# Personal Emergency Response Systems (PERS)

## SERVICE CAPACITY

* 1. Describe how your PERS work.
	2. After receiving a call from the ASAP to initiate service, describe your agency's procedures. Include expected time frames and average time between ASAP referral and the start of service to the consumer.
	3. Describe your process for responding to consumers who speak a language not spoken by your monitoring staff, are hearing impaired, or are confused.
	4. Describe your process for testing in-home equipment. How frequently is testing done? What is the procedure for replacing or repairing malfunctioning equipment?
	5. What documentation is kept on file? Who is responsible for the testing? Is the consumer able to replace the pendant battery?
	6. Where is your monitoring station located?
	7. How do you notify the ASAP regarding consumer PERS usage?

***NOTE:*** *Rates for PERS and PERS installation are standard MassHealth rates established by the Division of Health Care Finance and Policy.*

1. In the event of a power failure (e.g. electric, telephone), will the PERS continue to work?
2. What is your agency’s policy in the event that equipment is damaged or lost?
3. Describe the process for retrieval of equipment once a consumer is terminated from the ASAP.

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## 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 staff providing this service, including coordinators, installers, and, as applicable, monitoring station personnel.

## SUPERVISION

* 1. Describe the procedures for supervision, including frequency, documentation, and credentials/qualifications of supervisors for each position.
	2. Describe the systems and procedures employed to ensure that services are delivered to consumers as authorized.

Employee who completed this form Date:

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| EMPLOYEE Records Review |
| Provider Date Monitor |  |  |  |  |  |
| Start Date& Termination Date, if applicable |  |  |  |  |  |
| Number of reference checks |  |  |  |  |  |
| CORI Check |  |  |  |  |  |
| Orientation: Date |  |  |  |  |  |
| Job Description(s) |  |  |  |  |  |
| Physical: Latest date (if applicable) |  |  |  |  |  |
| TB: latest date (if applicable) |  |  |  |  |  |
| Ongoing training: dates |  |  |  |  |  |
| OIG monthly checks |  |  |  |  |  |
| Annual Performance Appraisal: Date |  |  |  |  |  |
| Comments |

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| CONSUMER Records Review |
| Provider:Date: Monitor: |  |  |  |  |  |
| ASAP authorization |  |  |  |  |  |
| ID Info – name; address; phone; DOB |  |  |  |  |  |
| Physician(s) name and phone |  |  |  |  |  |
| Current CM/RN and phone |  |  |  |  |  |
| Emergency Responder(s) name, phone, location of keys |  |  |  |  |  |
| Date of referral/installation |  |  |  |  |  |
| Hospital name and phone |  |  |  |  |  |
| Date of service termination |  |  |  |  |  |
| Date of unit removal |  |  |  |  |  |
| Comments |  |  |  |  |  |
| NOTE: Shaded data elements are only required in the Consumer File if provider is not on Provider Direct.  |
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