Provider Agency Name ____________________

RRDC ____________________

NEW YORK STATE DEPARTMENT OF HEALTH
Division of Long Term Care

Home and Community Based Services Medicaid Waiver
Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI)

RRDC Waiver Service Provider Interview

☐ NHTD Waiver
☐ TBI Waiver

Date ____________________

RRDS ____________________ Region(s) ____________________

Service Provider Agency Name ____________________

Service Provider Address ____________________

City ____________________ State ________ ZIP ________

Main Telephone Number ____________________

Regional Satellite Office(s)? ☐ Yes ☐ No (If Yes, please complete Section V of this interview form.)

Interested Region(s) ____________________

Interested County(ies) ____________________

Approved for other TBI/NHTD Waiver Services? ☐ Yes ☐ No

If Yes, what waiver and service(s)? ____________________

If Yes, approved in what region(s)? ____________________

If Yes, what county(ies) served? ____________________

Provider Contacts

Name and Title of Designee for Signing Contracts ____________________

Telephone Number ____________________ E-mail Address ____________________

Executive Director ____________________

Telephone Number ____________________ E-mail Address ____________________

Representatives of Agency in Attendance at Interview

Representative ____________________ Title ____________________

Representative ____________________ Title ____________________

Representative ____________________ Title ____________________

Representative ____________________ Title ____________________

Provider has requested to provide the following service(s):

NHTD:

- ☐ Service Coordination (SC)
- ☐ Assistive Technology (AT)
- ☐ Community Integration Counseling (CIC)
- ☐ Community Transitional Services (CTS)
- ☐ Congregate and Home Delivered Meals
- ☐ Environmental Modifications (eMods)
- ☐ Home and Community Support Services (HCSS)
- ☐ Home Visits by Medical Personnel
- ☐ Moving Assistance
- ☐ Nutritional Counseling
- ☐ Peer Mentoring
- ☐ Positive Behavioral Interventions and Supports (PBIS)
- ☐ Respiratory Therapy
- ☐ Structured Day Program (SDP)
- ☐ Respite Services
- ☐ Wellness Counseling
- ☐ Independent Living Skills Training (ILST)
- ☐ Vehicle Adaptation

TBI:

- ☐ Service Coordination (SC)
- ☐ Community Integration Counseling (CIC)
- ☐ Assistive Technology (AT)
- ☐ Community Transitional Services (CTS)
- ☐ Environmental Modifications (eMods)
- ☐ Home and Community Support Services (HCSS)
- ☐ Substance Abuse Program
- ☐ Independent Living Skills Training Services (ILST)
- ☐ Positive Behavioral Interventions and Supports (PBIS)
- ☐ Respite
- ☐ Structured Day Program (SDP)
- ☐ Assistive Technology (AT)
- ☐ Community Integration Counseling (CIC)

Part I: Program Questions

RRDS provides a comprehensive description of the program.

1. Does the provider indicate that they understand how the waiver program works? ☐ Yes ☐ No
   RRDS Comments:

   ____

   ____

   ____

2. In what capacity has the provider served as a provider of services to seniors and/or people with disabilities?
   Explain in detail:

   ____

   ____

   ____

3. The following written Policies and Procedures have been reviewed and are consistent with the corresponding section of the Program Manual:

   Providers applying for AT, CTS, Congregate and Home Delivered Meals, E-mods, Home Visits by Medical Personnel, Moving Assistance, and Respiratory Therapy must satisfy the following:

   ☐ HIPAA Compliance
   ☐ Safety and Emergency Procedures
   ☐ Human Resources Policies/Procedures
   ☐ Knowledge of Incident Reporting Policy
   ☐ Service Provision Tracking and Billing System
   ☐ Participant Satisfaction Survey
   ☐ Handling of Complaints and Grievances from Participants, Advocates and Family Members
   ☐ Recording/Addressing Concerns from Service Coordinator, RRDS/NE and QMS
   ☐ Record keeping/Documentation for Each Participant
   ☐ Cooperate with NYSDOH, OMIG and other Government Agencies with Jurisdiction to Conduct Surveys and Audits

