Service Specific Record Review – CDC+ Consultant

(Note: The Term WSC and CDC+ Consultant are used interchangeably in this tool)

#	Performance Measure/Standard	Protocol	Not Met Reasons

1	Level of care is reevaluated at least every 365 days and contains all required components for billing.	CMS Assurance - Level of Care
		iBudget Handbook
		FL DD Individual Budgeting (0867.R02) Waiver Appendix B
		
		Level of Care must be reevaluated at least every 365 days using the current Medicaid Waiver Eligibility Worksheet (MWES).
		
		Medicaid Waiver Eligibility Worksheet should be completed in iConnect, word merged, and uploaded to a note in iConnect with signatures to be considered complete. The MWES should be changed from “Pending/Draft/Open” to “Complete” status after filling out the document and prior to printing.
		
		Review the record to locate the Medicaid Waiver Eligibility Worksheet(s) covering the entire period of review to determine timely completion and the presence of the following required components for billing:
		• Name of the person receiving services.
		• Section I. Level of Care Eligibility - Option A, B or C is checked and the appropriate handicapping conditions or deficits in major life activities.
		  ○ If Option A is checked, no handicapping conditions or major life activities are required to be checked.
		  ○ If Option B is checked, at least one “handicapping condition” or at least three “major life activities” must be checked.
		  ○ If Option C is checked, at least three “major life activities” must be checked.
		• The dated signature/mark of the person or when applicable, the legal representative.
			1) Complete Medicaid Waiver Eligibility Worksheet was not in the record for the entire period of review. (B)
			2) Complete Medicaid Waiver Eligibility Worksheet was in the record for some but not all of the period of review. (B)
			3) Section I. Level of Care Eligibility was not completed. (B)
			4) Medicaid Waiver Eligibility Worksheet was not signed and dated by person receiving services. (B)
			5) Medicaid Waiver Eligibility Worksheet was not signed and dated by the legal representative. (B)
			6) Medicaid Waiver Eligibility Worksheet was not signed and dated by CDC+ Consultant. (B)

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		○ If the person signs their name with a mark, the mark should be identified in writing on the form as the person's mark/signature and should be witnessed by a caregiver or the WSC/CDC+ Consultant. ONLY the person should sign on the line provided for his or her signature. ○ Legal representative or witness should only sign the second line and indicate legal representative or witness. • When the signature of a legal representative or witness is required, the printed name and relationship to the person must be indicated. ○ If the person refuses to sign the Eligibility Worksheet and there is not a legal representative, the refusal should be noted on the form and signed by a witness. The Waiver Eligibility Worksheet must be completed in its entirety and **signed at intervals of no greater than 365 days**. ○ For example if the Eligibility Worksheet is completed and signed on September 3rd of one year it must be completed and signed no later than September 3rd the following year. While the MWES should be reviewed for accuracy and completed if not present immediately upon receiving a central record and prior to billing, a 30 day grace period will be applied when there has been a change in QO. **This standard is subject to a potential billing discrepancy**	
2	Level of care is reevaluated at least every 365 days and	CMS Assurance - Level of Care iBudget Handbook FL DD Individual Budgeting (0867.R02) Waiver Appendix B	1) Complete Medicaid Waiver Eligibility Worksheet was not in the record for the entire period of review.

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	contains all required components for compliance.	Level of Care must be reevaluated at least every 365 days using the current Medicaid Waiver Eligibility Worksheet.
		
		Medicaid Waiver Eligibility Worksheet should be completed in iConnect, word merged, and uploaded to a note in iConnect with signatures to be considered complete. The MWES should be changed from "Pending/Draft/Open" to "Complete" status after filling out the document and prior to printing.
		
		Review the record to locate the Medicaid Waiver Eligibility Worksheet(s) covering the entire period of review. Determine the following required components are present:
		• Support Plan effective date
		• Section II. Medicaid Eligibility
		  ○ If option A is checked, the correct Medicaid number is documented.
		  ○ If option B is checked, the "Eligible" box should be checked and date of determination for restoration of Medicaid should be entered.
		  – Option B is only to be used when the person receiving services was added to the waiver in the past year or the person's Medicaid eligibility was terminated and restored during the past year.
		• Section III. Eligibility Determination – Option A is checked
		• The Medicaid Waiver Eligibility Worksheet must be completed in its entirety and signed at intervals of no greater than 365 days.
			2) Complete Medicaid Waiver Eligibility Worksheet was in the record for some but not all of the period of review.
			3) Effective Date of the Support Plan was not on the Medicaid Waiver Eligibility Worksheet.
			4) Section II. Medicaid Eligibility was not completed.
			5) Option A was not selected in Section III. Eligibility Determination.

3	Level of care is completed accurately using the correct instrument/form.	CMS Assurance - Level of Care iBudget Handbook FL DD Individual Budgeting (0867.R02) Waiver Appendix B, APD Eligibility Rules: 65G-4.014 – 017	1) Complete Medicaid Waiver Eligibility Worksheet was not in the record.

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		Medicaid Waiver Eligibility Worksheet (MWES) should be completed in iConnect, word merged, and uploaded to a note in iConnect with signatures to be considered complete. The MWES should be changed from "Pending/Draft/Open" to "Complete" status after filling out the document and prior to printing. Review the Central Record for Psychological and/or Medical Record(s) used to establish eligibility in section I of the MWES covering the entire period of review for Level of Care Eligibility. ○ If Option A is checked: Review record for acceptable documentation supporting primary disability is Intellectual Disability with an IQ of 59 or less. ○ If Option B is checked: Review record for acceptable documentation supporting primary disability is Intellectual Disability with IQ of 60-69 and has at least one handicapping condition OR primary disability of Intellectual Disability with IQ of 60-69 and severe functional limitations in at least 3 major life activities. ○ If Option C is checked: Review record for acceptable documentation supporting eligibility under the category of Autism, Cerebral Palsy, Down Syndrome, Prader-Willi Syndrome, Spina Bifida or Phelan-McDermid Syndrome and has severe functional limitations in at least three major life activities. If the Central Record does not contain required eligibility documentation, the WSC must document within iConnect which supporting documents are missing according to the Level of Care identified on the MWES and document request was made to the APD Office to obtain proof of eligibility or applicable Eligibility Determination Level of Care Notice.	2) Complete Medicaid Waiver Eligibility Worksheet was in the record for some but not all of the period of review. 3) Option A, B, or C checked under section I was not consistent with the Psychological and/or Medical Record(s) in the record. 4) Handicapping Condition(s) checked were not consistent with the Psychological and/or Medical Record(s) in the record. 5) Major Life Activities checked were not consistent with the Psychological and/or Medical Record(s) in the record. 6) Psychological and/or Medical Record(s) in the record were not consistent with 65G-4 Eligibility Rules. 7) WSC had not submitted a request to APD for an Eligibility Determination Level of Care Notice and the Psychological and/or Medical Record(s) were not in the record. 8) WSC submitted a request to APD for an Eligibility Determination Level of Care Notice but not at least 30 days in advance of the scheduled review. 9) WSC submitted a request to APD for an Eligibility Determination Level of Care Notice at least 30 days in advance of the scheduled review but has not received the Notice from the Regional APD office. (***Not Met but not calculated into score)

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		Eligibility Determination Level of Care Notice should follow either the December 10th 2013 Eligibility Determination – Level of Care memorandum or the current WSC Advisory. ○ The statement must: be on official APD letterhead, with the APD Regional staff member's signature with applicable names, dates completed, and ABC/APD iConnect Division record attachments. ○ If the WSC submitted a needed request for the Eligibility Determination Level of Care Notice to APD at least 30 days in advance of the scheduled review but has not received the Notice, use Not Met reason #9. ○ If the WSC submitted the request but not at least 30 days in advance of the scheduled review and has not received Notice, use Not Met reason #8. Waiver enrollment after 12/4/2018, eligibility documentation should be in the Notes tab of iConnect under the Note Type, Application Collateral Docs. Waiver enrollment prior to 12/4/2018, eligibility documentation can be housed internally or externally to iConnect though adding the documentation to iConnect is highly recommended.	
4	Person receiving services is given a choice of waiver services or institutional care at least annually.	CMS Assurance - Level of Care iBudget Handbook FL DD Individual Budgeting (0867.R02) Waiver Appendix D Note: Section IV is the only section of the Eligibility Worksheet to be reviewed for this standard. If Section IV is complete, score as Met. Medicaid Waiver Eligibility Worksheet should be completed in iConnect, word merged, and uploaded to notes in iConnect with	1) Complete Medicaid Waiver Eligibility Worksheet was not in the record for the entire period of review. 2) Complete Medicaid Waiver Eligibility Worksheet was in the record for some but not all of the period of review. 3) Option A was not selected in Section IV. 4) Dated signature of person receiving services was not present.

