"People helping people help themselves"

Michael R. Pence, Governor
State of Indiana

Family and Social Services Administration
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083
1-800-545-7763

DIVISION OF AGING
Provider Compliance Review

CONTACT INFORMATION:

COORDINATOR:		**HR PHONE:**	
COORDINATOR PHONE:		**HR E-MAIL:**	
COORDINATOR E-MAIL:		**AGENCY CONTACT NAME:**	
SURVEYOR:		**2ND AGENCY CONTACT NAME:**	
SURVEYOR PHONE:		**2ND AGENCY CONTACT JOB TITLE:**	
SURVEYOR E-MAIL:		**2ND AGENCY CONTACT OFFICE PHONE:**	
REVIEW #:		**2ND AGENCY CONTACT CELL PHONE:**	
AGENCY FID:		**2ND AGENCY CONTACT E-MAIL:**	
AGENCY NAME:		**AGENCY STREET ADDRESS:**	
AGENCY INSITE ID:		**AGENCY CITY:**	
CEO NAME:		**STATE:**	
CEO PHONE#:		**ZIP CODE:**	
CEO E-MAIL#:		**COUNTY:**	
HR CONTACT NAME:		**AREA AGENCY ON AGING:**	

Indicate with an "X" the services approved to provide under the waivers (A&D, TBI).

Code	Service	AD	TBI
	Case Management		
	Adult Family Care		
	Adult Day Care		
	Attendant Care		
	Home Maker		
	Transportation		
	Residential Based Habilitation		
	Supported Employment		
	Behavior Management		
	Structured Day Program		
	Vehicle Modification		
	Home Delivered Meals		
	Environmental Modification		
	Personal Emergency Response		
	Specialized Medical Equipment		

Review 10% of personnel files for personnel (maximum of 20 files/minimum of 2 files).	
# OF PERSONNEL:	
# OF RECORDS REVIEWED DURING INITIAL:	

POST REFERRAL FOLLOW-UP:

REVIEW COORDINATOR NOTES:

INITIAL SURVEY			FOLLOW-UP		INDICATORS/PROBES	APPLICABLE SERVICES															
NA	MET	NOT MET	MET	NOT MET		CASE MANAGEMENT	ADULT FAMILY CARE	ADULT DAY SERVICE	ATTENDANT CARE	HOME MAKER	TRANSPORTATION	RESIDENTIAL BASED HABILITATION	SUPPORTED EMPLOYMENT	BEHAVIOR MANAGEMENT	STRUCTURED DAY PROGRAM	VEHICLE MODIFICATION	HOME DELIVERED MEALS	ENVIRONMENTAL MODIFICATION	PERSONAL EMERGENCY RESPONSE	SPECIALIZED MEDICAL EQUIPMENT	SOLO PROVIDER
					A1. A copy of current and signed provider agreement (455 IAC 2-6-1). (Schedule A)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
					A2. Pursuant to federal law the provider will give written notice to FSSA, the State's Medicaid Waiver Specialist and its fiscal agent, at least sixty (60) days before making a change in any of the following: 1) Name (legal name, DBA name, or name as registered with the Secretary of State); 2) Address (service location, "pay to", "mail to", or home office); 3) Federal Tax ID number(s); 4) Change in the providers direct or indirect ownership interest or controlling interest.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
					A3. For **Personal Service Providers** is the number of clients served less than 8 people? (individual providers are not to serve more than 7 people) (IC 26-4-4). Providers which are operating as an agency (under a FID), are required to be licensed.				X	X										
					A4. For **Adult Family Care**, is the number of clients served no more than that which they are approved for (not more than 4, but may be fewer based on approval by location)? HCBS waiver provider manual, section 8 (Per Waiver Guidelines).		X														
					A6. Primary Caregiver lives in the home (AFC Provider Checklist)(III)(E)(1). **Provider must live in the AFC home, unless another provider-contracted primary caregiver, who meets all providerqualifications, lives in the provider's home (Waiver Application, Service Definition for Adult Family Care)**		X													
					A7. Current professional and personal liability insurance policy to cover: personal injury, and property damage to an individual caused by fire, accident, or other casualty arising from the provision of services by the provider (455 IAC 2-6-2)(455 IAC 2-11-1). *AFC Providers are required to have Commercial General Liability Insurance.*	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
					B1. Written, **personnel policies** reviewed annually, and updated as needed to include (455 IAC 2-15-2)(a)(2):	X	X	X	X	X	X	X	X	X	X						
					B2. A procedure for conducting reference and employment, and criminal background on each prospective employee or agent (455 IAC 2-15-2)(b)(1).	X	X	X	X	X	X	X	X	X	X						
					B3. A prohibition against employing or contracting with a person convicted of: Sex Crime; Exploitation of an endangered adult; Abuse or Neglect of a child; Failure to report battery; Neglect or Exploitation of an adult or child; Theft; Murder; Voluntary or Involuntary Manslaughter; and Battery (455 IAC 2-15-2)(b)(2).	X	X	X	X	X	X	X	X	X	X						
					B4. Job descriptions for each position including minimum qualifications and major job duties of the position (455 IAC 2-15-2)(b)(4).	X	X	X	X	X	X	X	X	X	X						

