KEPRO
INTELLIGENT VALUE

TBI Waiver On-Site Provider Review Tool

TBI Waiver Provider Agency: _____
Review Number: _____
WV Provider ID Number: _____
Date of Review: _____
Provider Educator(s): _____
Review Period: _____
Participants Files: _____
Staff Files: _____
Total # Participants Served: _____

CEO/Responsible Person to Whom Reports Will Go (include mailing address)	Email Address

The Office of Program Integrity (OPI) may be contacted for referral to the Medicaid Fraud Control Unit and disallowances may be recommended for:

*Services delivered to program members who are not medically and/or financially eligible
*Services delivered related to an invalid Service Plan
*Services delivered with no (or insufficient) supporting documentation
*Services delivered by a staff or employee who is not qualified
*Services delivered that exceed service limits
*Services delivered that are not indicated as a need on the program member's Service Plan
*Services delivered outside the scope of the service definition

Items highlighted in Red will be recommended for disallowance.
Items highlighted in Yellow will not be recommended for disallowance; however, will be addressed on the Agency's Plan of Correction and Technical Assistance will be provided.

WV Medicaid TBI Waiver Policy is referenced for all items that are recommended for a potential disallowance.

TBI Waiver Provider Review Tool

Qualified Personnel Identifier				
	Provider First Name	**Provider Last Name**	**Provider Role (CM, PAs)**	**Hire Date**
P1				
P2				
P3				
P4				
P5				
P6				
P7				
P8				
P9				
P10				

CM=C
ase
Manag
er
PAs=Personal Attendant Staff

	Provider Agency Certification	Score 1 = Yes 0 = No NA
	512.2 Provider Agency Certification	
1	Is the Provider enrolled to provide both Case Management and Personal Attendant Service, if yes is there evidence of: A. A separate certification and WV Medicaid provider number for each service; B. Separate staffing; and, C. Separate files for Case Management and Personal Attendant Services.	
1A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
1B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
1C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
2	The following documentation was provided during review : A. A business license issued by the State of West Virginia. B. A federal tax identification number (FEIN). C. A competency based curriculum for required training areas for personal attendant staff D. An organizational chart E. A list of the Board of Directors (if applicable) F. A list of all agency staff, which includes their qualifications. G. A Quality Management Plan for the agency.	
2A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
2B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
2C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
2D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT	
2E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT	
2F	INDICATE WITH "X" IF "F" WAS NOT COMPLIANT	
2G	INDICATE WITH "X" IF "G" WAS NOT COMPLIANT	
	512.2 Provider Agency Certification -Required Written Policies and Procedures	
3	Written policies and procedures for processing complaints and grievances, from staff or people receiving TBIW services, that: A. Addresses the process for submitting a complaint B. Provides steps for remediation of the complaint including who will be involved in the process C. Steps include the process for notifying the person/staff of the findings and recommendations D. Provides steps for advancing the complaint if the person/staff does not feel the complaint has been resolved E. Ensures that a person receiving TBIW services or agency staff are not discharged, discriminated, or retaliated against in any way if they have been a complainant, on whose behalf a compliant has been submitted or who has participated in an investigation process that involves a TBIW provider.	
3A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
3B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
3C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
3D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT	
3E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT	
4	Written policies and procedures for the use of personally and agency owned electronic devices which includes, but is not limited to: A. Prohibits using personally identifiable information in texts and subject lines of emails; B. Prohibits the use of personally identifiable information in the body of emails unless the email is sent securely through a HIPAA compliant connection; C. Prohibits personally identifiable information be posted on social media sites; D. Prohibits using public Wi-Fi connections; E. Informs agency employees that during the course of an investigation, information related on their personal cell phone is discoverable; F. Requires all electronic devices be encrypted.	
4A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
4B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
4C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
4D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT	
4E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT	
4F	INDICATE WITH "X" IF "F" WAS NOT COMPLIANT	