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		signatures to be considered complete. The MWES should be changed from "Pending/Draft/Open" to "Complete" status after filling out the document and prior to printing.
		
		Review the Medicaid Waiver Eligibility Worksheet(s) covering the entire period of review.
		• Determine Section IV: Choice is complete and includes:
		  ○ A mark indicating option A selected as the choice of the person receiving services;
		  ○ The dated signature/mark of the person receiving services or when applicable the dated signature of the legal representative. Electronic signature is acceptable for legal representatives.
		  • Follow signature protocol in standard #1.
			5) Dated signature of the legal representative was not present.
			6) Dated signature of the witness was not present.

5	The Support Plan is developed with signatures timely.	CMS Assurance - Service Plan iBudget Handbook; Person Centered Support Plan Manual Approved Waiver FL0867.R02 Appendix D Review the Central Record in APD iConnect for the Support Plan(s) effective during the entire review period. Support Plans with effective dates on or after 9/1/2020 are completed on the Person Centered Support Plan format and completed in iConnect and uploaded to include dated signatures. Support Plans effective 4/1/2022 and after should be completed on the "Person- Centered Support Plan eff 11/4/2021" format found in the Forms tab of iConnect. Support Plans effective prior to 4/1/2022 can be completed on the "Person-Centered Support Plan eff 8/1/2019 format or the 4/1/2022 format. Determine if:	1) Support Plan was not in the record for entire period of review. (B) 2) Support Plan was in the record, but was not completed prior to the annual effective date. (B) 3) Support Plan was not signed and dated by the person. (B) 4) Support Plan was not signed and dated by CDC+ Consultant. (B) 5) Support Plan was not signed and dated by the legal representative and efforts to obtain signature were not documented. (B) 6) Support Plan was not developed/updated within 45 days following selection of the CDC+ Consultant when first added to the waiver. (B)

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		• The Support Plan was completed prior to the annual Support Plan effective date and present/effective for each month billed by the WSC/CDC+ Consultant for the entire period of review. • The Support Plan is present and the signature page contained all required dated signatures including: ▪ Dated signature of the person. (If the person signs their name with a mark, the mark should be identified in writing on the format as the person's mark/signature). ▪ Dated signature of the parent/legal representative if the person is a minor; ▪ Dated signature of the legal representative when applicable (Verify via legal court documents); ▪ Dated signature of the WSC/CDC+ Consultant. If a person is new to the waiver - • All documentation should be completed within 45 days of the person's selection of the WSC/CDC+ Consultant. If a person is added to the waiver through crisis determination - • All documentation should be completed within 30 days of the person's selection of the WSC/CDC+ Consultant. If a Support Plan has an extension granted, look for approval of the extension. Note: an extension changes the prior year, but not future year Support Plan effective dates. Note: Any documentation uploaded to iConnect should not include special characters. See applicable advisory for details.	7) Support Plan was not developed/updated within 30 days following selection of the CDC+ Consultant when first added to the waiver through crisis determination. (B)

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		While the Support Plan should be reviewed for accuracy and completed if not present immediately upon receiving a central record and prior to billing, a 30 day grace period will be applied when there has been a change in QO. **This standard is subject to a potential billing discrepancy**	
5a NEW	The Support Plan has all required components complete.	iBudget Handbook; Person Centered Support Plan Manual Approved Waiver FL0867.R02 Appendix D All components of the document must be completed in order to be considered a complete Support Plan. The Support Plan template is divided into four major types of information and the sections below are included for this standard. Note: Some goals may carry over year to year. **Identifying information and demographics** • Legal Status • Primary Diagnosis • Secondary Diagnosis, if applicable • Living Setting • Legal Representative, if applicable • Family, Friends, Support System • Other People Who Support Me or Work for Me • Other Funding Sources for Supports Note: For CDC+ Directly Hired Employees (DHE) are not required to be listed in the Support Plan. **Person-Centered Information** • My current day to day life	1) Support Plan section identifying information and demographics had components not present on the Plan. 2) Support Plan section identifying information and demographics had components not updated/corrected on the Plan. 3) Support Plan section Person-Centered Information had components not present on the Plan. 4) Support Plan section Person-Centered Information had components not updated on the Plan. 5) Support Plan section Person-Centered Information was generic and not specific to the Plan of the person. 6) Support Plan section Person-Centered Information did not change from one Support Plan to the next. 7) Support Plan section including Future Goals had components not present on the Plan. 8) Support Plan section including Future Goals was generic and not specific to the Plan of the person.

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		• My interests, talents, abilities, strengths, preferences, and skills • Things I would like to change • Things I would like to stay the same • Important aspects from my personal history, dated • How I communicate and make choices and decisions **Past Accomplishments and Future Goals** • Goals I worked on last year • What I want in the next few years • Personal Goals **Health** • Important health history • Medications • Allergies • Critical health follow up areas and preventative health plan • Health Care Contact Info and Details • Equipment and Supplies	9) Support Plan section including Future Goals did not change from one Support Plan to the next. 10) Support Plan section Health had components not present on the Plan. 11) Support Plan section Health was generic and not specific to the Plan of the person. 12) Support Plan section Health did not change from one Support Plan to the next.
6	CDC+ Consultant completed accurate Significant Additional Need (SAN) requests.	CMS Assurance - Service Plan iBudget Handbook Rule 59G-13.070, F.A.C., 65G-4.0213 through 65G-4.0218, F.A.C. WSC Job Aid for Cost Plan and SAN documentation The SAN submission process is for individuals who have a final iBudget amount established and require additional funds to meet their needs Review the Person-Centered Support Plan, QSI Report, Progress Notes, Behavior Assessments/Plans, Functional Community	1) CDC+ Consultant sent in incomplete SANS. 2) CDC+ Consultant did not include justification for request in initial submission. 3) CDC+ Consultant unresponsive to RAI from APD. 4) Need or Risk identified indicate a need for a SANs request, but the CDC+ Consultant did not submit one.