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INITIAL SURVEY			FOLLOW-UP		INDICATORS/PROBES	APPLICABLE SERVICES																
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					B5. A process for evaluation of job performance at the end of a training period and, annually, and including a process from individuals receiving services to give feedback on an employee or agent (455 IAC 2-15-2)(b)(3).	X	X	X	X	X	X	X	X	X	X						
					B6. Disciplinary procedures (455 IAC 2-15-2)(b)(4).	X	X	X	X	X	X	X	X	X	X						
					B7. Description of grounds for disciplinary action or dismissal of employee of Agent (455 IAC 2-15-2)(b)(5).	X	X	X	X	X	X	X	X	X	X						
					B8. Description of an employee's right and responsibilities, including responsibilities of administrators and supervisors (2-15-2)(b)(6).	X	X	X	X	X	X	X	X	X	X						
					B9. Procedure to ensure compliance with HIPAA, confidentiality, and privacy requirements (455 IAC 2-15-2)(b)(7); (455 IAC 2-21-1)(8)(A).	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
					B10. A client's file, if not at the clients' home, or primary site of services is located at the office of the provider (455 IAC 2-16-2)(a).	X	X	X	X	X	X	X	X	X	X						X
					B11. A provider shall maintain in the provider's office, files for each employee or agent of the provider (455 IAC 2-14-1)(a).	X	X	X	X	X	X	X	X	X	X						
					B12. A provider or its agent shall maintain, in the provider's office, documentation of all services provided to an individual (455 IAC 2-16-1)(a).	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
					B13. Back Up Plan – Provider most produce a plan that covers backup services which must be provided by a qualified individual familiar with the individuals needs for those times when the primary caregiver is absent from the home or otherwise cannot provide the necessary level of care (TBI and A&D Waiver Application, AFC Service Standards). For Back up, provider required to assure B2, B3, B5, and B7 are included.		X														X
					B14. A system in place for the transfer of information to and from each provider listed on the individual's plan (455 IAC 2-16-2)(b)	X	X	X	X	X	X	X	X	X	X						X
					B15. Maintain a current organization chart to include Parent organization and subsidiary organization (455 IAC 2-9-1)	X	X	X	X	X	X	X	X	X	X						
					B16. A written quality assurance and quality improvement system, updated annually, that includes: (455 IAC 2-9-5)	X	X	X	X	X	X	X	X	X	X						X
					B16a. Focus on an individual (455 IAC 2-9-5)(a)(1).	X	X	X	X	X	X	X	X	X	X						X
					B16b. Appropriate for services being provided (455 IAC 2-9-5)(a)(2).	X	X	X	X	X	X	X	X	X	X						X
					B16c. Includes a process for analyzing data for reportable incidents, developing and reviewing recommendations to reduce risk of future incidents (455 IAC 2-9-5)(b).	X	X	X	X	X	X	X	X	X	X						X

