ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT
Short Term Care

Check all that apply:
Adult Foster Care ☐ Rest Home ☐ Hospital Based Adult Respite ☐
Skilled Nursing Facility ☐ Assisted Living Facility ☐

I. GENERAL POLICIES AND PROCEDURES

A. Attach a copy of your last Department of Public Health survey and Plan of Correction (if applicable).

B. What is your referral procedure? Can you accept consumers on short notice?

C. Describe your medication policy with respect to ASAP referrals (i.e., should the consumer bring their own medications with them?).

D. Describe your policy to notify ASAP agency when there is a change in the consumer's status &/or needs (i.e. hospitalization).

E. 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).

II. ADULT FOSTER CARE

A. Describe your procedure for selecting homes where consumers will be placed.

B. Describe your procedure for supervising the care of consumers while they are in those homes.

III. RATE

A. What is your proposed rate for Short Term Care? Describe any additional charges.

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

Provider employee who completed this form
Name: Date:

SERVICE SPECIFIC ON-SITE REVIEW

Short Term 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 On Site Evaluation

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					

SERVICE SPECIFIC ON-SITE REVIEW

Short Term 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 On Site Evaluation

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. Otherwise the PD Demonstrator will be asked to illustrate “on screen”.					

Name and Position of Provider Direct Demonstrator	