## SERVICE CAPACITY

* 1. What is your proposed rate for Companion Services? per
  2. Provide the number of Companion workers with your agency.

Also include what percentage of your direct care workforce is available to work the following schedules:

* + 1. Evenings
    2. Overnights
    3. Weekends
  1. Provide a detailed, concrete description of how staffing is managed day-to-day, including scheduled and unscheduled worker absences, orientation of substitutes, notifications, evening and weekend coverage, etc.
  2. In the event of emergency, describe your agency’s process/policy for maintaining an accessible current list for

Risk Level 1 & 2 to ensure services to these consumers

* 1. Describe your policy regarding the provision of Companion service outside the home.

## STAFF QUALIFICATIONS:

* 1. Describe the experience and qualifications of the person responsible for service provision (the manager of the program), if different from the information provided in the Administrative Overview.
  2. Describe the experience and qualifications you require for Companions.

## TRAINING AND IN-SERVICE EDUCATION

* 1. Describe your requirements for job specific training prior to placement, including ensuring worker sensitivity to elders, recognition of and reporting requirements regarding elder abuse and neglect, other emergency response issues, etc.
  2. Describe the on-going training program for Companions
  3. What are required mandated trainings?

## SUPERVISION

* 1. Describe the procedures for supervision, including frequency, documentation, and credentials/qualifications of supervisors for each position (direct care, coordinators, supervisors, etc.).
  2. Describe the systems and procedures employed to ensure that services are delivered to consumers as authorized, including telephony, unannounced field visits, quality assurance calls, etc.
  3. Describe the supervisory support available to direct care workers during non-business hours, including how supervisors are contacted, the titles and, as applicable, licensure of available supervisors.

# Employee who completed this form Date:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| EMPLOYEE Records Review | | | | | |
| Provider Date Monitor |  |  |  |  |  |
| Start date  & Termination Date , if applicable |  |  |  |  |  |
| Number of reference checks |  |  |  |  |  |
| CORI Check |  |  |  |  |  |
| DPH Registry Check |  |  |  |  |  |
| Orientation: Date |  |  |  |  |  |
| Job Description(s) |  |  |  |  |  |
| Field visit/Supervision dates |  |  |  |  |  |
| OIG monthly checks |  |  |  |  |  |
| Ongoing training dates  (6 hours annually + 3 mandatory training hours HIPPA, Abuse, OSHA) |  |  |  |  |  |
| Comments | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| CONSUMER Records Review | | | | | | |
| Provider:Date:Monitor: |  |  | |  |  |  |
| ASAP Authorization |  |  | |  |  |  |
| ID Info – name; address; phone; DOB |  |  | |  |  |  |
| Emergency contact(s) and phone |  |  | |  |  |  |
| Physician(s) name and phone |  |  | |  |  |  |
| Hospital name and phone |  |  | |  |  |  |
| Medical/social diagnosis |  |  | |  |  |  |
| Task/preferences |  |  | |  |  |  |
| Therapeutic goal noted in Service Plan |  |  | |  |  |  |
| Consumer feedback solicited? Dates: |  |  | |  |  |  |
| Termination date, if applicable |  |  | |  |  |  |
| Comments | | | | | | |
| NOTE: Shaded data elements are only required in the Consumer File if provider is not on Provider Direct. | | | | | | |
|  | | |  | | | |