   Providers applying for all other services must satisfy the following:

   ☐ HIPAA Compliance
   ☐ Safety and Emergency Procedures
   ☐ Human Resources Policies/Procedures
   ☐ Incident Reporting/SRI Committee
   ☐ Service Provision Tracking System
   ☐ Plan for Self-appraisal of Services Provision Including Suggestions and Methods for Improvements
   ☐ Participant Satisfaction Survey
   ☐ Recording/Addressing Concerns from SC, RRDS, QMS, and/or DOH Waiver Management Staff
   ☐ Record keeping/Documentation for Each Participant
   ☐ Waiver Service Training
   ☐ Handling of Complaints and Grievances from Participants, Advocates and Family Members
   ☐ Additional Training Programs for Staff
   ☐ Cooperate with NYSDOH, OMIG and Other Government Agencies with Jurisdiction to Conduct Surveys and Audits

   RRDS Comments:

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   ____

Part I: Program Questions *(continued)*

4. Is the provider currently enrolled as a provider in eMedNY? ☐ Yes ☐ No
   In what capacity/for what program(s)?
   RRDS Comments:

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   ____

   ____

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5. Does the provider currently have a MMIS Provider ID assigned to the waiver? ☐ Yes ☐ No
   If Yes, what is the Provider ID? ____________________

6. If a brand-new provider, applying for both the NHTD and TBI Waiver programs? ☐ Yes ☐ No
   If Yes, two (2) eMedNY applications and application fees have been submitted? ☐ Yes ☐ No

7. Did the provider read the Program Manual before applying to become a provider? ☐ Yes ☐ No
   RRDS Comments:

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8. Does the provider understand the importance and timeliness issues associated with the Service Plan and Individual Service Reports as well as the policy related to late submission? ☐ Yes ☐ No
   RRDS Comments:

   ____

   ____

   ____

   ____

   ____

   ____

Part II: Services

Name of Service ____

(If applying for more than one service, attach additional copies of this section.)

The RRDS explains the service, the qualifications and responsibilities of the provider. (Refer to Program Manual.)

Does the provider indicate that they understand:

1. The definition of the service? ☐ Yes ☐ No
2. The qualification requirements for: (a) provider? ☐ Yes ☐ No
   (b) staff? ☐ Yes ☐ No
3. How this service relates to other services? ☐ Yes ☐ No
4. The agency's record keeping responsibilities? ☐ Yes ☐ No
5. The participant's Right of Choice? ☐ Yes ☐ No
6. The role of the Service Coordinator? ☐ Yes ☐ No
7. That this is a prior approval program? ☐ Yes ☐ No
8. The survey/audit procedures? ☐ Yes ☐ No
9. Does the provider understand the qualifications (including any requirements of licensure/certification) and requirements of the entity providing the service and/or the qualifications for the individuals providing this service? ☐ Yes ☐ No
   If licensure is required, the RRDS must review the entity's license.
10. Did the provider submit a separate Employee Verification of Qualification form and resume/applicable certificates/licensure for each individual who is projected to provide this service? ☐ Yes ☐ No
11. List the names of the individuals whom are being submitted and appear to be qualified to provide this service.

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General comments:

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Part II: Services *(continued)*

Structured Day Program

The RRDS explains the service and the qualifications and responsibilities of the Structured Day Program provider.

Does the provider indicate that they understand:

1. The definition of the service? ☐ Yes ☐ No

2. The qualification requirements for: (a) provider? ☐ Yes ☐ No
   (b) staff? ☐ Yes ☐ No

3. How this service relates to other services? ☐ Yes ☐ No

4. The agency's record keeping responsibilities? ☐ Yes ☐ No

5. The participant's Right of Choice? ☐ Yes ☐ No

6. The role of the Service Coordinator? ☐ Yes ☐ No

7. That this is a prior approval program? ☐ Yes ☐ No

8. The survey/audit procedures? ☐ Yes ☐ No

9. Does the provider understand the qualifications (including any requirements of licensure/certification) and requirements of the entity providing the service and/or the qualifications for the individuals providing this service? ☐ Yes ☐ No
   If licensure is required, the RRDS must review the entity's license.

