**Supportive Day Care**

**I. General Policies and Procedures**

1. Describe the time span between referral and assessment.

1. Describe the time span between assessment and consumer participation.

1. What is your proposed rate for Supportive Day Care? Describe any additional charges.

1. Describe the following assessment procedures and who is responsible for the procedures:
2. Intake/Screening

1. Physician Report

1. Plan of Care (including activity plan)

1. Enrollment Agreement

1. Reassessment of Care Plan Timetable

1. Discharge criteria and notification

1. Describe your participant orientation procedure

1. Describe your record keeping method for each consumer including quarterly progress notes

1. Describe your policy and training for reporting suspected abuse or neglect of a participant

1. Describe your consumer grievance procedure

1. Attach a copy of your participant bill of rights and responsibilities that is posted and distributed to all participants6

1. Describe your procedure for handling participant medical emergencies.

1. Describe your emergency plan that includes plans for evacuation and relocation of participants in the event of an emergency such as fire, loss of power (lights and/or heat), and hurricanes/snowstorms:

1. Describe your nutrition services including how often and who provides the meals.

1. Attach a monthly schedule of participant activities.

1. Describe your arrangements or contract for transportation to your facility.

**II. Program Administration**

1. Do you have a governing body responsible for operation of your program?

1. Do you have an advisory committee?

1. Is your written plan of operation reviewed and updated annually?

1. Do you have an updated organizational chart?

1. Do you have a formally established fee schedule?

**III. Personnel Procedure**

1. Describe policy/procedure and frequency for:

|  |
| --- |
| **Tuberculosis Screening** |

1. Describe procedure and frequency for the following trainings, if applicable:

|  |
| --- |
| **CPR**    **First Aid** |

C. Describe procedure for staff and volunteer orientation.

D. Describe procedure and frequency for supervision and in-service training, including the use of standard protocols for communicable diseases and infection control

E. Do you perform evaluations for employees? How often?

F. Describe how you achieve the mandatory minimum staff to consumer ratio.

Provider employee who completed this form

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Supportive Day Care**

Please note the documents and records which will be required for the Consumer files and/or Employee files to be reviewed at the time of On Site Evaluation

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| EMPLOYEE Records Review | | | | | |
| Provider  Date  Monitor |  |  |  |  |  |
| Start Date  & Termination Date, if applicable |  |  |  |  |  |
| Number of reference checks |  |  |  |  |  |
| CORI Check |  |  |  |  |  |
| Orientation: Date |  |  |  |  |  |
| Job Description(s) |  |  |  |  |  |
| Licenses/Certificate of Training  Current/expired? |  |  |  |  |  |
| Ongoing training: dates  Communicable Diseases and Infection Control: Dates |  |  |  |  |  |
| CPR: latest dates  First Aid: latest dates  Current/expired? |  |  |  |  |  |
| Physical: latest date  (if applicable) |  |  |  |  |  |
| Performance Appraisal Date: |  |  |  |  |  |
| OIG monthly check |  |  |  |  |  |
| TB: latest date |  |  |  |  |  |
| Comments | | | | | |

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|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Consumer Records Review | | | | | |
| Provider  Date  Monitor |  |  |  |  |  |
| ASAP Authorization |  |  |  |  |  |
| Service start date  & termination date, if applicable |  |  |  |  |  |
| ID Info – name; address; phone; DOB |  |  |  |  |  |
| Emergency contact(s) and phone |  |  |  |  |  |
| Physician(s) report including medical |  |  |  |  |  |
| Plan of Care |  |  |  |  |  |
| Enrollment agreement |  |  |  |  |  |
| Semi-annual reassessment |  |  |  |  |  |
| Quarterly progress notes |  |  |  |  |  |
| Name of current CM |  |  |  |  |  |
| Comments | | | | | |
| NOTE: Shaded data elements are only required in the Consumer File if provider is not on Provider Direct. Otherwise the PD Demonstrator will be asked to illustrate “on screen”. | | | | | |

|  |  |
| --- | --- |
| **Name and Position of Provider Direct Demonstrator** |  |