	Provider Agency Certification	Score 1 = Yes 0 = No NA
5	Written policies and procedures for people to transfer which includes, but is not limited to:(512.31) A. The person and/or legal representative must signed Request to Transfer Form and the form is sent to the UMC B. Transferring Agency Responsibilities C. Receiving Agency Responsibilities D. Emergency Transfers (512.32) E. Ensure that a person receiving TBIW services is not discharged unless a viable discharge/transfer plan is in place that effectively transfers all services that the person needs to another provider(s) and is agreed upon by the person and/or their legal representative and the receiving provider(s).	
5A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
5B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
5C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
5D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT	
5E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT	
6	Written policies and procedures for the discontinuation of person's services which includes but is not limited to: (512.33) A. Use of the BMS approved form-Request for Discontinuation Services Form B. Situations that warrant a request for discontinuation of services are outlined and match policy (512.33) C. All Requests for the Discontinuation of Services must be submitted and approved by the UMC	
6A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
6B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
6C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
7	Written policies and procedures to avoid conflict of interest (if agency is providing both Case Management and Personal Attendant Services) must include at a minimum A. Education of Case Managers on general Conflict of Interest/Professional Ethics with verification; B. Annual signed Conflict of Interest Statements for all Case Managers and the agency director; C. Process for investigating reports on conflict of interest complaints; D. Process for reporting to BMS; E. Process for complaints to professional licensing boards for ethics violations.	
7A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
7B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
7C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
7D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT	
7E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT	
8	Written policies and procedures for people with limited English proficiency and/or accessible format needs that are culturally and linguistically appropriate to ensure meaningful access to services.	
9	A written Agency Emergency Plan (for people receiving TBIW services and office operations). This plan must include: A. Office Emergency Back-Up Plan ensuring office staffing and facilities are in place during emergencies such as floods, fires, etc. B. Temporary facilities must meet requirements set forth by Chapter 512 C. UMC notify within 48 hours if temporary facilities are used D. Providers must inform people receiving TBIW services of their Emergency Back-Up Plan.	
9A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
9B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
9C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
9D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT	
	512.4 Incident Management/512.4.2 Incident Management Tracking and Reporting	

	Provider Agency Certification	Score 1 = Yes 0 = No NA
10	Written policies and procedures for thoroughly reviewing, investigating, and tracking all incidents involving the risk or potential risk to the health and safety of the people they serve, and shall include at a minimum: A. The provider's responsibility for taking appropriate action on both an individual and systemic basis in order to identify potential harms, or to prevent further harm, to the health and safety of all people served B. Classified all incidents as one of the following: Abuse, Neglect, Exploitation, Critical Incidents and/or Simple Incidents C. Review and analyze incident reports to identify health and safety trends D. Identified that health and safety concerns and remediation strategies will be incorporated into the agency Quality Management Plan.	
10A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
10B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
10C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
10D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT	
11	Participate in all mandatory training sessions, with proof of attendance certificate on file with the provider-in effective for reviews conducted after **4/2016.**	
	512.2.2 Office Criteria (Each office must meet the following criteria:)	
12	The TBIW provider physical office must: A. Be readily identifiable to the public. B. Maintain a primary telephone number that is listed with the name and local address of the business. (Note: Exclusive use of a pager, answering service, a telephone line shared with another business/individual, facsimile machine, cell phone, or answering machine does not constitute a primary business telephone.) C. Maintain an agency secure Health Insurance Portability and Accountability Act (HIPAA) compliant e-mail address for communication with BMS and the UMC for all staff. D. At a minimum, must have access to a computer, fax, email address, scanner, and internet. E. Utilize any database system, software, etc., compatible with/approved and/or mandated by BMS. F. Be open to the public at least 40 hours per week. G. Contain space for securely maintaining program and personnel records. H. Maintain a 24-hour contact method .	
12A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
12B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
12C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
18D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT	
12E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT	
12F	INDICATE WITH "X" IF "F" WAS NOT COMPLIANT	
12G	INDICATE WITH "X" IF "G" WAS NOT COMPLIANT	
12H	INDICATE WITH "X" IF "H" WAS NOT COMPLIANT	
13	Office space allows for confidentiality of the person receiving TBIW services.	
14	Is the provider using electronic and/or stamped signatures, if yes the following basic requirements are evident: A. Unique to the person using it B. Capable of verification C. Under the sole control of the person using it, and D. Linked to the data in such a manner that if the data is changed, the signature is invalidated.	
14A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
14B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
14C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
14D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT	
	512.2.4 Records Requirements	
15	There is evidence that the provider has used all required TBIW forms (program and personnel records) 4/2016	

