Provider Agency Name:_____
RRDC:_____

Waiver Service Provider Interview

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Regional Resource Development Specialist

RRDS:_____Region(s):_____ Date:_____

Service Provider Agency:_____ Contact Person: _____Title:_____

Service Provider Address:_____Telephone:_____

Regional Satellite Office(s)? ☐ Yes ☐ No If Yes, please complete attached page at the end of this interview form.

Interested region(s): _____

Interested county(ies):_____

Approved for other TBI/NHTD Waiver Services ☐ Yes ☐ No If Yes, what service(s)/waiver: _____

Approved in what region(s): _____

What counties served: _____

Name and title of designee for signing contracts:_____Telephone:_____

Executive Director:_____Telephone:_____

Representatives of Agency in Attendance:

Representative:_____Title:_____

Representative:_____Title:_____

Representative:_____ Title:_____

Provider has requested to provide the following services:

___Service Coordination
___Assistive Technology
___Community Integration Counseling
___Community Transitional Services
___Congregate and Home Delivered Meals
___Environmental Modifications Services
___Home and Community Support Services
___Home Visits by Medical Personnel
___Independent Living Skills Training Services
___Moving Assistance
___Nutritional Counseling/Educational Services
___Peer Mentoring
___Positive Behavioral Interventions and Supports
___Respiratory Therapy
___Respite Services
___Structured Day Program Services
___Wellness Counseling Service

Waiver Service Provider Interview
Part I: Overall Questions

RRDS provides a comprehensive description of the program.

1. Does the provider representative indicate that he/she understands 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 & Emergency Procedures
__Human Resources Policies/Procedures
__Knowledge of Incident Reporting Policy
__Service provision tracking & 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
__Recordkeeping/documentation for each participant
__Cooperate with NYS DOH, OMIG & other government agencies with jurisdiction to conduct surveys & audits

Providers applying for all other services must satisfy the following:

__HIPAA compliance
__Safety & 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
__Recordkeeping/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 NYS DOH, OMIG & other government agencies with jurisdiction to conduct surveys & audits

RRDS Comments:

Provider Agency Name:_____
RRDC:_____

Waiver Service Provider Interview
Part I continued

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

5. Did the provider representative read the Program Manual before applying to become a provider? Yes ( ) No ( )
   RRDS Comments:

6. Does he/she 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:

Waiver Service Provider Interview
Part II Specific Services

A. _____(if applying for more than one service, attach additional copies of this section)
Name of Service

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

Does the provider representative indicate that he/she understands:

1. The definition of the service? Yes ( ) No ( )
2. The qualification requirements for: (a) provider, and 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 procedure? Yes ( ) No ( )
9. Does the provider understand the qualifications (including any requirements of licensure) 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 resume and an Employee Verification Qualification form for each individual who is projected to provide this service? Yes ( ) No ( )
11. The RRDS should list the names of the individuals who appear to be qualified to provide this service.

    _____
    _____
    _____

    General comments:

Waiver Service Provider Interview
Part II continued

B. Structured Day Program

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

Does the provider representative indicate that he/she understands?

1. The definition of the service? Yes ( ) No ( )
2. The qualification requirements for: (a) provider, and 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 procedure? Yes ( ) No ( )
9. The qualifications (including any requirements of licensure) and requirements of the entity providing the service and/or the qualifications for the individuals providing this service? Yes ( ) No ( ) *If licensure is require, the RRDS must review the entity's license.*
10. Did the provider submit a resume and an Employee Verification Qualification form for each individual who is projected to provide this service? Yes ( ) No ( )
11. The RRDS should list the names of the individuals who appear to be qualified to provide this service.

    _____
    _____
    _____

11. Did the provider submit a copy of the Certificate of Occupancy? Yes ( ) No ( )
12. From the site visit, the RRDS should list any outstanding issues that need to be addressed in order to be considered as a provider of this service:

Provider Agency Name:_____
RRDC:_____

Waiver Service Provider Interview
Part III

1. Does the provider representative have any other questions? Yes ( ) No ( )
   If yes, what are they?

2. Were you able to answer his/her questions? Yes ( ) No ( )

3. Did the provider understand your responses? Yes ( ) No ( )

4. Did you need to refer him/her to someone else to answer questions? Yes ( ) No ( )
   If yes, who?

5. RRDS Evaluation of Agency (Strengths, weaknesses and/or concerns):

Provider Agency Name:_____
RRDC:_____

Waiver Service Provider Interview

Part III continued

6. RRDS recommends this agency to provide the following services: (please specify regions(s)):

Applied To Provide		Service	Recommended	Not Recommended	Counties
Yes	No				
☐	☐	Service Coordination	☐	☐	
☐	☐	Assistive Technology	☐	☐	
☐	☐	Community Transitional Services	☐	☐	
☐	☐	Community Integration Counseling	☐	☐	
☐	☐	Congregate and Home Delivered Meals	☐	☐	
☐	☐	Environmental Modifications Services	☐	☐	
☐	☐	Home and Community Support Services	☐	☐	
☐	☐	Home Visits by Medical Personnel	☐	☐	
☐	☐	Independent Living Skills Training	☐	☐	
☐	☐	Moving Assistance	☐	☐	
☐	☐	Nutritional Counseling/Educational Services	☐	☐	
☐	☐	Peer Mentoring	☐	☐	
☐	☐	Positive Behavioral Interventions and Supports	☐	☐	
☐	☐	Respiratory Therapy	☐	☐	
☐	☐	Respite Care Services	☐	☐	
☐	☐	Structured Day Program	☐	☐	
☐	☐	Wellness Counseling Service	☐	☐	

7. RRDS Reasons for the Decision:

_____
RRDS Signature/Date

Provider Agency Name:_____
RRDC:_____

Waiver Service Provider Interview
Part IV

DOH Waiver Management Decision:

___Approves
___Disapproves

DOH Waiver Management Comments:

_____
DOH Waiver Management Signature/Date

Waiver Service Provider Interview
Part V

Regional Satellite Office:____

County(ies) served:____

Contact Person/Title:_________________________

Telephone:________________________________

Address:__________________________________

City/Zip:__________________________________
Note: Have you verified the LHCSA license for this satellite office? Yes ( ) No ( )

Regional Satellite Office:____

County(ies) served:____

Contact Person/Title:_________________________

Telephone:________________________________

Address:__________________________________

City/Zip:__________________________________
Note: Have you verified the LHCSA license for this satellite office? Yes ( ) No ( )

Regional Satellite Office:____

County(ies) served:____

Contact Person/Title:_________________________

Telephone:________________________________

Address:__________________________________

City/Zip:__________________________________
Note: Have you verified the LHCSA license for this satellite office? Yes ( ) No ( )

Regional Satellite Office:____

County(ies) served:____

Contact Person/Title:_________________________

Telephone:________________________________

Address:__________________________________

City/Zip:__________________________________
Note: Have you verified the LHCSA license for this satellite office? Yes ( ) No ( )

****If you need additional space, please make copies of this page.**