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					B16d. Annual survey of individual satisfaction in accordance with contract (455 IAC 2-9-5)(b)(1).	X	X	X	X	X	X	X	X	X	X						X
					B16e. Record of findings of annual satisfaction survey (455 IAC 2-9-5)(b)(2).	X	X	X	X	X	X	X	X	X	X						X
					B16f. Documentation of efforts to improve services based on survey feedback (455 IAC 2-9-5)(b)(3).	X	X	X	X	X	X	X	X	X	X						X
					B17. A written operations manual addressing the requirements in 455 IAC 2 and regularly updated and revised at least annually (455 IAC 2-15-3)	X	X	X	X	X	X	X	X	X	X						X
					B17a. For incident filing and review (455 IAC 2-8-1, 455 IAC 2-8-2. Wavier Assurance G-1): A written procedure for filing within 24 hours, any suspected Abuse, Neglect or Exploitation, or Death of a participant with APS, or CPS and DA's Incident Reporting website consistent with provider requirements.	X	X	X	X	X	X	X	X	X	X						X
					B17b. A procedure in place for filing within 48 hours of any unusual occurrence via DA's Incident Reporting website consistent with provider requirements (455 IAC 2-8-2).	X	X	X	X	X	X	X	X	X	X						X
					B17c. A review of incidents filed over last month (or at least the last 5 incidents) show compliance with procedures and provider requirements (455 IAC 2-8-1)	X	X	X	X	X	X	X	X	X	X						X
					B18. Records of regular and appropriate maintenance of all vehicles used in the transportation services (455 IAC 2-12-1)(1).						X										
					B19. Current vehicle registration from the Indiana Bureau of Motor Vehicles; or current registration in the state that the vehicle's owner resides in (455 IAC 2-12-1)(3).						X										
					B20. Maintain financial records in accordance with generally accepted accounting and bookkeeping practices (455 IAC 2-10-1)(a)(1) ****Some evidence of a filing or accounting system (**all providers**). Check applicable service(s): (Review the last 5 jobs)* ☐ **E-MOD/V-MOD:** Receipts maintained for all incurred expenses related to the modifications. ☐ **Specialized Medical Equipment and Supplies:** Receipts for purchases. ☐ **PERS:** Documentation of expense for installation. Documentation of monthly rental fee if applicable.											X	X	X	X	X	X

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					B21. Supply a warranty effective for at least one (1) year from the date of new installation or the date the individual received the new item, whichever is applicable. (455 IAC 2-18-1) *** VMOD, EMOD, Durable medical Equipment, and PERS only. (Review the last 5 jobs to ensure a Warranty was provided)											X		X	X	X	X
					B22. If needed, is diet/nutrition counseling provided by a registered dietician? (ask if they provide diet/nutrition counseling; If yes, ask who delivers)												X				
					B23. Diet modification according to a physician's order as required, meeting the recipient's medical and nutritional needs (if needed) Do any individuals you serve require or request specialized diets? If so, are you able to provide specialized diets? How do you ensure that these are consistent with needs and/or a physician's order? Look for evidence of practice (2011 HCBS Waiver Provider Manual, Section 22).												X				
					C1. Be at least 18 years of Age (455 IAC 2-6-3)(1); (AFC Provider Checklist)(III)(E)(2).	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
					C2. Demonstrate ability to provide services under individual's plan of care as documented by staff training records including training topics, date of training, and qualifications or trainers. (455 IAC 2-14-1)(b)(5).		X	X	X		X	X	X		X							
					C3. Current Professional Licensure, certification or registration (455 IAC 2-14-1)(c)(2), including renewals as applicable. ***The Provider will be licensed, certified, registered or otherwise properly qualified under federal state or local laws applicable to the particular service that the applicant is performing (e.g., Licensed Architect; PT; OT; Dietician, Plumbers, Electricians, Construction Licenses, etc.)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
					C4. Negative TB test or negative chest X-Ray updated yearly (455 IAC 2-6-3)(4); (455 IAC 2-14-1)(b)(1).		X	X	X		X	X	X		X							X
					C5. If transporting, a valid driver's license (455 IAC 2-6-3)(5).		X	X	X		X	X	X		X							X
					C6. If transporting, current insurance on vehicle (455 IAC 2-6-3)(6).		X	X	X		X	X	X		X							X
					C9. All Case Managers must annually obtain at least 20 hours of training regarding case management services (In a calendar year). Ten hours of this training must be training approved by DA under the Nursing Facility Waiver Program (455 IAC 2-14-1; 455 IAC 2-17-2; HCBS Waiver Provider Manual)	X															X
					C10. Limited Criminal Background checks from the Indiana State police central repository for employees before provide direct services (455 IAC 2-6-2)(3).	X	X	X	X	X	X	X	X	X	X							X

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					C11. A document from the Nurse Aide Registry of Indiana State Department of Health verifying that each direct care employee has no findings entered into the registry before providing direct care. (455 IAC 2-6-2)(a)(4) https://mylicense.in.gov/everification/Search.aspx		X	X	X		X	X	X	X	X						X
					C12. That licensed health professionals are checked for findings through the Indiana Professional Licensing agency (455 IAC 2-6-3(2)(C))											X	X	X	X	X	X

BEST PRACTICE

CRIMINAL BACKGROUND CHECKS

Applicable to providers who are not required to complete criminal background checks (as noted above)

ASK: Are Limited Criminal Background checks from the Indiana State Police Central Repository for employees before they enter into a person's home? (2-15-2)

Please answer these questions:

1. Does the provider (or their employees) enter a person's home when delivering the service? [ ] Yes [ ] No

2. If a provider enters into a person's home, ask if they (and their employees) have a criminal background check? [ ] Yes [ ] No