	Provider Staff Certification	Score 1 = Yes 0 = No NA
	512.3.4 Personal Attendant Initial /512.3.5 Annual Training Requirements	
1	A competency based curriculum, including goals/objectives and evaluation system to gauge competencies, for the required training areas for Personal Attendant direct care staff exists. A. Cardiopulmonary Resuscitation (CPR) Training B. First Aid Training C. Infectious Disease Control Training D. Direct Care Skills Training E. Abuse, Neglect and Exploitation Training F. HIPAA Training G. Personal Attendant Professional Ethics Training H. Health and Welfare Training I. People First Language Training	
1A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
1B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
1C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
1D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT	
1E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT	
1F	INDICATE WITH "X" IF "F" WAS NOT COMPLIANT	
1G	INDICATE WITH "X" IF "G" WAS NOT COMPLIANT	
1H	INDICATE WITH "X" IF "H" WAS NOT COMPLIANT	
1I	INDICATE WITH "X" IF "I" WAS NOT COMPLIANT	
2	The Personal Attendant direct care training was provided by a qualified staff as directed in policy. A. Cardiopulmonary Resuscitation (CPR) - training by an agency nurse or certified trainer B. First Aid - training by an agency nurse or certified trainer C. Infectious Disease Control Training - materials used for training must be current D. Direct Care Skills Training - training by Registered Nurse, social worker/counselor, a documented specialist or an approved internet training provider E. Abuse, Neglect and Exploitation Training - training by a Registered Nurse, social worker/counselor, a documented specialist or an approved internet training provider F. HIPAA Training - training by a Registered Nurse, social worker/counselor, a documented specialist or an approved internet training provider G. Personal Attendant Professional Ethics Training - training by a Registered Nurse, social worker/counselor, a documented specialist or an approved internet training provider H. Member Health and Welfare Training - training by a Registered Nurse, social worker/counselor, a documented specialist or an approved internet training provider I. People First Language Training	
2A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
2B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
2C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
2D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT	
2E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT	
2F	INDICATE WITH "X" IF "F" WAS NOT COMPLIANT	
2G	INDICATE WITH "X" IF "G" WAS NOT COMPLIANT	
2H	INDICATE WITH "X" IF "H" WAS NOT COMPLIANT	
2I	INDICATE WITH "X" IF "I" WAS NOT COMPLIANT	
	512.3.2 Case Manager Initial and Annual Training Requirements	
3	A competency based curriculum, including goals/objectives and evaluation system to gauge competencies, for the required training areas for Case Manager exist: A. Conflict Free Case Management B. Personal Options Service Delivery Model C. Recognize and reporting Abuse, Neglect and Exploitation D HIPAA E. Person-Centered Planning and Service Plan Development	
3A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT	
3B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT	
3C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT	
3D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT	
3E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT	

	Qualified Personnel	Score	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
	512.3.8 (Criminal Investigation Background Check)											
1	There is evidence that a CIB background check was initiated prior to providing services and the outcome meets the TBI Waiver program requirements.	1 = Yes 0 = No										
2	There is evidence that a CIB background check was completed every three (3) years and the outcome meets the TBI Waiver program requirements. (WV Cares documentation required for re checks completed 01.2016 and forward)	1 = Yes 0 = No NA										
	512.3. 8 (Office of the Inspector General)											
3	Monthly documentation is present for the previous twelve months to indicate that staff persons are not on the list of excluded individuals maintained by the Office of the Inspector General and the outcome meets the TBI Waiver program requirements.	1 = Yes 0 = No										
	The following subset is applicable only to those providing **Personal Attendant Service**											
	512.3.5 Personal Attendant Service Staff Requirements											
4	There is documentation which verifies the provider is 18 years of age or older.	1 = Yes 0 = No										
5	Personal Attendant Service Staff must have completed the following competency based training **before** providing services to TBI Waiver members:	1 = Yes 0 = No										
A.	A current and valid copy of the CPR certification card is present	1 = Yes 0 = No										
B.	A current and valid copy of the First Aid certification card is present	1 = Yes 0 = No										
C.	There is evidence that training in OSHA has occurred	1 = Yes 0 = No										
D.	There is evidence that Personal Attendant Skills training focused on assisting individuals with TBI with ADL's has occurred.	1 = Yes 0 = No										
E.	There is evidence that HIPAA compliance training has occurred	1 = Yes 0 = No										
F.	There is evidence that training on Direct Care Ethics including promoting physical and emotional well-being, respect, integrity, responsibility, justice, fairness and equity when working with a member has occurred	1 = Yes 0 = No										
G.	There is evidence that training in Member Health and Welfare including emergency plan response, fall prevention, home and safety risk management has occurred initially and frequently as changes occur	1 = Yes 0 = No										
H.	There is evidence that training in the recognition and reporting of Abuse, Neglect and Exploitation has occurred	1 = Yes 0 = No										
I.	Crisis Intervention Training	1 = Yes 0 = No NA										
6	Personal Attendant Service Staff and Personal Options direct care staff meet all **annual** training requirements:	1 = Yes 0 = No NA										
A.	A current and valid copy of the CPR certification card is present **Evidence that skills was demonstrated (After 4/2016)**	1 = Yes 0 = No NA										
B.	A current and valid copy of the First Aid certification card is present	1 = Yes 0 = No NA										
C.	There is evidence that training OSHA**(*Infectious Disease Control)** training has occurred on an annual basis *After 4/2016	1 = Yes 0 = No NA										
E.	There is evidence that HIPAA compliance training has occurred on an annual basis	1 = Yes 0 = No NA										
F.	There is evidence that 4 hours of training focusing on enhancing direct care service delivery knowledge and skills has occurred on an annual basis	1 = Yes 0 = No NA										
G.	There is evidence that training in the recognition and reporting of Abuse, Neglect and Exploitation has occurred on an annual basis	1 = Yes 0 = No NA										

