## General Policies and Procedures

* 1. Describe the time span between referral and assessment.
  2. Describe the time span between assessment and consumer participation.
  3. What is your proposed rate for Supportive Day Care?
  4. Describe any additional charges.
  5. Describe the following assessment procedures and who is responsible for the procedures:
     1. Intake/Screening
     2. Physician Report
     3. Plan of Care (including activity plan). Is Supportive Day Care staff knowledgeable about each participant’s capabilities, interests, preferences and needs? Are such preferences and needs supported in the development and review of the participant’s care plan?
     4. Enrollment Agreement
     5. Reassessment of Care Plan Timetable. Also, how do you support ongoing considerations for preferences and needs in the development and review of the participant’s care plan?
     6. Discharge criteria and notification
  6. Describe your participant orientation procedure. How do you convey the practice of including each participant’s capabilities, interests, preferences and needs in the development and review of the participant’s care plan at the time of orientation?
  7. 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.
2. Describe your consumer grievance procedure.
3. Attach a copy of your participant bill of rights and responsibilities that is posted and distributed to all participants.
4. Describe your procedure for handling participant medical emergencies.
5. 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.
6. Describe your nutrition services including how often and who provides the meals.
7. Describe what the Supportive Day Care Program considers to be a meaningful day for individuals in the Supportive Day Care program.
8. Attach a monthly schedule of participant activities.
9. Describe your arrangements or contract for transportation to your facility.

## Program Administration

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

Yes

* 1. Do you have an advisory committee?

Yes

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

Yes

* 1. Do you have an updated organizational chart?

Yes

* 1. Do you have a formally established fee schedule?

Yes

## Personnel Procedure

* 1. Describe policy/procedure and frequency for Tuberculosis Screening
  2. Describe procedure and frequency for the following trainings, if applicable CPR

First Aid

1. Describe procedure for staff and volunteer orientation.
2. Describe procedure and frequency for supervision and in-service training, including the use of standard protocols for communicable diseases and infection control.
3. Do you perform evaluations for employees?

Yes

How often?

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

## Physical Setting

* 1. Is the Supportive Day Care program co-located in the same building (or in the same campus setting) with other

services/ supports?

Yes

If yes, what other programs are located with it?

Hospital Nursing Facility Residential

Senior Center/Council on Aging Other

If yes, are individuals allowed to move about inside and outside of their specific service setting as opposed to one restricted room or area?

Select One

B. Is the Supportive Day Care program co-located or adjacent to the following sites? Medical Facility/Hospital

Intermediate Care Facility (ICF) Nursing Facility

C. Describe the physical setting of the Supportive Day Care program

Residential neighborhood Industrial area Retail/commercial area Other

Employee who completed this form 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 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 (at hire and every 2 years) |  |  |  |  |  |
| Comments  **Obtain current copy of DPH ADH License** | | | | | |

**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 Evaluation

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 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. | | | | | | |
|  | |  | | | | |