3. If they report that they have a criminal background check, can you verify? [ ] Yes [ ] No

GUARDIAN

1. Is the provider also the guardian or acting as the guardian? [ ] Yes [ ] No

REPRESENTATIVE (REP) PAYEE

1. Is the provider a REP PAYEE for any DA WAIVER participant? [ ] Yes [ ] No

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REVIEW FINDINGS:

INDICATOR NOT MET (OUT OF COMPLIANCE)	Finding	Minimum Components of required Corrective Action Plan	Corrective Action Plan			Follow up Verification	
Choose an item.			**Corrective Action Plan 1 - to be completed in space below by Provider**	**Title of Person Responsible – to be completed by Provider**	**Status (Accept/Denied) If denied state reason**	**Follow-up Type**	**Results of Follow-up Verification (Implemented/Not Implemented) – If not implemented document evidence**
			Corrective Action Plan 2 – only to be completed if CAP1 is denied	**Title of Person Responsible – to be completed by Provider**	**Status (Accept/Denied) If denied state reason**		

INDICATOR NOT MET (OUT OF COMPLIANCE)	Finding	Minimum Components of required Corrective Action Plan	Corrective Action Plan			Follow up Verification	
Choose an item.			**Corrective Action Plan 1 - to be completed in space below by Provider**	**Title of Person Responsible – to be completed by Provider**	**Status (Accept/Denied) If denied state reason**	**Follow-up Type**	**Results of Follow-up Verification (Implemented/Not Implemented) – If not implemented document evidence**
			Corrective Action Plan 2 – only to be completed if CAP1 is denied	**Title of Person Responsible – to be completed by Provider**	**Status (Accept/Denied) If denied state reason**		

PROVIDER COMPLIANCE TRANSMISSION DATA

1.	**PROVIDER IS RESPONSIBLE FOR ENTERING DATA IN ALL FIELDS HIGHLIGHTED IN LAVENDAR**
2.	**SURVEYOR IS RESPONSIBLE FOR ENTERING DATA IN ALL FILEDS HIGHLIGHTED IN BLUE**
3.	**COORDINATOR IS RESPONSIBLE FOR ENTERING DATA IN ALL FIELDS HIGHLIGHTED IN PINK**
4.	**DMS IS RESPONIBLE FOR ENTERING DATA IN ALL OTHER FIELDS.**

DATE SCHEDULING BEGAN:		REVISED DATE CAP1 DUE FROM PROVIDER:		DATE CAP2 RECEIVED FROM PROVIDER:		DATE FOLLOW-UP VERIFICATION RESULTS SENT TO DMS:	
DATE ANNOUNCEMENT SENT:		DATE CAP1 RECEIVED FROM PROVIDER:		DATE CAP2 SENT TO SURVEYOR:		FOLLOW-UP VIERIFCATION – IMPLEMENTED / PARTIALLY / NOT IMPLEMENTED	
DATE OF REVIEW:		DATE CAP1 SENT TO SURVEYOR:		DATE CAP2 SENT TO COORDINATOR:		DATE FOLLOW-UP VERIFICATION RESULTS SENT TO PROVIDER:	
DATE OF CLOSING MEETING:		DATE CAP1 SENT TO COORDINATOR:		DATE CAP2 SENT TO DMS:		DATE REVIEW COMPLETED:	
DATE FINDINGS REPORT SENT TO COORDINATOR:		DATE CAP1 SENT TO DMS:		CAP2 - APPROVED / PARTIALLY / DENIED		DATE REVIEW CLOSED:	
DATE FINDINGS REPORT SENT TO DMS:		CAP1 - APPROVED/ DENIED:		DATE CAP2 RESULTS SENT TO PROVIDER:		REVIEW REFERRED (YES/NO):	
REVIEW HAD FINDINGS (YES/NO):		DATE CAP1 RESULTS SENT TO PROVIDER:		CAP IMPLEMENTATION DATE:		DATE REFERRED:	
DATE INITIAL RESULTS SENT TO PROVIDER:		DATE CAP2 DUE FROM PROVIDER:		DATE OF ANTICIPATED FOLLOW-UP VERIFICATION:		REASON FOR REFERRAL:	Choose an item.
DATE CAP1 DUE FROM PROVIDER:		DATE CAP1 RESULTS RE-SENT TO PROVIDER:		DATE FOLLOW-UP VERIFICATION COMPLETED:			
DATE INITIAL RESULTS RE-SENT TO PROVIDER:		REVISED DATE CAP2 DUE FROM PROVIDER:		DATE FOLLOW-UP VERIFICATION RESULTS SENT TO COORDINATOR:			

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