	Qualified Personnel	Score	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
	The following subset is applicable only to those providing **Case Management**											
	512.3.6 Case Manager Qualifications											
7	There is evidence that the case manager meets licensure requirements by a valid copy of license in the personnel file.	1 = Yes 0 = No										
8	There is evidence that the case manager received training:(Initial/Annual after **4/2016** (when due): A. Conflict Free Case Management B. Personal Options Service Delivery Model C. Recognize and reporting Abuse, Neglect and Exploitation D HIPAA E. Person-Centered Planning and Service Plan Development F. Professional Licensure training	1 = Yes 0 = No NA										
8A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT											
8B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT											
8C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT											
8D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT											
8E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT											
8F	INDICATE WITH "X" IF "F" WAS NOT COMPLIANT											
	512.3.3 Record Requirement Personnel Files											
8	Original and/or legible copies of personnel documents are maintained in the personnel file.	1 = Yes 0 = No										
9	Minimum credentials for professional staff is verified upon hire and thereafter based upon their individual professional license requirements.	1 = Yes 0 = No NA										
10	There is evidence that confidentiality agreement is in the file.	1 = Yes 0 = No										
11	There is evidence that the case manager has signed the conflict of interest statement.(04/2016 and forward)	1 = Yes 0 = No										
12	All documentation for the staff member is kept in the designated office that represents the county where services were provided.	1 = Yes 0 = No										
13	Prior to use of an internet provider for training, approval was received by APS Healthcare **512.3.5**.	1 = Yes 0 = No NA										
14	Training Documentation includes the training topic, date, beginning and end time of the training, location of the training and signatures of the instructor and trainee or for **Personal Options , the member and/or legal rep. 512.3.5.2**.	1 = Yes 0 = No										
15	Personnel Files contain all documented evidence of staff qualifications including:	1 = Yes 0 = No										
A.	License	1 = Yes 0 = No NA										
B.	Transcript	1 = Yes 0 = No NA										
C.	Certificates	1 = Yes 0 = No NA										
D.	References	1 = Yes 0 = No										
16	There is evidence that the agency has conducted an internal review process to ensure that employees meet the minimum qualifications.	1 = Yes 0 = No										

	Incident Reporting	Score	Record ID# Score	Record ID # Score	Record ID # Score	Record ID # Score	Record ID # Score
512.4.1 Reporting Requirements, Incident Management Documentation and Investigation Procedures							
1	Any incidents involving a person utilizing the TBIW must be reported to the UMC (or when available) entered into the West Virginia Incident Management System (WV IMS) within the next business day of learning of the incident. A. The Agency Director, designated agency staff, or Case Manager will immediately review each incident report. B. All Critical Incidents must be investigated. C. All incidents involving abuse, neglect and/or exploitation must be reported to Adult Protective Services or Child Protective Services. D. All incidents involving abuse, neglect and/or exploitation must be reported to the UMC (and noted in WV IMS when available).	1 = Yes 0 = No NA					
1A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
1B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
1C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT						
1D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT						
2	An Incident Report documenting the outcomes of the investigation must be completed and reported to the UMC (or when available entered into the WV IMS) within 14 calendar days of learning of the incident. Each Incident Report must be printed, reviewed and signed by the Director and placed in an administrative file. Providers are to report monthly if there were no incidents.	1 = Yes 0 = No NA					
3	If a death occurs in addition to reporting to the UMC (or WV IMS when available) the Case Manager must complete the Mortality Notification(*West Virginia Home and Community-Based (HCB) Waiver Notification of Death*) form within the next business day of learning of the death of a person utilizing the TBIW, and send the form to the UMC. **(Effective 10/2015)**	1 = Yes 0 = No NA					
4	Personal Attendant Service provider agencies must report to the UMC (or WV IMS when available) monthly the number of hospitalizations which occurred during the month. In addition, providers are to report if there were no incidents.	1= Yes 0 = No NA					
5	The criteria utilized for a thorough investigation includes but is not limited to: A. Report was fully documented to include the date of the incident, date the agency learned of the incident, facts of the incident type of incident, initial determination of the incident and verification that an approved professional conducted the investigation. B. All parties were interviewed and incident facts were evaluated. C. Person was interviewed. D. Determination of the cause of the incident. E. Identification of preventive measures. F. Documentation of any action taken as the result of the incident (worker training, personnel action, removal of staff, changes in the Service Plan) and G. Change in needs were addressed on the Service Plan.	1= Yes 0 = No NA					
5A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
5B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
5C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT						
5D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT						
5E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT						
5F	INDICATE WITH "X" IF "F" WAS NOT COMPLIANT						
5G	INDICATE WITH "X" IF "G" WAS NOT COMPLIANT						