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		Assessments, Safety Plan, OT, PT, ST assessments, and any other applicable supporting documentation in the central record to identify increased needs of the person. Ask the WSC/CDC+ Consultant if the person has had any changes in their needs that have required funding greater than what is in the current Cost Plan. If yes, review the record for SAN Request documentation. There may be more than one request during the review period. The WSC/CDC+ Consultant is permitted to show documents electronically. Review the SAN Request for the following: ○ WSC Job Aid SAN Documentation Checklist including the following for CDC+ Participants: ○ Current approved purchasing plan. ○ Documentation of efforts made to adjust budget within purchasing plan. ○ Explanation on Savings available, including how it was adjusted to meet needs. If not adjusted, explain why. ○ Current Account Reconciliation. ○ Look for a combination of the following items, as applicable, to identify the most recent information reflective of the current needs of the person that documents the issues of concern: ○ Support Plans, QSI, Cost Plans, expenditure history, current living situation, information about interviews with the person, their providers and caregivers, prescriptions, previous therapy and intervention documentation, assessments and provider documentation.	5) Need or Risk identified indicated a need for a SANs requests, but the CDC+ Consultant did not request an updated QSI. 6) Delay in accurate request caused the need or risk to be paid through IFS funding. 7) CDC+ Consultant made request prior to seeing if money can be moved within the existing budget. 8) Initial request was submitted without a Cost Plan proposal. 9) CDC+ Consultant did respond to APD's RAI, however response was delayed due to service provider(s) not sending documentation in a timely manner (***Not Met but not calculated into score).

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		Ask the WSC/CDC+ Consultant if APD requested additional information after initial submission of the SAN request. If yes, review the record for the following: ○ If closed due to being incomplete based on requirements in http://flrules.elaws.us/fac/65g-4.0218/?a=(7)#(7) ○ RAI through Notes in iConnect ○ A RAI (request for additional information) is not always due to an incomplete submission. Review details requested on the RAI to determine if RAI is due to incomplete submission ○ Evidence the WSC/CDC+ Consultant responded to the request for additional information ○ If the WSC/CDC+ Consultant has not responded to the RAI and it is due to service provider delays in submitting documents, look for WSC/CDC+ Consultant documented due diligence. ○ All documentation on the WSC Job Aid is required if the consumer is using an iBudget Waiver provider. However, if the consumer is hiring someone to perform the service who is not a Waiver provider, all documents must be provided, with the exception of service logs, quarterly summaries, and daily progress notes. Score this Standard N/A if there were no SAN requests for the person during the review period.	
7	CDC+ Consultant solicits and addresses the person's preferences with regard to employment.	CMS Assurance - Service Plan iBudget Handbook Review the record to determine employment preferences: ○ Ask the WSC/CDC+ Consultant about the person's employment preferences	1) Current Support Plan was not in the record. 2) Current Support Plan did not reflect the person's goals/outcomes related to employment. 3) Current Support Plan reflected preferences for employment, but CDC+ Consultant

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		○ Review the QSI for information about employment preferences ○ Review the Person-Centered Support Plan employment section for person's expressed desire to work or to change jobs ○ If employment is desired, review the record for documentation of a referral to Vocational Rehabilitation (VR). If VR services were not available, look for evidence the WSC/CDC+ Consultant ensured next steps were taken to access employment services ○ Review Progress Notes for actions taken to facilitate preferences listed in the QSI and/or Person-Centered Support Plan.	documentation did not reflect actions taken over the period of review. 4) QSI documents preferences of the person to be employed, but CDC+ Consultant documentation did not address employment preferences over the period of review.
8	The current Annual Report is in the record.	CMS Assurance - Service Plan iBudget Handbook; Person Centered Support Plan Manual 393.0651, F.S The Person Centered Support Plan identifies the annual report will be captured in the "What I Accomplished Last Year" sections. Review the record to locate the Annual Report. The Annual Report must include at a minimum: ○ Report of the supports and services received throughout the year; ○ Description of progress toward meeting individually determined goals; and ○ Any pertinent information about significant events that have happened in the life of the person during the previous year.	1) The record did not include a current Annual Report. 2) The Annual Report did not include a report of the supports and services received throughout the year. 3) The Annual Report did not include a description of progress toward meeting one or more individually determined goals. 4) The Annual Report did not include any pertinent information about significant events that happened in the life of the person during the previous year. 5) The Annual Report did not include pertinent follow-up on all incident reports.

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		▪ *Examples of "any pertinent information about significant events that occurred in the person's life during the previous year" will vary by person and could include but not be limited to major milestones achieved, significant events in the person's personal or social life that may have influenced daily activities, significant health events, a change in residence, etc. ▪ Follow-up on all incident reports should be included in the Annual Report in the Support Plan. • Review previous Support Plan to determine the Annual Report addresses all identified goals/outcomes and services. • Review progress notes and other service provider Annual Reports for additional information.	
9	The Support Plan is updated when warranted by changes in the needs of the person.	CMS Assurance - Service Plan iBudget Handbook; Person Centered Support Plan Manual Review the record to determine the process the Support Coordinator uses to update the Support Plan when the needs of the person change. • Review the record to determine if there have been any changes in the person's needs warranting an update to the Support Plan. • Review Support Plan(s), QSI, SANS requests, Progress Notes, emails, Behavioral reports, Incident reports, Medical reports, quarterly reviews when applicable, the annual report and any other applicable supporting documentation in the Central Record to determine whether: ○ Activities, supports, and contacts contain information about changes in the needs of the person. ○ When the person does not have a functional means of communication, look for documentation the Support	1) Support Plan was not in the record for entire period of review. 2) CDC+ Consultant documentation did not demonstrate the Support Plan was updated when the needs of the person changed. 3) QSI was conducted in the period of review and the Support Plan was not updated. 4) SANS were requested in the period of review and the Support Plan was not updated. 5) Incident Report(s) in the period of review indicate changes in the needs of the person and the Support Plan was not updated.

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		Coordinator has obtained information and recommendations from the circle of supports. ○ If any changes in the needs of the person are noted, review the applicable Support Plan to see if it has been updated/revised accordingly. • If no changes in needs were warranted for the entire period of review, score as N/A. • A life change that resulted in a SANs request is documented in a Support Plan update.	
10	Consultant documents a copy of the Support Plan is provided to the person or the legal representative, within 10 days of the Support Plan effective date.	CMS Assurance - Service Plan iBudget Handbook, Person Centered Support Plan Manual Review the record to determine the method used to document the date and method by which the Support Plan was distributed to the person or when applicable, the legal representative. ○ Review the signature page of the Support Plan or other supporting documentation in the Central Record to determine if the Support Plan was: ○ Provided to the person within 10 working days of the Support Plan effective date. ○ Provided to the legal representative, when applicable, within 10 working days of the Support Plan effective date.	1) Consultant documentation did not demonstrate a copy of the Support Plan was distributed to the person or when applicable the legal representative within 10 days of the effective date. 2) Consultant documentation demonstrated a copy of the Support Plan was distributed to the person or when applicable, the legal representative but not within 10 days of the effective date.
11	Consultant documentation demonstrates a copy of the Support Plan is provided to the CDC+ Representative within 30 calendar days of the Support Plan effective date.	CMS Assurance - Service Plan iBudget Handbook Review the record to determine the method used to document the date and method by which the Support Plan was distributed to the CDC+ Representative. • Review Consultant documentation to determine if a copy of the Support Plan was distributed to the CDC+	1) Consultant documentation did not demonstrate a copy of the Support Plan was distributed to the CDC+ Representative within 30 days of effective date. 2) Consultant documentation demonstrated a copy of the Support Plan was distributed to

