

2007 PROVIDER COMPLIANCE REVIEW
Required Documents List for DESK REVIEWS on Selected Waiver Services

Individual Provider & ODMRDD #:

County of Services: Type county name here

Date of Review: Type date of review here

Agency Provider Name & ODMRDD #:

The following information is requested for a Provider Compliance DESK Review. Please submit the documents indicated in the tables below by mail or fax to your assigned surveyor:

Type surveyor name and title here

Type the name of the department or county board here

Type the street number and street name here

Type the city, state and zip code here

Type the fax number here

Surveyor instructions: Before mailing

1. Mark the box [X] below to indicate the type of waiver.
2. Mark the box [X] below to indicate the services for this desk review.
3. Delete all tables that do not apply to the services for this desk review, maintain only the tables marked [X] below.
4. ***Delete this instruction box before sending the Required Documents List to the provider. ***

Individual Options Waiver Services Only	Level One Waiver Services Only
<input type="checkbox"/> Table A: Interpreter	<input type="checkbox"/> Table H: Specialized Medical Equipment & Supplies
<input type="checkbox"/> Table B: Social Work	<input type="checkbox"/> Table I: Environmental Accessibility Adaptations
<input type="checkbox"/> Table C: Home Delivered Meals	<input type="checkbox"/> Table J: Personal Emergency Response System
<input type="checkbox"/> Table D: Nutrition	<input type="checkbox"/> Table K: Informal Respite
<input type="checkbox"/> Table E: Environmental Modifications	
<input type="checkbox"/> Table F: Adaptive & Assistive Equipment	
<input type="checkbox"/> Table G: Supported Employment	
	<i>* Other waiver services not listed under IO or Level 1 can only be completed through the ON-SITE Review process</i>

Table A: Agency/Individual Provider: Individual Options Waiver (IO): Interpreter Services

1. Evidence of **Certification** or of other requirements needed for certification:
 - a. Certification by Registry of Interpreters for the Deaf, Inc. (RID) OR
 - b. Documentation of two (2) years of interpreter training programs and one year of service experience OR
 - c. Successful written test and one year of service experience OR
 - d. Two (2) years of service experience.
2. Copy of the Individual's **current ISP** that provides evidence of participation as/when requested by consumer.

Table B: Agency/Individual Provider: Individual Options Waiver (IO): Social Work Services

1. Evidence of **Licensing** as required for certification:
 - a. Social Worker License for the State of Ohio as defined in Division (C) of Section 4757.01 of the Ohio Revised Code and 4757-15-02 and 4757-15-03 of the Administrative Code OR
 - b. Professional Counseling License for the State of Ohio as defined in division (a) and (b) of Section 4757.01 of the Ohio Revised Code.
2. Copy of the Individual's **current ISP** and documentation of the SW services OR
3. Social Work/Counseling **Plan of Treatment**

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Table C: Agency/Individual Provider: Individual Options Waiver (IO): Home Delivered Meals

1. Evidence that the provider of this service meets all applicable **regulatory requirements** for preparation, packaging and delivery of home delivered meals as defined by the Ohio Department of Aging Title III-C.
2. Copy of the Individual's **current ISP** which, evidences participation when requested by consumer.
3. **Documentation** that verifies the Home Delivered Meals Services were provided.
4. Information on how the provider **initiates new orders**.
5. **Meal delivery records** to verify meals have been delivered in requires timelines.
6. Copy of **menus** and special menus approved by a dietician.
7. Evidence that provider is able to **provide two (2) meals per day, seven days per week**.
8. Copy of roster of **drivers** who are trained and have available back-up staff for scheduled meal deliveries.

Table D: Agency/Individual Provider: Individual Options Waiver (IO): Nutrition Services

1. Evidence the **dietician** is licensed by the State of Ohio.
2. Copy of the Individual's **current ISP** which, evidences participation when requested by consumer.
3. **Documentation** verifying the tasks and duties outlined in the ISP are performed.
4. Documentation of **hands-on programming** provided to and on behalf of the individual.
5. Copies of nutritional **assessments** and or evaluations.
1. (*Agency Only*) Evidence the agency provider has employed dieticians who have demonstrated one (1) year's **experience** in a medical care facility or in a community or public health agency with responsibility for nutritional assessment and counseling.

Table E: Agency/Individual Provider: Individual Options Waiver (IO): Environmental Modifications

1. Evidence of prior **experience** in the area of work that is to be modified.
2. Copy of the Individual's **current ISP** which, evidences participation when requested by consumer.
3. **Documentation** that verifies modifications and/or repairs are completed as authorized by the service plan
4. Evidence that the provider complied with state and local building **codes**

Table F: Agency/Individual Provider: Individual Options Waiver (IO): Adaptive and Assistive Equipment

1. Evidence that the provider has maintained **provider qualifications**.
 - a. Documentation verifying the provider is functioning in the capacity of a medical equipment company OR
 - b. Documentation verifying the provider is approved as an adaptive/assistive equipment provider under the Medicaid state plan OR
 - c. Documentation verifying the provider is an appropriately licensed veterinarian in the State of Ohio providing services to support animals.
2. Documentation that evidences that the provider supplied only appropriate **units of service**.
3. Documentation that evidences the provider provided **training** to the individual, family, and/or other appropriate individuals on the proper utilization of said equipment.
4. Copy of the Individual's **current ISP** which, evidences participation when requested by consumer.
5. **Documentation** of equipment repair, if required.
6. **Documentation** of follow-up services, if required.
7. **Documentation** of equipment installation, if required.
8. **Documentation** that the provider properly maintained rental equipment, if required.
9. **Documentation** that the provider assumes full liability for equipment improperly installed or maintained.