	Member Record	Score	Record ID# Score	Record ID# Score	Record ID# Score	Record ID# Score	Record ID# Score
	512.10 Member Assessment						
1	Person-Centered Assessment was completed within seven (7) calendar days from receipt of Enrollment Confirmation Notice.	1 = Yes 0 = No NA					
2	Original, signed Member Assessment is in the member's record and includes the member and/or his/her legal representative signature. **(Initial or Annual)**	1 = Yes 0 = No NA					
3	A new Person-Centered assessment was completed as the Participant's needs change, when one or more of the following conditions were recorded on the Case Manager's Monthly Contact Document: A. Did you get all the services you were supposed to get last month? If not, then what services did you not receive? INDICATE with " X " IF Q 1 WAS CHECKED NO B. Are there times when you needed help and you didn't get it? If yes, what happened? INDICATE WITH "X" IF Q 3 WAS CHECKED YES C. Have your needs for assistance changed since we last talked? If so, how? INDICATE WITH "X" IF Q 4 WAS CHECKED YES D. Do you need any additional medical equipment, services or resources? If yes, what? INDICATE WITH "X" IF Q 7 WAS CHECKED YES E. Are you having any problems paying for or getting food, housing, utilities or medications? INDICATE WITH "X" IF Q 8 WAS CHECKED YES F. Have there been any changes in your life that affect your need for service (death, loss, divorce, etc.)? INDICATE WITH "X" IF Q 9 WAS CHECKED YES G. Have there been any changes to your prescribed medications? INDICATE WITH "X" IF Q 13 WAS CHECKED YES H. Did you use your Personal Attendant Services this month? INDICATE WITH "X" IF Q 14 WAS CHECKED YES	1 = Yes 0 = No NA					
3A	INDICATE WITH "X" IF CIRCUMSTANCE "A" WAS PRESENT						
3B	INDICATE WITH "X" IF CIRCUMSTANCE "B" WAS PRESENT						
3C	INDICATE WITH "X" IF CIRCUMSTANCE "C" WAS PRESENT						
3D	INDICATE WITH "X" IF CIRCUMSTANCE "D" WAS PRESENT						
3E	INDICATE WITH "X" IF CIRCUMSTANCE "E" WAS PRESENT						
3F	INDICATE WITH "X" IF CIRCUMSTANCE "F" WAS PRESENT						
3G	INDICATE WITH "X" IF CIRCUMSTANCE "G" WAS PRESENT						
3H	INDICATE WITH "X" IF CIRCUMSTANCE "H" WAS PRESENT						
4	A copy of all Assessments must be provided to the person and/or their legal representative (if applicable)	1 = Yes 0 = No					
5	A copy of all Assessments must be provided to the Personal Attendant Provider Agency and the F/EA if self-directing	1 = Yes 0 = No					