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		Representative within 30 calendar days of the Support Plan effective date.	the CDC+ Representative but not within 30 days of the effective date.
12	The Support Plan includes supports and services consistent with assessed needs.	CMS Assurance - Service Plan iBudget Handbook; Person Centered Support Plan Manual Approved Waiver FL0867.R02.00 NOTE: For the purposes of this standard, only the "current Support Plan" will be reviewed. This is defined as the Support Plan in effect at the time of the record review. WSC/CDC+ Consultant should reference the Person Centered Support Plan Manual and ensure all sections are completed for the person in the Significant Needs and Risks section including the other risk/needs related to me, needs/risks related to my caregiver, back up plans for my critical needs/risks, and if warranted safety plan. The Needs/Risks Related to My Caregiver section is applicable to family home only. Review the current Support Plan to identify the current supports and services. • Review the QSI report, Progress Notes, Behavior Assessments/Plans, Functional Community Assessments, Safety Plan, OT, PT, ST assessments, and any other applicable supporting documentation in the central record to determine the assessed needs of the person. • Conduct a comparative review of documentation to determine if the supports and services identified in the Support Plan are consistent with the assessed needs identified in supporting documentation.	1) Current Support Plan was not in the record. 2) Current Support Plan included documentation related to some, but not all assessed needs. 3) Current Support Plan did not include documentation related to the assessed needs. 4) Current Support Plan did not include supports/services identified for assessed needs. 5) Current Support Plan did not include back up plan for assessed needs. 6) Current Support Plan did not include strategies for assessed needs. 7) Current Support Plan did not include applicable supports/services identified for other needs related to me. 8) Current Support Plan did not include applicable strategies identified for other needs related to me. 9) Current Support Plan did not include applicable supports/services identified for needs related to my caregiver. 10) Current Support Plan did not include applicable strategies identified for other needs related to my caregiver.

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		• This section is looking at supports and services important "for" the person.
		• Examples of needs could include but are in no way limited to, adaptive equipment to prevent falls/injuries or to promote independence, medical needs such as diabetes, emotional needs related to mental health diagnosis, needs stemming from past history of Abuse, Neglect or Exploitation.
		• Use copy-shared response feature for QSI assessment
		  ○ Merely copying QSI findings or writing "see QSI" is not acceptable. Documentation should be specific to the person on the Support Plan document.
		• Only items where the QSI indicates no need (0) can be left blank. However the WSC should add details when there is no functional limitation but assistance is required.
		  • If an ICA (Individual Comprehensive Assessment) is completed instead of a QSI, the results are to be transferred to the Support Plan.	

13	The Support Plan reflects support and services necessary to address assessed risks.	CMS Assurance - Service Plan iBudget Handbook; Person Centered Support Plan Manual Approved Waiver FL0867.R01.01 NOTE: For the purposes of this standard, only the "current Support Plan" will be reviewed. This is defined as the Support Plan in effect at the time of the record review. WSC/CDC+ Consultant should reference the Person Centered Support Plan Manual and ensure all sections are completed for the person in the Significant Needs and Risks section including the other risk/needs related to me, needs/risks related to my caregiver, back up plans for my critical needs/risks, and if warranted safety plan.	1) Current Support Plan was not in the record. 2) Current Support Plan included documentation related to some, but not all assessed risks. 3) Current Support Plan did not include documentation related to the assessed risks. 4) Current Support Plan did not include supports/services identified for assessed risks. 5) Current Support Plan did not include back up plan for assessed risks.

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		The Needs/Risks Related to My Caregiver section is applicable to family home only. Review the current Support Plan to identify the current supports and services. • Review the QSI report, Progress Notes, Functional Community Assessments, Safety Plan, OT, PT, ST assessments, Behavior Assessments/Plans, and any other applicable supporting documentation in the Central Record to determine the assessed risks of the person. • Conduct a comparative review of documentation to determine if the supports and services identified in the Support Plan are consistent with the assessed risks identified in supporting documentation. • The Person-Centered Support Plan states that assessed risks and measures to address risks must be documented in the Other Services Needed for Health and Safety section. • Examples of risks could include but are in no way limited to aging caregiver, lack of natural supports, inability to support basic necessities such as food, and housing, elopement, self-injury and/or other significant behaviors, depression, person's vulnerability stemming from past history of Abuse or Exploitation. • Use copy-shared response feature for QSI assessment ○ Merely copying QSI findings or writing "see QSI" is not acceptable. Documentation should be specific to the person on the Support Plan document. • Only items where the QSI indicates no need (0) can be left blank. However the WSC should add details when there is no functional limitation but assistance is required.	6) Current Support Plan did not include strategies for assessed risks. 7) Current Support Plan did not include a Safety Plan that is warranted. 8) Current Support Plan did not include applicable supports/services identified for other risks related to me. 9) Current Support Plan did not include applicable strategies identified for other risks related to me. 10) Current Support Plan did not include applicable supports/services identified for risks related to my caregiver. 11) Current Support Plan did not include applicable strategies identified for other risks related to my caregiver.

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		• If an ICA (Individual Comprehensive Assessment) is completed instead of a QSI, the results are to be transferred to the Support Plan.	
14	The record includes a current complete Safety Plan when warranted.	CMS Assurance - Service Plan iBudget Handbook If the person does not have a documented history as defined in the iBudget Handbook under Safety Plan definition, score N/A. NOTE: A Safety Plan is a distinct and separate document from the Support Plan but you access the plan via a checkbox in the Support Plan within iConnect or for paper Support Plans it is typically attached to the Support Plan. A Safety Plan covers a Support Plan year and needs to be completed annually whenever a new Support Plan is developed and updated whenever changes warrant it to be. Review the record to determine the method for gathering information necessary to develop and update the Safety Plan at least annually. • Look for documentation demonstrating collaboration with the person's behavioral supports and others in the circle of supports. • Review the current Support Plan to determine the Safety Plan is included and has been updated as needed but at least annually with the Support Plan effective date. • The "safety plan" should address, at minimum: a) Brief summary of historical behavior b) Any related criminal charges c) Court order, probationary or registration requirements, when appropriate	1) Current Support Plan was not in the record. 2) Current Support Plan did not include a Safety Plan. 3) CDC+ Consultant did not update the Safety Plan at least annually. 4) CDC+ Consultant did not update the Safety Plan when change warranted an update. 5) The current Safety Plan did not include a brief summary of the person's historical behavior. 6) The current Safety Plan did not include a description of any related criminal charges. 7) The current Safety Plan did not include information on any current court orders, probationary or registration requirements, when appropriate. 8) The current Safety Plan did not identify current behaviors of concern. 9) The current Safety Plan did not identify triggers, high-risk situations, environmental stressors, and personal stressors. 10) The current Safety Plan did not identify any known predatory "grooming" behaviors.

#	Performance Measure/Standard	Protocol	Not Met Reasons
		d) Behaviors of concern e) Triggers, high-risk situations, environmental stressors and personal stressors f) Known predatory "grooming" behaviors g) Any limitations on access to media or community outings concerns h) Avoidance behaviors requiring training or prompting i) Level and type of supervision required throughout the day j) Any need for alarms or monitoring devices.	11) The current Safety Plan did not identify limitations on access to media or community outing concerns. 12) The current Safety Plan did not identify avoidance behaviors requiring training or prompting. 13) The current Safety Plan did not identify level and type of supervision needed throughout the day. 14) The current Safety Plan did not identify any need for alarms or monitoring devices.
15	The Safety Plan was distributed and reviewed with pertinent providers.	CMS Assurance - Service Plan iBudget Handbook The WSC should ensure the Safety Plan is distributed with pertinent providers. Review the record to locate the Safety Plan. The Safety Plan is a component of the Person-Centered Support Plan. Determine the method used to document the date and method by which the Safety Plan was distributed to pertinent providers rendering services to the person. ○ Review the Support Plan, Cost Plan and/or Service Authorizations to determine current service providers ○ Review WSC/CDC+ Consultant documentation to determine the Safety Plan was developed or updated in conjunction with the individual's circle of supports; this may have occurred at the time of the Support Plan Meeting since it is a component of the Support Plan	1) The current Safety Plan was not in the record. 2) The current Safety Plan was not distributed to any providers. 3) The current Safety Plan was distributed to some, but not all pertinent providers. 4) There was no documentation to support the CDC+ Consultant reviewed the Safety Plan with pertinent providers.

