Frail Elder Waiver Provider Virtual Review Assessment

commonwealth care alliance

Administrative Information
Administrator's Name *(Required)*:
Administrator's Title *(Required)*:
Administrator's Phone *(Required)*:
Administrator's Email *(Required)*:
Provider Information
Provider Name/Entity Name *(Required)*:
NPI *(Required)*:
TIN (*Please avoid entering personal details such as Social Security numbers if that is used as your TIN.)*:
Street Address *(Required)*:

1. Provider Type *(Select all that apply. Required)*:

Agency

- ☐ Adult Day Health Agency
- ☐ Adult Foster Care Provider
- ☐ Alzheimer's/Dementia Coaching
- ☐ Assisted Living Residence
- ☐ Assistive Technology/Telehealth Provider Agency
- ☐ Chore Provider Agency
- ☐ Companion Provider Agency
- ☐ Electronic Comfort Animal Supplier
- ☐ Environmental Accessibility Adaptation Agency
- ☐ Evidence Based Education Program Provider Agency
- ☐ Goal Engagement Program Agency
- ☐ Grocery Shopping and Delivery Provider Agency
- ☐ Home Based Wandering Response Provider Agency
- ☐ Home Care Agency
- ☐ Home Delivered Meal Providers
- ☐ Home Health Agency
- ☐ Homemaker/Personal Care Agency
- ☐ Hospital
- ☐ Human Service Agencies
- ☐ Laundry Provider Agency
- ☐ Peer Support Agency
- ☐ Personal Emergency Response Provider
- ☐ Pharmacy
- ☐ Rest Home
- ☐ Senior Care Organization
- ☐ Skilled Nursing Facility
- ☐ Specialized Medical Equipment Provider
- ☐ Supportive Day Program Provider Agency
- ☐ Transportation Provider Agency
- ☐ Virtual Communication and Monitoring Provider
- ☐ Other (Enter Provider Type here): _____

Individual

- ☐ Assistive Technology/Telehealth Provider
- ☐ Certified Orientation and Mobility Specialists (COMS)
- ☐ Individual Occupational Therapist
- ☐ Qualified Individual Providers of Alzheimer's/Dementia Coaching
- ☐ Other (Enter Provider Type here): _____

3. Services Provided *(Select all that apply. Required)*:

- ☐ Alzheimer's/Dementia Coaching
- ☐ Assisted Transportation
- ☐ Assistive Technology – Electronic Comfort Animals
- ☐ Assistive Technology for Telehealth
- ☐ Chore
- ☐ Companion
- ☐ Complex Care Training and Oversight
- ☐ Enhanced Technology/Cellular Personal Emergency Response System (ET/CPERS)
- ☐ Environmental Accessibility Adaptation
- ☐ Evidence Based Education Programs
- ☐ Goal Engagement Program
- ☐ Grocery Shopping and Delivery
- ☐ Home Based Wandering Response Systems
- ☐ Home Delivered Meals
- ☐ Home Delivery of Pre-packaged Medication
- ☐ Home Safety/Independence Evaluations (formerly Occupational Therapy)
- ☐ Home Health Aide
- ☐ Homemaker
- ☐ Laundry
- ☐ Medication Dispensing System
- ☐ Orientation and Mobility Services
- ☐ Peer Support
- ☐ Personal Care
- ☐ Respite
- ☐ Supportive Day Program
- ☐ Supportive Home Care Aide
- ☐ Transitional Assistance
- ☐ Transportation
- ☐ Virtual Communication and Monitoring (VCAM)
- ☐ Not Applicable

Section I: License/Certification Requirements – Please review Frail Elder Waiver requirements, which can be found at ccama.org/FEWForm

1. Do you meet all the agency-level license and certification requirements for your provider type? Please indicate Yes or No. *(Required)*	☐ Yes ☐ No

Email a copy of agency-level license or certification, if applicable, as listed in above section to credentialing@commonwealthcare.org.

2. If the agency-level license and/or certification requirements have not been met, please explain why: *(If "Yes" was selected in Question 1, please respond with "Not Applicable". If "No" was selected in Question 1, an explanation must be provided. Required)*

Section II: Staff File Review – All Providers	
1. Enter the number of staff files you reviewed. *(Required)*	
Staff Training – Please review Frail Elder Waiver requirements, which can be found at ccama.org/FEWForm	
1. Of the staff files you reviewed, enter the number of staff who were required to complete annual training in the calendar year. *(Required)*	
2. Of the staff files you reviewed, enter the number of staff who were required to complete annual training in the calendar year and did complete the required training. *(Required)*	
3. Of the staff files you reviewed, if any staff who were required to complete annual training in the calendar year did not have the required training, please explain why and any remediation or corrective action that has been taken: *(Required)*	
Mandated Reporter Training – Please review Frail Elder Waiver requirements, which can be found at ccama.org/FEWForm	
1. Provider attests their case management entity staff received required training on their responsibilities as mandated reporters of abuse, neglect, exploitation, and unexplained death. *(Required)*	☐ Yes ☐ No ☐ N/A
2. Of the staff files you reviewed, enter the number of staff who were required to have mandated reporter training. *(Required)*	
3. Of the staff files you reviewed that were required to complete mandated reporter training, enter the number of staff did have documentation of mandated reporter training. *(Required)*	
4. If required staff did not have mandated reporter training, please explain why and any remediation or corrective actions that has been taken: *(If all staff completed their required training, please respond with "Not Applicable". If any staff did not complete their required mandated reporter training, an explanation must be provided. Required)*	

CORI Checks – Please review Frail Elder Waiver requirements, which can be found at ccama.org/FEWForm	
1. Provider attests to conducting CORI checks on all staff pursuant to federal and/or state requirements. *(Required)*	☐ Yes ☐ No ☐ N/A
2. Of the staff files you reviewed, enter the number of staff who were required to have CORI checks. *(Required)*	
3. Of the staff files you reviewed that were required to have CORI checks, enter the number of staff that did have documentation of CORI checks. *(Required)*	
4. If required staff did not have CORI checks, please explain why and any remediation or corrective actions that has been taken: *(If all required staff completed their CORI check, please respond with "Not Applicable". If any staff did not complete their required CORI check, an explanation must be provided. Required)*	

☐ Provider attests that a copy of agency-level license and/or certification, if applicable, have been emailed to credentialing@commonwealthcare.org. *(Required)*

☐ I declare that the information provided in this document is, to the best of my knowledge and belief, accurate, truthful, and complete. I affirm that: All statements and representations made are honest and accurate.

_____

Signature *(Required)*

_____

Printed Name & Title of Signatory *(Required)*

_____

Date *(Required)*