	Member Record	Score	Record ID# Score	Record ID# Score	Record ID# Score	Record ID# Score	Record ID# Score
	512.11 Service Plan Development						
1	Original, signed Service Plan is in the member's record and includes the member and/or his/her legal representative signature. **(Initial/6month or Annual)**	1= Yes 0=No					
2	Member's service plan (in effect at the time of the review) comprehensively addresses his or her identified needs, health care and other services in accordance with his or her expressed personal preferences and goals. A. Detail of all services are in the member's Service Plan including, Service Type, Provider of Service, frequency. B. Informal Supports that provide assistance are documented in the member's Service Plan. C. Needs identified in the Pre Admission Screening are addressed in the member's Service Plan. D. Needs identified in the Member's Assessment are addressed in the member's Service Plan. E. The member's goals and preferences are addressed in the Service Plan. F. Signature Sheet (and rationale for disagreement if necessary). G. Service Plan contains reference to any other services regardless of source of payment.	1= Yes 0=No					
2A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
2B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
2C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT						
2D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT						
2E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT						
3	The Service Plan meeting must be scheduled and held within seven (7) calendar days of the person's Assessment	1 = Yes 0 = No					
4	100 % of the member's Health and Safety Factors issues (as identified through the Member Assessment) were addressed and documented on page 4 of the member's Service Plan.	1 = Yes 0 = No					
5	Significant changes in the member's needs or circumstances promptly trigger consideration of modifications in his or her service plan. During the review period, if the following questions from the Case Management Monthly Contact form was "yes", look to see if consideration for a service plan modification was made. Not all members Service Plans will need revision during the review period. A. Did you get all the services you were supposed to get last month? If not, then what services did you not receive? INDICATE with " X " IF Q 1 WAS CHECKED NO. B. Are there times when you needed help and you didn't get it? If yes, what happened? INDICATE WITH "X" IF Q 3 WAS CHECKED YES. C. Have your needs for assistance changed since we last talked? If so, how? INDICATE WITH "X" IF Q 4 WAS CHECKED YES. D. Do you need any additional medical equipment, services or resources? If yes, what? INDICATE WITH "X" IF Q 7 WAS CHECKED YES. E. Are you having any problems paying for or getting food, housing, utilities or medications? INDICATE WITH "X" IF Q 8 WAS CHECKED YES. F. Have there been any changes in your life that affect your need for service (death, loss, divorce, etc.)? INDICATE WITH "X" IF Q 9 WAS CHECKED YES. G. Have there been any changes to your prescribed medications? INDICATE WITH "X" IF Q 13 WAS CHECKED YES. H. Did you use your Personal Attendant Services this month? INDICATE WITH "X" IF Q 14 WAS CHECKED YES	1 = Yes 0 = No NA					
5A	INDICATE WITH "X" IF CIRCUMSTANCE "A" WAS PRESENT						
5B	INDICATE WITH "X" IF CIRCUMSTANCE "B" WAS PRESENT						
5C	INDICATE WITH "X" IF CIRCUMSTANCE "C" WAS PRESENT						
5D	INDICATE WITH "X" IF CIRCUMSTANCE "D" WAS PRESENT						
5E	INDICATE WITH "X" IF CIRCUMSTANCE "E" WAS PRESENT						
5F	INDICATE WITH "X" IF CIRCUMSTANCE "F" WAS PRESENT						
5G	INDICATE WITH "X" IF CIRCUMSTANCE "G" WAS PRESENT						
5H	INDICATE WITH "X" IF CIRCUMSTANCE "H" WAS PRESENT						
	512.13.1 6-month, On-going, and Service Plan Addendum						
6	Member attended (in person) and signed his/her six month service plan.	1 = Yes 0 = No NA					
7	Representative (if applicable) attended (in person) and signed the six (6) month Service Plan.	1 = Yes 0 = No NA					
8	Case Manager attended (in person) and signed the six (6) month Service Plan.	1 = Yes 0 = No NA					
9	The Personal Attendant Service provider agency representative attended (in person) and signed the six (6) month Service Plan.	1 = Yes 0 = No NA					
10	A Service Plan Addendum is completed to document a change in the person's needs.	1 = Yes 0 = No NA					
11	The member attended (in person) and signed his/her Annual Service Plan.	1 = Yes 0 = No NA					

	Member Record	Score	Record ID# Score	Record ID# Score	Record ID# Score	Record ID# Score	Record ID# Score
12	Legal representative (if applicable) attended (in person) and signed the Annual Service Plan.	1 = Yes 0 = No NA					
13	Case Manager attended (in person) and signed the Annual Service Plan.	1 = Yes 0 = No NA					
14	The Personal Attendant Service provider agency representative attended (in person) and signed the Annual Service Plan.	1 = Yes 0 = No NA					
15	An Interim Service Plan was developed immediately to address any health and safety concerns. A. The Interim Service Plan was in effect for up to 21 calendars days from the date of the Enrollment Confirmation Notice B. Direct Care Services (Personal Attendant) were initiated with 3 business days	1 = Yes 0 = No NA					
15A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
15B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
16	Initial Service Plan is completed prior to the initiation of ANY services being billed.	1 = Yes 0 = No NA					
17	Documentation exists that shows that the member received the services specified in the Service Plan.	1 = Yes 0 = No					
	512.15 Transfers						
18	If the Member requested a transfer to another CMA or PASA during the review period, the initiating agency attempted to complete transfer with 45 days from the receipt of request to transfer.	1 = Yes 0 = No NA					
19	Transferring Agency - Case Management: A. Services were provided until transfer was complete B. Documentation exists that on the day of the transfer, a copy of the current PAS, the applicable Rancho Los Amigos Scale, the Service Plan, a copy of the Enrollment Confirmation Notice and any other pertinent documentation C. To maintain all original documents for monitoring purposes.	1 = Yes 0 = No NA					
19A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
19B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
19C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT						
20	Transferring Agency - Personal Attendant Services: A. Services were provided until transfer was complete B. Documentation exist that the member's current PAS, the Service Plan was provided to the receiving agency	1 = Yes 0 = No NA					
20A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
20B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
21	Receiving Agency - Case Management: A. Member Assessment was conducted within seven (7) business days of the transfer effective date B. Member Service Plan was developed within seven (7) business days of transfer effective date.	1 = Yes 0 = No NA					
21A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
21B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
22	Receiving Agency - Personal Attendant Services: Documentation exist that a face to face meeting with the member and /or legal representative occurred within 7 business to review the Service Plan.	1 = Yes 0 = No NA					
	512.23 Dual Provision of Service						
23	Is the member receiving dual services (TBI and PC) according to the Service Plan? If yes, the following documents must be included: A. Traumatic Brain Injury Waiver and Personal Care Dual Service Provision Request B. RN Personal Care Plan of Care C. Prior Authorization Notice - Approval	1 = Yes 0 = No NA					
23A	INDICATE WITH "X" IF "A" IS NOT VERIFIED						
23B	INDICATE WITH "X" IF "B" IS NOT VERIFIED						
23C	INDICATE WITH "X" IF "C" IS NOT VERIFIED						
	Evidence existed to substantiate that services billed were provided on the dates listed and were for the actual amount of time and number of units claimed						
24	Total number of member claims (within the review period) paid with appropriate supporting documentation	#					
25	Total number of member claims paid for the review period	#					