#	Performance Measure/Standard	Protocol	Not Met Reasons
		○ Review WSC/CDC+ Consultant documentation to determine if a copy of the Safety Plan was distributed to all pertinent providers rendering services to the person If the person does not have a documented history as defined under Safety Plan in the iBudget Handbook, score N/A.	
16	CDC+ Consultant documentation demonstrates use of a person centered approach to define the personal goals/outcomes important to the person.	CMS Assurance - Service Plan iBudget Handbook; Person Centered Support Plan Manual NOTE: For the purposes of this standard, only the "current Support Plan" will be reviewed. This is defined as the Support Plan in effect at the time of the record review. Waiver Support Coordinators must use a person-centered approach to identify a person's goals and plan and implement supports and services to achieve them. • Review the current Support Plan to identify the person's goals/outcomes. ○ Goals should not be service based, or focused only on a person's needs ○ Goals should reflect person centered language and what is Important To the person ○ Goals should lead to achievement of Outcomes that are enriching, fulfilling and important to the person. • Review the Support Plan, Progress Notes, emails, quarterly reviews when applicable, the Annual Report and any other applicable supporting documentation in the Central Record to determine whether:	1) Current Support Plan was not in the record. 2) Current Support Plan did not reflect the person's goals/outcomes. 3) Current Support Plan Goals were all need based, focused only on what is "important for" instead of "important to" the person. 4) CDC+ Consultant documentation did not demonstrate use of a Person Centered approach to determine the personal goals of the person. 5) CDC+ Consultant documentation did not demonstrate use of circle of supports in identifying the personal goals of the person. 6) CDC+ Consultant documentation demonstrated support-planning process was driven primarily by circle of supports instead of the person. 7) Current Support Plan was essentially identical to the previous Support Plan.

#	Performance Measure/Standard	Protocol	Not Met Reasons
		○ Activities, supports and contacts contain information about working with the person to identify and define his/her goals. ○ When the person does not have a functional means of communication, look for documentation the Support Coordinator has obtained information and recommendations from the circle of supports. • Compare the information identified in the record with the information reflected in the Support Plan to determine if the Support Plan reflects the personal goals of the person. • Compare Current Support Plan to previous plan(s), to see if plan is identical showing little to no effort on the part of the WSC/CDC+ Consultant to develop a new Support Plan.	
17	CDC+ Consultant documentation demonstrates efforts to solicit natural, community supports for the person prior to waiver service requests.	CMS Assurance - Service Plan iBudget Handbook; Person Centered Support Plan Manual NOTE: For the purposes of this standard, only the "current Support Plan" will be reviewed. This is defined as the Support Plan in effect at the time of the record review. Funding sources shall be accessed to include but not be limited to the following in this order: ○ Natural and community supports; ○ Third Party Payer, such as private insurance; ○ Medicare; ○ Other Medicaid programs; and ○ Home and Community Based Services Waiver, which is the payer of last resort. • Review the record to determine what natural, community, and paid resources for the person are being used.	1) Current Support Plan was not in the record. 2) Current Support Plan did not identify natural supports. 3) Current Support Plan did not identify community supports. 4) Documentation did not reflect ongoing efforts to reduce reliance on Waiver supports.

#	Performance Measure/Standard	Protocol	Not Met Reasons
		• Review the current Support Plan to determine if natural, community and paid resources apart from the Waiver are identified. • Review Progress Notes to see if efforts are made to find natural/community supports prior to making a SANS request. Even if supports have not changed in the period of review, WSC/CDC+ Consultant should document periodic attempts to reduce reliance on waiver supports and services.	
18	CDC+ Consultant monitors service delivery to ensure services are delivered in accordance with the Support Plan and Cost Plan.	CMS Assurance - Service Plan iBudget Handbook For CDC+ Participants, the Purchasing Plan outlines what services will be delivered. • Review the current Cost Plan to determine what services are needed to address goals. • Review services on the Purchasing Plan and applicable Quick Updates. • Determine if the services on the Purchasing Plan are comparable with the services outlined in the Cost Plan. • Note: Cost Plan cannot have a line for CDC+ Consultant and one other line with all other services listed in reserve/unencumbered. Cost Plan should be reflective of all the service needs. • Based on services the person receives, review CDC+ Consultant Progress Notes for documentation reflecting ongoing review of services and service documentation. ○ Documentation in Progress Notes should reflect conversations with the person to evaluate if service is	1) Current Cost Plan was not in the record. 2) Purchasing Plan was not in the record. 3) Services on the Purchasing Plan were not comparable to services identified on the Cost Plan. 4) Services on the Cost Plan were not reflective of all service needs. 5) CDC+ Consultant documentation did not reflect follow-up when Support Plan goals were not being addressed by the provider. 6) CDC+ Consultant documentation did not reflect follow-up with the provider when services are rendered not in accordance with the service authorization including over or under utilization.

#	Performance Measure/Standard	Protocol	Not Met Reasons
		being provided in accordance with the person's Support Plan goals/outcomes. ○ Documentation in Progress Notes should reflect CDC+ Consultant efforts to review claims and ensure services are being provided in accordance of the type, scope, duration, and frequency specified on the Cost Plan and Purchasing Plan. ○ Documentation in Progress Notes should reflect CDC+ Consultant follow-up with representative when claims indicate representative is over and/or under billing for services ○ Documentation in Progress Notes should reflect CDC+ Consultant follow up when service limitations and requirements are not being adhered to by the representative. If Applicable: • Ask the CDC+ Consultant about any services from the Cost Plan not being utilized under CDC+. • If CDC+ Consultant indicates service is not being utilized due to lack of available providers or choice of person/family, review for documentation in the record showing Consultant's efforts to address. • If documentation supports CDC+ Consultant's reasons for service(s) not being rendered as approved, score as Met and add a discovery.	
19	CDC+ Consultant bills for services after required contacts are rendered.	CMS Assurance – Financial Accountability iBudget Handbook CDC+ Consultant is not to bill for services prior to rendering.	1) CDC+ Consultant billed prior to meeting minimum contact requirements for one or more months during the period of review.

#	Performance Measure/Standard	Protocol	Not Met Reasons
		For each month in the period of review: • Determine the minimum number and type of contacts required for each month • Review Progress Notes to determine the date minimum billing requirements were met for each month. • Compare month billing requirements were met to "claim billed date" in claims. • Determine if services were rendered prior to billing for each date of service during the period of review. If one or more months were billed prior to completing minimum required contacts, score NM and add a discovery identifying the month(s).	
20	The CDC+ Consultant Progress Notes demonstrate pre-Support Plan planning activities were conducted.	CMS Assurance - Service Plan iBudget Handbook Approved Waiver FL0867.R02.001 Appendix D Prior to the expiration of the plan, the CDC+ Consultant discusses with the person the purpose of the planning process and provides a summary of the past year's plan and services. The person is asked to identify changes to the goals or services received and a discussion of changes of providers if needed. The meeting is planned based on the person's preferences for the dates and times of the meeting. In addition, the CDC+ Consultant discusses who the person would like to invite to the meeting, including providers, family members, and friends. The CDC+ Consultant notifies invitees of the person's choice of the time, place, and date of the meeting.	1) CDC+ Consultant documentation did not demonstrate pre-support planning activities took place. 2) CDC+ Consultant documentation demonstrated pre-support plan activities took place but did not document discussions about the purpose of the planning meeting. 3) CDC+ Consultant documentation demonstrated pre-support plan activities took place but did not document review of status of current goals/outcomes and discussions of potential changes/updates to goals/outcomes for the next year. 4) CDC+ Consultant documentation demonstrated pre-support plan activities took place but did not document review of current services and providers.

