#### SERVICE CAPACITY

* 1. Attach copies of all policies and procedures related to the provision of Bill Payer/Rep Payee services.
	2. Describe your professional qualifications to provide Bill Payer/Rep Payee Services, including a brief history of your organization’s engagement in providing this service. Attach relevant designations/certifications.
	3. Describe the process for matching consumers and Bill Payers/Rep Payees.
	4. Describe the documentation requirements for the service.
	5. How do you monitor the services provided to ensure the consumer’s funds are safe and protected from misappropriation and/or financial exploitation?
	6. Describe your policy for ensuring consumer choice in the provision of this service.
1. Is this service currently subject to audit by any other payer(s)? If so, provide details.
2. What is your proposed rate for Bill Payer Services? per Describe any additional charges

#### STAFF QUALIFICATIONS

* 1. What experience and qualifications are required for those providing direct service to consumers?
	2. Describe in detail the screening and interviewing process.

#### TRAINING AND IN-SERVICE EDUCATION

* 1. Describe the initial training and orientation of Bill Payers/Rep Payees. Attach a copy of the curriculum for training Bill Payers/Rep Payees.
	2. Describe the ongoing training requirements.

#### SUPERVISION

* 1. Describe the procedures for supervision, including frequency, documentation, and credentials/qualifications of supervisors.
	2. Describe the procedures for reviewing bank and financial statements, including frequency and persons responsible.

Employee who completed this form Date:

SERVICE SPECIFIC ON-SITE REVIEW

**Bill Payer/Representative Payee Services**

### 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 Evaluation

|  |  |
| --- | --- |
| CONSUMER Record Review |  |
| Provider Date Monitor |  |  |  |  |  |  |
| Authorization/referral form |  |  |  |  |  |  |
| ID Info – name; address; phone; DOB |  |  |  |  |  |  |
| Emergency contact(s) and phone |  |  |  |  |  |  |
| Functional status/limitations |  |  |  |  |  |  |
| Name of current CM/RN |  |  |  |  |  |  |
| Service start date& Termination date, if applicable |  |  |  |  |  |  |
| Comments |  |  |  |  |  |  |
| NOTE: Shaded data elements are only required in the Consumer File if provider is not on Provider Direct.  |
|  |  |

# Bill Payer/Representative Payee Services

## SERVICE SPECIFIC ON-SITE REVIEW

### 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 Evaluation

|  |
| --- |
| EMPLOYEE Record Review |
| Provider Date Monitor |  |  |  |  |  |
| Service start date& Termination date, if applicable |  |  |  |  |  |
| Number of reference checks |  |  |  |  |  |
| CORI Check |  |  |  |  |  |
| Job Description(s) |  |  |  |  |  |
| Ongoing training dates: if applicable |  |  |  |  |  |
| OIG monthly checks |  |  |  |  |  |
| Annual Performance Appraisal: Date |  |  |  |  |  |
| Comments |