	Health & Welfare	Score	Record ID# Score	Record ID# Score	Record ID# Score	Record ID# Score	Record ID# Score
	512.10 Enrollment						
1	There is evidence of the Enrollment Confirmation Notice located in the Participant record for providers.	1 = Yes 0 = No					
2	There is evidence of the following required items located in the member record for Personal Attendant Services providers: A. Enrollment Confirmation Notice B. A copy of the completed initial/annual PAS C. A copy of the completed initial/annual Rancho LOC Assessment	1 = Yes 0 = No NA					
2A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
2B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
2C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT						
	512.5 Reporting						
3	The Case Management Agency has submitted the required monthly report to *KEPRO* during the review period. Monthly reports were submitted by the sixth (6th) business day of every month. A. Case Management Agency B. Monthly Incident Report	1 = Yes 0 = No NA					
3A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
3B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
	512.16.1 Case Management Responsibilities						
4	Initial contact by the Case Manager to the Participant was conducted within 7 calendar days after the start of direct care services from the Personal Attendant . **Document the start date for each reviewed member.**	1 = Yes 0 = No NA	Start Date:	Start Date:	Start Date:	Start Date:	Start Date:
5	Documentation exists which indicates that the changes in the Participants' needs are shared with all service providers listed on the Participant's service plan.	1 = Yes 0 = No NA					
6	Address a person's changing needs as reported by the person and/or their legal representative (if applicable), Personal Attendant professional, or informal support	1 = Yes 0 = No NA					
7	Case Manager or agency designee informs members/legal representatives of their rights, including: A. Information about grievance procedures B. Fair Hearing processes	1 = Yes 0 = No NA					
7A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
7B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
8	The member's Initial Service Planning Meeting was scheduled within seven (7) calendar days of the Person-Centered Assessment.	1 = Yes 0 = No NA					
9	The Person-Centered Service Plan was completed within 14 days from the completion of the Person-Centered Assessment.	1 = Yes 0 = No NA					
10	Documentation exists that the CM disseminated copies of the Service Plan to the Service Planning members and Participant-Directed Service Option providers (if applicable) within 14 calendar days from the date that the Service Plan meeting was held. A. Annual SP meeting B. 6 month SP meeting	1 = Yes 0 = No NA					
10A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
10B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
	512.12.1.2 On-going Case Management						
11	Monthly contact was made by the CM to the member each month during the review period.	1 = Yes 0 = No NA					
12	The Case Management Monthly Contact Form was completed and located in the member file for each month during the review period.	1 = Yes 0 = No NA					
	512.3.3 Record Requirements						
13	Participant's file contains all original documentation for services provided to them by the CM Agency. A. Completed, signed and current PAS is in the record B. Completed, signed Informed Consent Form is in the record C. Completed, signed Agency/Provider Selection Form is in the record D. Completed, signed Service Delivery Model Selection Form is in the record	1= Yes 0 = No NA					
13A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
13B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
13C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT						
13D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT						
14	All TBIW Service Plans have a section on the plan to document the crisis/backup plan for the following events: Disruption in Personal Attendant Services, natural disasters and weather conditions, compliance is determined if the section is completed with all items addressed from Page 8 of Service Plan.	1= Yes 0 = No NA					
	512.3.5Personal Attendant Responsibilities						
15	Personal Attendant Service Staff Requirements: A. The member's service plan should reflect his or her needs. If special needs are evident that requires specific training to assist in caring for the member, that training was provided to the Personal Attendant Service Staff B. An agency is responsible to ensure that the Personal Attendant Service staff is properly trained; this may include standardized crisis intervention training curriculums. The level of crisis intervention training must meet the member's needs						
15A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
15B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						