#	Performance Measure/Standard	Protocol	Not Met Reasons
		Review the record to determine the method used for conducting and documenting pre-support plan activities. ○ Review Progress Notes to determine if pre-support plan activities were completed prior to the Support Plan effective date. ○ Review Progress Notes to determine the following content is included: ○ Discussed with the person about the purpose of the planning process. ○ Reviewed status of current goals/outcomes and discussed potential changes or updates to goals/outcomes for the next year. ○ Reviewed status of current services and providers and discussed any needed changes to either. ○ Discussed possible dates, times, and locations for the meeting based on the person's preferences as well as who the person would like to invite to the meeting including providers, family members and friends. Pre-Support Plan activities may be documented in more than one Progress Note. Activities may happen on different days leading up to the Support Plan meeting.	5) CDC+ Consultant documentation demonstrated pre-support plan activities took place but did not document discussions of potential dates, times, and locations for the meeting. 6) CDC+ Consultant documentation demonstrated pre-support plan activities took place but did not document discussions of whom the person would like to invite to the meeting.
21	Progress Notes reflecting required monthly contact/activities are filed in the Participant's record prior to billing each month.	CONSUMER-DIRECTED CARE PLUS - October 2015 The CDC+ Consultant is required to complete and document a minimum of one monthly contact every month on a Progress Note. Note: CDC+ Consultant should follow requirements set forth by APD as instructed in applicable advisories.	1) Progress Notes were not present for one or more months. (B) 2) Progress Notes did not demonstrate a bi-annual face to face visit. (B) 3) Progress Notes did not demonstrate an annual Home visit. (B) 4) Progress Note did not include all required components. (B)

#	Performance Measure/Standard	Protocol	Not Met Reasons
		• At least 1 Progress Note per month for billing purposes should be conducted with the CDC+ Representative. • A face to face visit is required once every six months and at least annually a face to face visit needs to occur in the Participant's home. • Participant Monthly Review Forms are not a replacement for a Progress Note, but can be completed in addition to the Progress Note. • Progress Notes must contain the following required components: ▪ Monthly Deposit was correct, Participant is spending within monthly budget, and consistent with all sections of the Purchasing plan. ▪ Participant maintained an up-to-date account reconciliation. ▪ Participant submitted claims in a timely manner (within 6 weeks), and all claims have cleared (none are pended) ▪ Services and supports purchased are consistent with the Purchasing plan and providers utilized are consistent with the Purchasing Plan ▪ If an emergency backup provider was used consistently a revised Purchasing Plan was developed or if use of emergency backup providers resulted in 4 or more regular DHE's, participant purchased and provided proof of Workers Compensation Insurance ▪ Items in savings are being tracked and will be able to be purchased within the timeframe noted in the Purchasing Plan.	5) Progress Note was documented but was not with the CDC+ Representative. (B)

#	Performance Measure/Standard	Protocol	Not Met Reasons
		▪ If applicable, APD was contacted for adjustments ▪ If applicable, additional information, counseling, training, and assistance to address deficiencies ▪ If applicable, a CAP was developed and implemented within five business days. Face-to-face contacts shall accomplish the following: • Assist the Participant to reach the goals stated on the Support Plan and Purchasing Plan; • Monitor the health and well-being of the Participant, look for indicators of fraud, abuse, neglect, or exploitation and report these indicators to the proper authorities within 24 hours; • Monitor the Participant's involvement in the community; • Assist the Participant to make informed choices and to advocate for his or her self; and • Follow-up on the Participant's or Representative's concerns If a Representative review has been conducted and reconciliation was not present, score Met but add a discovery regarding the disconnect between the Representative record and the CDC+ Progress Notes/Monthly Participant Review Form. If not met reason # 4 is used, add a discovery regarding what components were not present. Other considerations:	

#	Performance Measure/Standard	Protocol	Not Met Reasons
		➢ Administrative activities such as typing letters, filing, mailing, or leaving messages **do not** qualify as contacts/activities. ➢ Activities including telephone calls to schedule meetings, setting up face-to-face visits, or scheduling meetings with the person's employer, family, or providers **do not** qualify as additional contacts. ➢ Sending an email or text is only considered billable upon response; otherwise it is like leaving a message. ➢ Sending of resources is billable if individualized to the person. A mass email to share resources with all or much of caseload would not be billable. **This standard is subject to a potential billing discrepancy**	
22	CDC+ Consultant Progress Notes include meaningful information to effectively assist the person in achieving goals/outcomes.	CMS Assurance – Service Plan iBudget Handbook The purpose of a face-to-face visit: discuss progress, changes, or both, to goals/outcomes, status of any unresolved issues, and satisfaction with current supports received. Each contact should be viewed as an opportunity to give or receive meaningful information that can be used to effectively assist the person in achieving goals/outcomes. Review the record to ensure Progress Notes cover the following content. Face to face contacts must relate to or accomplish one or more of the following: ✓ Assist the person to reach individually determined goals on the Support Plan, including gathering information to identify outcomes; ✓ Monitor the health and well-being of the person;	1) Progress Notes were generic and not individualized. 2) Progress Notes did not address person's progress towards goals. 3) Progress Notes did not reflect efforts to increase the person's involvement in the community. 4) Progress Notes did not reflect efforts to advocate on behalf of the person when needed. 5) Progress Notes did not reflect development of natural/generic resources based on need or request. 6) Progress Notes did not show follow-up on concerns or conflicts when needed.

#	Performance Measure/Standard	Protocol	Not Met Reasons
		✓ Obtain, develop and maintain resources needed or requested by the person to include natural supports, generic community supports and other types of resources; ✓ Increase the person's involvement in the community; ✓ Promote advocacy or informed choice for the person and/or; ✓ Follow up on unresolved concerns or conflicts. Secondary contacts with or on behalf of the person: ✓ Must be documented in Progress Notes ✓ Must be individualized and related to services and benefits specific to the person. ✓ Not merely incidental, but planned. ✓ Can be with the person, people important in the person's life, family members, legal representatives, service providers, or community members. ✓ By telephone/text, letter writing, or e-mail transmission. All contacts on behalf of the person should be completed in secure manner to assure compliance with HIPAA.	
23	CDC+ Consultant documents ongoing efforts to assist the person/legal representative to know about rights.	CMS Assurance - Service Plan iBudget Handbook; 393 F.S. The Person-Centered Support Plan includes the "Personal Rights" section; however, just completing in the Support Plan would not address on-going needs throughout the course of the period of review and should include documentation of ongoing efforts in this area.	1) CDC+ Consultant documentation did not demonstrate efforts to assist the person/legal representative to know about their rights. 2) CDC+ Consultant documentation demonstrated efforts to assist the person/legal representative to know about their rights but not on an ongoing basis. 3) CDC+ Consultant documentation did not demonstrate efforts to follow up on rights restrictions in place.

