



# CDC+ Monthly Consumer Contact



Consumer Name:	
Consumer ID#:	
Today's Date:	
Month/Year Of Contact:	

Areas to be Reviewed	YES	NO*	*If NO - enter CAP Initiated Date
1. Are all services and supports in place and being purchased in accordance with the approved Budget Plan?			
2. Has the Monthly Account Statement been reviewed with the consumer/representative and no problems identified for which the consumer/representative is responsible?			
3. Does the consumer have all receipts for cash purchases made during the month?			
4. Were all cash purchases for items identified on the approved budget plan?			
5. Is the consumer receiving all medically necessary supports and services to ensure his/her health, safety, and welfare needs are met?			

Problems/Concerns	How Problem(s)/Concern(s) Will Be Addressed

**Consultant's Name (Printed):** \_\_\_\_\_

**Consultant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