Case Management Notes 512.12.1, 512.12.1.1, 512.12.1.2		Score	Record ID# Score	Record ID# Score	Record ID# Score	Record ID# Score	Record ID# Score
# of Notes Reviewed:		#					
# of Notes Reviewed that Meet Requirements:		#					
# of Notes Reviewed Found to be Deficient (if an item is found to be deficient, specific information will be documented below):		#					
1	Service is indicated on the member's Service Plan.	1 = Yes 0 = No	**ALL NOTES REVIEWED WERE COMPLIANT WITH POLICY STANDARDS.** **___OR___** **THERE ARE RECOMMENDATIONS FOR DISALLOWANCE AND/OR TECHNICAL ASSISTANCE FOR THIS SECTION. FOR ADDITIONAL INFORMATION ON RECORD ID#S: (ENTER ALL APPLICABLE RECORD ID#s HERE) SEE BELOW.**				
2	Prior Authorization for each service was obtained **before** services were delivered.	1 = Yes 0 = No					
3	Name of TBI Waiver Member.	1 = Yes 0 = No					
4	Date of Service.	1 = Yes 0 = No					
5	Start time/Stop time.	1 = Yes 0 = No					
6	Signatures and Credentials of Case Manager.	1 = Yes 0 = No					
7	Activity documented reflects a valid Case Management service and is provided within the guidelines identified in the TBI Waiver Manual.	1 = Yes 0 = No					
8	Type of contact (face-to-face, phone, written).	1 = Yes 0 = No					

Provider Educator Notes - Case Management Documentation	Record ID #	Item #	Date/Time

	Personal Attendant Worksheet	Score	Record ID# Score	Record ID# Score	Record ID# Score	Record ID# Score	Record ID# Score
	512.12.2, 512.12.2.1						
	# of Worksheets Reviewed:	#					
	# of Worksheets Reviewed that Meet Requirements:	#					
	# of Worksheets Reviewed Found to be Deficient (if an item is found to be deficient, specific information will be documented below):	#					
1	Service is indicated on the member's Service Plan (For F/EA services provided must be reflected on the spending plan).	1 = Yes 0 = No					
2	Prior authorization for each service was obtained **before** services were delivered (For F/EA, items billed must be reflected on the Service Plan).	1 = Yes 0 = No					
3	The member's record includes a completed and signed Personal Attendant Worksheet for each month during the review period. Worksheets are 2 weeks in duration. Worksheet includes Supervisor signature, personal attendant signature , and member or legal representative signature. All three (3) signatures must be present on the worksheet for a score of 1.	1 = Yes 0 = No					
4	The completed and signed Personal Attendant Worksheet contains all of the following require elements: A. Name of the TBI Waiver member B. Personal Attendant Name C. Begin Date D. End Date E. Personal Attendant Services on the worksheet are identified on the member's service plan F. Personal Attendant's time of arrival G. Personal Attendant's time of departure H. Total # of hours worked that day I. Member or Legal Representative initials J. Personal Attendant's initials	1 = Yes 0 = No					
4A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
4B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
4C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT						
4D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT						
4E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT						
4F	INDICATE WITH "X" IF "F" WAS NOT COMPLIANT						
4G	INDICATE WITH "X" IF "G" WAS NOT COMPLIANT						
4H	INDICATE WITH "X" IF "H" WAS NOT COMPLIANT						
4I	INDICATE WITH "X" IF "I" WAS NOT COMPLIANT						
4J	INDICATE WITH "X" IF "J" WAS NOT COMPLIANT						
	512.12.2.2, 512.12.2.3 Transportation	NA					
5	Service is indicated on the member's Service Plan (For F/EA services provided must be reflected on the spending plan.)	1 = Yes 0 = No					
6	Prior authorization for each service was obtained **before** services were delivered. (For F/EA items billed must be reflected on the Service Plan.)	1 = Yes 0 = No					
7	Transportation services provided must be documented in the member record and include the following: A. Date of Service B. Total Miles driven C. Travel Time D. Destination E. Purpose of Travel F. Type of travel indicated	1 = Yes 0 = No					
7A	INDICATE WITH "X" IF "A" WAS NOT COMPLIANT						
7B	INDICATE WITH "X" IF "B" WAS NOT COMPLIANT						
7C	INDICATE WITH "X" IF "C" WAS NOT COMPLIANT						
7D	INDICATE WITH "X" IF "D" WAS NOT COMPLIANT						
7E	INDICATE WITH "X" IF "E" WAS NOT COMPLIANT						
7F	INDICATE WITH "X" IF "F" WAS NOT COMPLIANT						
8	Member must be present if transportation was used for community activities.	1 = Yes 0 = No NA					

ALL WORKSHEETS REVIEWED WERE COMPLIANT WITH POLICY STANDARDS.
___OR___
THERE ARE RECOMMENDATIONS FOR DISALLOWANCE AND/OR TECHNICAL ASSISTANCE FOR THIS SECTION. FOR ADDITIONAL INFORMATION ON UMC ID#s: (ENTER ALL APPLICABLE RECORD ID#s HERE) SEE BELOW.

Provider Educator Notes - PA Worksheet	Record ID #	Item #	Date/Time

Record or Staff ID	Section of Review Tool	Date/Time	Item #	Provider Educator Notes