Table G: Agency/Individual Provider: Individual Options Waiver (IO): Supported Employment –
See Page 2 and Page 3 for required items for Table G.

1. Documentation of evidence of having receiving **formal training** in community/supported employment OR
2. Documentation of one year's **experience** providing supported employment services.

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Table G: Agency/Individual Provider: Individual Options Waiver (IO): Supported Employment –
See Page 2 and Page 3 for required items for Table G.

3. Copy of the Individual's **current ISP** which, evidences participation when requested by consumer.
4. Evidence of **training** by the professional responsible for a program should the program be developed by someone other than the Supported Employment provider.
5. Copies of **assessments** or evaluations completed as recommended in the ISP.
6. Copy of Program Implementation Plan (**PIP**).
7. **Documentation** of hands-on programming performed by Supported Employment Provider.
8. **Documentation** of in-service training of professional, paraprofessional, direct care workers, habilitation specialists, family members, guardians, vocational/school staff (including public personnel) as needed.
9. Evidence that the **consumer's progress** is reviewed as needed and that input is provided to the ISP team.

Table H: Agency/Individual Provider: Level One Waiver (L1): Specialized Medical Equipment & Supplies

1. Documentation of the individual or agency provider's **experience** in providing the services identified in the Level 1 Waiver and the individuals' ISPs.
2. Written documentation that shows the individual or agency provider's compliance with all **state and local regulations** that apply to the operation of the business/trade.
3. **A list** of the individuals receiving services from this individual or agency provider.
4. Copies of the **ISPs** for the individuals receiving services from the individual or agency provider in the county being reviewed.
1. (*Agency Only*) List of any **subcontractors** used by the agency, if subcontractors are used.
2. (*Agency Only*) Copy of written **contracts** with the subcontractors.

Table I: Agency/Individual Provider: Level One Waiver (L1): Environmental Accessibility Adaptations

1. Documentation of the individual or agency provider's **experience** in providing the services identified in the Level 1 Waiver and the individuals' ISPs.
2. Written documentation that shows the individual or agency provider's compliance with all **state and local regulations** that apply to the operation of the business/trade.
3. **A list** of the individuals receiving services from this individual or agency provider.
4. Copies of the **ISPs** for the individuals receiving services from the individual or agency provider in the county being reviewed.
1. (*Agency Only*) List of any **subcontractors** used by the agency, if subcontractors are used.
2. (*Agency Only*) Copy of written **contracts** with the subcontractors.

Table J: Agency/Individual Provider: Level One Waiver (L1): Personal Emergency Response System

1. Documentation of the individual or agency provider's **experience** in providing the services identified in the Level 1 Waiver and the individuals' ISPs.
2. Written documentation that shows the individual or agency provider's compliance with all **state and local regulations** that apply to the operation of the business/trade.
3. **A list** of the individuals receiving services from this individual or agency provider.
4. Copies of the **ISPs** for the individuals receiving services from the individual or agency provider in the county being reviewed.
5. Copy of **documentation** on the provider's provision of response center coverage twenty-four hours per day and seven days per week.
6. Copy of **documentation** of the provider's preventative maintenance checks for all equipment.
7. Copy of **documentation** of the provider's quarterly tests of the provider's equipment.
8. Log of **documentation** of the provider's notification by electronic means to emergency personnel such as police, fire, ambulance, and psychiatric crisis response entities.
9. **Documentation** of training provided to individuals using the personal emergency response system.
1. (*Agency Only*) List of any **subcontractors** used by the agency, if subcontractors are used.
2. (*Agency Only*) Copy of written **contracts** with the subcontractors.

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Table K: Limited (Individual) Provider Only: Level One Waiver (L1): Informal Respite

The Limited Provider shall provide evidence that the responsible family member documented the following on forms and according to procedures prescribed by the department:

1. Evidence that standards and requirements for continuing certification of limited providers were met:
 - a. **Evidence** that the limited **provider is aware** that he/she shall make a report to the department if he or she is ever formally charged with, convicted of, or pleads guilty to any offenses.
 - b. The limited provider shall provide written **documentation** from the individual's ISP that he or she has been **selected** by the individual or the individual's guardian to provide informal respite services
 - c. **Evidence of orientation** and training by family member **prior to the delivery of ISP** and assessed needs services
 - d. Provide **written assurance** that the limited provider understands reporting requirements relating to **incidents** adversely affecting health;
 - e. **Written assurance** that the limited provider understands the **rights** of an individual
 - f. **Documentation** of the frequency and duration of the **services delivered** as outlined on the ISP