10. Did the provider submit a separate Employee Verification of Qualification form and resume/applicable certificates/licensure for each individual who is projected to provide this service? ☐ Yes ☐ No

11. List the names of the individuals whom are being submitted and appear to be qualified to provide this service.

____

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12. Did the provider submit a copy of the Certificate of Occupancy and Fire Inspection? ☐ Yes ☐ No

13. From the site visit, conducted by the RRDS, list any outstanding issues that need to be addressed in order to be considered as an approved provider of this service:

Date of Site Visit ______________

____

____

____

Part III: General

1. Does the provider have any other questions? ☐ Yes ☐ No
   If Yes, what are they?

2. Were you able to answer their questions? ☐ Yes ☐ No

3. Did the provider understand your responses? ☐ Yes ☐ No

4. Did the RRDS refer the provider to someone else to answer questions? ☐ Yes ☐ No
   If Yes, who and for what?

5. RRDS evaluation of provider agency (Strengths, weaknesses, concerns, etc.)

Part III: General *(continued)*

6. RRDS recommends this agency to provide the following services: (Please specify county(ies) for each service.)

Applied to Provide	Service	Recommended	Not Recommended	Counties
☐	Service Coordination	☐	☐	
☐	Assistive Technology	☐	☐	
☐	Community Transitional Services	☐	☐	
☐	Community Integration Counseling	☐	☐	
☐	Congregate and Home Delivered Meals	☐	☐	
☐	Environmental Modifications	☐	☐	
☐	Home and Community Support Services	☐	☐	
☐	Home Visits by Medical Personnel	☐	☐	
☐	Independent Living Skills Training	☐	☐	
☐	Moving Assistance	☐	☐	
☐	Nutritional Counseling	☐	☐	
☐	Peer Mentoring	☐	☐	
☐	Positive Behavioral Interventions and Supports	☐	☐	
☐	Respiratory Therapy	☐	☐	
☐	Respite	☐	☐	
☐	Structured Day Program	☐	☐	
☐	Wellness Counseling	☐	☐	
☐	Vehicle Adaptation	☐	☐	
☐	Substance Abuse Program	☐	☐	

7. RRDS Reasons for the Decision:

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____
RRDS Name

____
RRDS Signature

____
Date

Part IV: Approval/Denial

DOH Waiver Management Decision:

☐ Approves
☐ Disapproves

DOH Waiver Management Comments:

DOH Waiver Management Name

DOH Waiver Management Signature

Date

Part V: Regional Satellite Office(s)

1. Regional Satellite Office

County(ies) Served

Contact Person/Title

Telephone Number E-mail

Address

City State ZIP

Has the RRDS verified the LHCSA license for this satellite office? (Include a copy.) ☐ Yes ☐ No

2. Regional Satellite Office

County(ies) Served

Contact Person/Title

Telephone Number E-mail

Address

City State ZIP

Has the RRDS verified the LHCSA license for this satellite office? (Include a copy.) ☐ Yes ☐ No

3. Regional Satellite Office

County(ies) Served

Contact Person/Title

Telephone Number E-mail

Address

City State ZIP

Has the RRDS verified the LHCSA license for this satellite office? (Include a copy.) ☐ Yes ☐ No

4. Regional Satellite Office

County(ies) Served

Contact Person/Title

Telephone Number E-mail

Address

City State ZIP

Has the RRDS verified the LHCSA license for this satellite office? (Include a copy.) ☐ Yes ☐ No

***If you need additional space, please make copies of this page. **Attach NHTD or TBI Address Grid.**