# ADMINISTRATIVE OVERVIEW
# SERVICE SPECIFIC ATTACHMENT
# **Companion**

## I. SERVICE CAPACITY

A. Provide the number of regular full- and part-time Companions:
Full time:
Part time:

B. Provide an overview of workforce capacity initiatives, including recent turnover rates, ratio of service requests to staffing capacity, workforce adequacy evaluation, recruitment initiatives, linguistic or other special capabilities, etc.

C. Provide a detailed, concrete description of how staffing is managed day-to-day, including scheduled and unscheduled worker absences, ensuring service to Risk Level 1 and 2 and other high need consumers, orientation of substitutes, notifications, evening and weekend coverage, etc.

D. What percentage of your direct care workforce is available to work the following schedules:
1) Evenings:
2) Overnights:
3) Weekends:

E. Describe your agency process for maintaining a current list of Risk Level 1 and 2 consumers that is accessible in the event of an emergency.

F. Describe your policy regarding the provision of Companion service outside the home.

G. What is your proposed rate?
$
Describe any additional charges.

## II. STAFF QUALIFICATIONS:

A. Describe the experience and qualifications of the person responsible for service provision (the manager of the program), if different from the information provided in the Administrative Overview.

B. Describe the experience and qualifications you require for Companions.

## III. TRAINING AND IN-SERVICE EDUCATION

A. Describe your requirements for job specific training prior to placement, including ensuring worker sensitivity to elders, recognition of and reporting requirements regarding elder abuse and neglect, other emergency response issues, etc.

B. Describe the on-going training program for Companions.

ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT

ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT
**Companion**

**IV. SUPERVISION**

A. Describe the procedures for supervision, including frequency, documentation, and credentials/qualifications of supervisors for each position (direct care, coordinators, supervisors, etc.).

B. Describe the systems and procedures employed to ensure that services are delivered to consumers as authorized, including telephony, unannounced field visits, quality assurance calls, etc.

C. Describe the supervisory support available to direct care workers during non-business hours, including how supervisors are contacted, the titles and, as applicable, licensure of available supervisors.

Provider employee who completed this form
Name: Date:

SERVICE SPECIFIC ON-SITE REVIEW

**Companion**

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<br><br>Date<br><br>Monitor | | | | | |
| Start date<br>& Termination Date , if applicable | | | | | |
| Number of reference checks | | | | | |
| CORI Check | | | | | |
| DPH Registry Check | | | | | |
| Orientation: Date | | | | | |
| Job Description(s) | | | | | |
| Field visit/Supervision dates | | | | | |
| OIG monthly checks | | | | | |
| Ongoing training dates | | | | | |
| Comments | | | | | |

SERVICE SPECIFIC ON-SITE REVIEW

**Companion**

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<br><br>Date<br><br>Monitor | | | | | |
| ASAP Authorization | | | | | |
| ID Info – name; address; phone; DOB | | | | | |
| Emergency contact(s) and phone | | | | | |
| Physician(s) name and phone | | | | | |
| Hospital name and phone | | | | | |
| Medical/social diagnosis | | | | | |
| Task/preferences | | | | | |
| Therapeutic goal noted in Service Plan | | | | | |
| Consumer feedback solicited? Dates: | | | | | |
| Termination date, if applicable | | | | | |
| 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 | |