documents. ISS representatives have not inspected the property nor can we confirm the validity of the information reported above. Any issues identified should be brought to the attention of OPWDD.

____ ____________

Fiscal Intermediary Representative Signature Date