#	Performance Measure/Standard	Protocol	Not Met Reasons
		Ask the WSC/CDC+ Consultant to describe method of assisting the person and when applicable, legal representatives to know about their rights and responsibilities as related to this service. • Review WSC/CDC+ Consultant documentation supporting stated methods for WSC/CDC+ Consultant efforts to assist the person/legal representative to know about rights on an ongoing basis. • Review Progress Notes and other documentation demonstrating efforts to support the personal, and when applicable the legal representative to know about rights. *Examples of efforts to assist the person/legal representative to know about rights will vary by person and frequency of service. Information could include, but not be limited to, identification of rights most important to the person, access to personal possessions, fair wages, voting, freedom from discrimination, specific rights restrictions identified on a behavior plan, education on Informed Consent, confidentiality, voting, privacy, religion, freedom from harm, self-determination, etc.	4) CDC+ Consultant documentation did not demonstrate rights education was individualized to the learning style of the person.
24	CDC+ Consultant documents ongoing efforts to ensure all of the person's health care needs are addressed.	CMS Assurance - Health and Welfare iBudget Handbook Health and health care needs include medical conditions, medications (prescription and over-the-counter), preventive healthcare, wellness exams, therapeutic interventions, medical devices/apparatus. The Person-Centered Support Plan includes the "Other Services Needed for Health and Safety" section; however, just completing in the Support Plan would not address on-going needs throughout the	1) CDC+ Consultant documentation did not demonstrate efforts to gather information about the person's physical health and health care needs. 2) CDC+ Consultant documentation demonstrated knowledge of the person's physical health and health care needs but not ongoing efforts to address identified needs. 3) Key and critical physical health and/or healthcare needs have not been addressed.

#	Performance Measure/Standard	Protocol	Not Met Reasons
		course of the period of review and should include documentation of on-going efforts in this area. Ask the WSC/CDC+ Consultant to describe the method used to gather and document knowledge of person's health and health care needs. • Ask the WSC/CDC+ Consultant to describe method used to gather and document knowledge of person's behavioral/emotional health information relevant to the service provided. • Ask the WSC/CDC+ Consultant how health information is maintained and updated on an ongoing basis. • Review WSC/CDC+ Consultant documentation supporting stated methods for WSC/CDC+ Consultant efforts to gather and learn information regarding the person's health and health care needs and steps taken to address the person's needs. ○ For example: scheduled medical appointments, provided education, and procured medical services/devices. • Review the record for documentation related to routine and preventative medical and dental care. • Review Progress Notes and other related health care documentation for evidence the WSC/CDC+ Consultant identifies and addresses the person's health and healthcare needs on a routine basis. *Key/critical health and health care information will vary per person, and could include, but not be limited to diagnosis, certain environmental factors, medication related information, food	4) CDC+ Consultant documentation did not demonstrate efforts to gather information about the person's behavioral/emotional health needs. 5) CDC+ Consultant documentation demonstrated knowledge of the person's behavioral/emotional health needs but not ongoing efforts to address identified needs. 6) Key and critical behavioral/emotional health needs have not been addressed.

#	Performance Measure/Standard	Protocol	Not Met Reasons
		allergies, specialized equipment needs, and other factors critical to maintaining the health of the person. • Ask the WSC/CDC+ Consultant how information related to behavioral/emotional health is maintained and updated on an ongoing basis. • Review record for documentation supporting stated method. • Supporting documentation may be found in Support Plans, intake forms, stand-alone forms, or other available WSC/CDC+ Consultant documentation. *Key/critical behavioral/emotional health information will vary by person and could include, but not be limited to diagnosis, certain environmental factors, medication and related information, Baker Acts, police involvement, Behavior Plans, Safety Plans, emotional well-being (stress, anxiety, depression, grief, other emotional issues or diagnosis) and any other information critical to the behavioral/emotional health of the person and relevant to the service being provided. For some, these not met reasons would not be applicable.	
25	CDC+ Consultant documents ongoing efforts to assess and address the person's safety needs.	CMS Assurance - Health and Welfare iBudget Handbook The Person-Centered Support Plan includes the "Other Services Needed for Health and Safety" section; however, just completing in the Support Plan would not address on-going needs throughout the course of the period of review and should include documentation of on-going efforts in this area. Ask the WSC/CDC+ Consultant to describe method used to gather and document knowledge related to safety needs of the person.	1) CDC+ Consultant documentation did not demonstrate efforts to assess the person's safety needs. 2) CDC+ Consultant documentation demonstrated knowledge of the person's safety needs but not ongoing efforts to address identified needs. 3) Key and critical safety needs have not been addressed.

#	Performance Measure/Standard	Protocol	Not Met Reasons
		• Ask the WSC/CDC+ Consultant how this information is maintained and updated on an ongoing basis. • Review record for documentation supporting WSC/CDC+ Consultant efforts to assess the person's safety skills and safety needs including steps taken to address the person's needs on an ongoing basis. • Review Progress Notes or other documentation supporting personalized efforts towards evaluation/training in areas such as community awareness/safety, home safety, education related to extreme weather events, etc. • Review Progress Notes and other available and applicable provider documentation such as Functional Community Assessments, Implementation Plans, Housing Survey's, Personal Disaster Plan, Safety Plan, Behavior Plan, etc. for identified safety needs to determine if the person's safety needs are being addressed. • Personal Disaster Plan template can be found on the APD website and should be updated annually.	4) CDC+ Consultant documentation did not include a personal disaster plan for the person completed in the period of review.
26	CDC+ Consultant documents person's history regarding abuse, neglect and/or exploitation.	CMS Assurance - Health and Welfare iBudget Handbook Ask the WSC/CDC+ Consultant to describe method used to gather and document information about the person's history related to abuse, neglect, and/or exploitation. • Review WSC/CDC+ Consultant documentation demonstrating WSC/CDC+ Consultant efforts to gather and document past or present instances of alleged or confirmed abuse, neglect and/or exploitation and WSC/CDC+ Consultant efforts to identify and address the person's needs on an ongoing basis.	1) CDC+ Consultant documentation did not demonstrate efforts to gather information about the person's history regarding abuse, neglect, and/or exploitation. 2) Key and Critical issues related to abuse, neglect, and exploitation needs have not been addressed.

#	Performance Measure/Standard	Protocol	Not Met Reasons
		• Review Progress Notes, Support Plans, other available WSC/CDC+ Consultant documentation, and available service provider documentation. • This should carefully be revisited periodically in the event the person has a history, but has not felt comfortable enough to share. • Based on review of Progress Notes, available Support Plans and other available provider documentation, if there is no indication of a history of abuse, neglect and/or exploitation, score N/A.	
27	CDC+ Consultant documents efforts to assist the person to define abuse, neglect, and exploitation.	CMS Assurance - Health and Welfare iBudget Handbook Ask the WSC/CDC+ Consultant to describe the process used to gather and document efforts to assist the person to define abuse, neglect, and exploitation. • Review WSC/CDC+ Consultant documentation demonstrating **individualized efforts** to support the person to recognize all types of abuse, neglect and exploitation on an ongoing basis. ○ Types of abuse include physical, verbal, sexual and emotional • Supporting documentation may include the Support Plan, Progress Notes, evidence of customized training techniques used to support people with different learning styles and levels of understanding, documented training sessions indicating specific scenarios reviewed and feedback received or any other documented methods used by the WSC/CDC+ Consultant demonstrating efforts to assist the person to define abuse, neglect and exploitation. Documentation must show this is addressed at least annually.	1) CDC+ Consultant documentation did not demonstrate individualized efforts to assist the person to define abuse, neglect, and exploitation. 2) CDC+ Consultant documentation demonstrated individualized efforts to define some but not all aspects of abuse, neglect and exploitation.

