# Short Term Care

**Check all that apply**: Adult Foster Care

Rest Home Hospital Based Adult Respite

Skilled Nursing Facility Assisted Living Facility

## GENERAL POLICIES AND PROCEDURES

* 1. Attach a copy of your last Department of Public Health survey and Plan of Correction (if applicable).
  2. What is your referral procedure? Can you accept consumers on short notice?
  3. Describe your medication policy with respect to ASAP referrals (i.e., should the consumer bring their own medications with them?).
  4. Describe your policy to notify ASAP agency when there is a change in the consumer’s status &/or needs (i.e. hospitalization).
  5. Describe your policy to notify ASAP agency when service is altered from what was authorized (i. e. discharged prior to authorized date/ approval for MassHealth).

## ADULT FOSTER CARE

* 1. Describe your procedure for selecting homes where consumers will be placed.
  2. Describe your procedure for supervising the care of consumers while they are in those homes.

## RATE

* 1. What is your proposed rate for Short Term Care? per

Describe any additional charges.

* 1. Attach a copy of your current approved MMQ rates (if applicable).

Employee who completed this form Date:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| EMPLOYEE Records Review | | | | | |
| Provider Date Monitor |  |  |  |  |  |
| Start Date  & Termination Date, if applicable |  |  |  |  |  |
| Number of reference checks |  |  |  |  |  |
| CORI check |  |  |  |  |  |
| Orientation: Date |  |  |  |  |  |
| Job description(s) |  |  |  |  |  |
| Ongoing training: dates |  |  |  |  |  |
| OIG monthly checks |  |  |  |  |  |
| Annual performance Appraisal: date |  |  |  |  |  |
| Comments  **Obtain current copy of DPH license for long-term care facility** | | | | | |

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| --- | --- | --- | --- | --- | --- | --- |
| CONSUMER Records Review | | | | | | |
| Provider Date Monitor |  |  | |  |  |  |
| ASAP authorization |  |  | |  |  |  |
| ID Info – name; address; phone; DOB |  |  | |  |  |  |
| Emergency contact(s) name and phone |  |  | |  |  |  |
| Physician(s) name and phone |  |  | |  |  |  |
| Hospital name and phone |  |  | |  |  |  |
| Medical/ social diagnosis |  |  | |  |  |  |
| Current CM/RN |  |  | |  |  |  |
| Service start/termination date |  |  | |  |  |  |
| Date of referral |  |  | |  |  |  |
| Service Plan |  |  | |  |  |  |
| Comments | | | | | | |
| NOTE: Shaded data elements are only required in the Consumer File if provider is not on Provider Direct. | | | | | | |
|  | | |  | | | |