Service Specific Record Review – CDC+ Consultant

(Note: The Term WSC and CDC+ Consultant are used interchangeably in this tool)

#	Performance Measure/Standard	Protocol	Not Met Reasons
28	CDC+ Consultant documents efforts to assist person with knowing when and how to report any incidents of Abuse, Neglect and/or Exploitation.	CMS Assurance - Health and Welfare iBudget Handbook Ask the WSC/CDC+ Consultant to describe the process used to gather and document efforts to assist the person to know when and how to report any incidents. • Review WSC/CDC+ Consultant documentation demonstrating **individualized efforts** to assist the person to know when and how to report abuse, neglect and exploitation (Call Abuse Hotline, tell WSC/CDC+ Consultant, Police, Family, etc.) on an ongoing basis. Supporting documentation may include the Support Plan, Progress Notes, evidence of customized training techniques used to support people with different learning styles and levels of understanding, documented training sessions indicating specific scenarios reviewed and feedback received or any other documented methods used by the WSC/CDC+ Consultant demonstrating efforts to assist the person to define report abuse, neglect and exploitation. Documentation must show this is addressed at least annually.	1) CDC+ Consultant documentation did not demonstrate when and how the person would report any incidents of abuse, neglect, and exploitation. 2) CDC+ Consultant documentation did not demonstrate individualized education for the person based on their learning style.
29	CDC+ Consultant documents the invitation to take the satisfaction survey to the person receiving services.	The Qualified Organization shall provide each person receiving services or, if applicable, the legal representative, with an Invitation to Take a Client Satisfaction Survey, APD Form 65G-14.003 A, effective July 1, 2021 during the annual Support Plan meeting in compliance with the iBudget Handbook.	1) CDC+ Consultant documentation did not demonstrate the invitation to the satisfaction survey was provided to the person receiving services. 2) CDC+ Consultant documentation did not demonstrate the invitation to the satisfaction survey was provided to the legal representative.

#	Performance Measure/Standard	Protocol	Not Met Reasons
		Note: The expectation is not that receipt of the invitation has to be signed by the person receiving services/legal representative, but the information should be documented in Progress Notes. Satisfaction Survey can only be generated once every 10 months.	3) CDC+ Consultant documentation did demonstrate the invitation to the satisfaction was provided, but not annually.
30	CDC+ Consultant documents the review of the QO's disciplinary process to the person receiving services.	The Qualified Organization must review the disciplinary process with each person receiving services or, if applicable, the legal representative on an annual basis or immediately upon request. Note: The expectation is not that receipt of the disciplinary process has to be signed by the person receiving services/legal representative, but the information should be documented in Progress Notes.	1) CDC+ Consultant documentation did not demonstrate review of the QO's disciplinary process was provided to the person receiving services. 2) CDC+ Consultant documentation did not demonstrate review of the QO's disciplinary process was provided to the legal representative. 3) CDC+ Consultant documentation did demonstrate review of the QO's disciplinary process was provided, but not annually.
31	CDC+ Consultant documents the review of the QO's code of ethics to the person receiving services.	The Qualified Organization must review the code of ethics with each person receiving services or, if applicable, the legal representative on an annual basis or immediately upon request. Note: The expectation is not that receipt of the QO's code of ethics has to be signed by the person receiving services/legal representative, but the information should be documented in Progress Notes.	1) CDC+ Consultant documentation did not demonstrate review of the QO's code of ethics was provided to the person receiving services. 2) CDC+ Consultant documentation did not demonstrate review of the QO's code of ethics was provided to the legal representative. 3) CDC+ Consultant documentation did demonstrate review of the QO's code of ethics was provided, but not annually.

Service Specific Record Review – CDC+ Consultant

(Note: The Term WSC and CDC+ Consultant are used interchangeably in this tool)

#	Performance Measure/Standard	Protocol	Not Met Reasons
32	Completed/signed Participant-Consultant Agreement is in the record.	CONSUMER-DIRECTED CARE PLUS - October 2015 • Determine Participant-Consultant Agreement is in the record. • Determine Agreement is signed and dated by Consultant and Participant/Guardian. • The Participant/Consultant agreement should be signed for any CDC+ Consultant change and APD should be notified of the selection of the CDC+ Consultant before officially acting as the CDC+ Consultant.	1) The Current Participant-Consultant Agreement was not present in the record. 2) The Participant-Consultant Agreement was not signed and dated by Participant/CDC+ representative. 3) The Participant-Consultant Agreement was not signed and dated by CDC+ Consultant.
33	Completed/signed CDC+ Consent Form is in the record.	CONSUMER-DIRECTED CARE PLUS - October 2015 • Determine CDC+ Consent form is in the record. • Determine Consent form is complete & signed by Participant/Guardian, Representative and CDC+ Consultant. • This is a form that, if needed, the CDC+ Representative is authorized to sign.	1) The CDC+ Consent Form was not present in the record. 2) The CDC+ Consent Form was not signed and dated by participant/CDC+ Representative. 3) The CDC+ Consent Form was not signed and dated by the CDC+ Consultant. 4) The CDC+ Consent Form was in the record and signed but it was not complete.
34	Completed/signed Participant-Representative Agreement is in the record.	CONSUMER-DIRECTED CARE PLUS - October 2015 • Determine Participant-Representative Agreement is in the record. • Determine Agreement is complete & signed. • If a new Representative has taken over, a new form should be in the file with the current Representative. • Older versions of this form are simply called “Representative Agreement”. • Agreement is required even if participant is their own representative.	1) The Participant-Representative Agreement was not present in the record. 2) The Participant-Representative Agreement was not signed and dated by the Participant/legal representative. 3) The Participant-Representative Agreement was not signed and dated by CDC+ Representative. 4) The Participant-Representative Agreement was in the record but not for the current CDC+ Representative.

#	Performance Measure/Standard	Protocol	Not Met Reasons
			5) The Participant-Representative Agreement was in the record but was not signed and dated by the CDC+ Consultant.
35	All applicable completed/signed Purchasing Plans are in the record.	CONSUMER-DIRECTED CARE PLUS - October 2015 • Determine Purchasing Plan(s) for the period of review are in the record. • Determine Purchasing Plan is complete. • Determine Plan is signed by Participant and/or Representative, CDC+ Consultant and local Regional/Area office CDC+ Liaison on the first page and the back signature page.	1) Purchasing Plan was not present in the record. 2) Purchasing Plan in the record was not the current Purchasing Plan. 3) Purchasing Plan was not signed and dated by Participant and/or CDC+ Representative. 4) Purchasing Plan was not signed and dated by CDC+ Consultant. 5) Purchasing Plan was not signed and dated by Regional/Area CDC+ Liaison.
36	The Purchasing Plan reflects the goals/needs outlined in Participant's Support Plan.	CONSUMER-DIRECTED CARE PLUS - October 2015. • Ask the CDC+ Consultant if there have been any changes in the person's needs warranting an update to the Support Plan. Changes in the person's needs warranting an update to the Purchasing Plan would also need to be addressed in Standard #7 for Support Plan Updates. • Review goals identified on the current Support Plan. • Review needs section of current Purchasing Plan. • Verify Purchasing Plan is consistent with goals/needs outlined in the Support Plan. • Note: APD will provide date of current Purchasing Plan.	1) Current Support Plan was not in the record. 2) Purchasing Plan was not in the record. 3) Services listed in the Purchasing Plan were not consistent with the Participant's goals/needs. 4) Goals/needs on the current Support Plan were not consistent with needs and services in the Purchasing Plan.
37	All applicable completed/signed Quick Updates are in the Record.	CONSUMER-DIRECTED CARE PLUS - October 2015 • Determine if any Quick Updates have been completed.	1) One or more Quick Updates were not present in the record. 2) Quick Update form (s) was not signed by Participant and/or Representative.

#	Performance Measure/Standard	Protocol	Not Met Reasons
		• Determine Quick Update(s) is signed by Participant and/or Representative, CDC+ Consultant and local Regional/Area office CDC+ Liaison. • Note: APD will provide number and dates of applicable Quick Updates. • Note: if no Quick Updates required/done, score N/A.	3) Quick Update form (s) was not signed by CDC+ Consultant. 4) Quick Update form (s) was not signed by Regional/Area CDC+ Liaison.
38	Participant's Information Update form is completed and submitted to Regional/Area CDC+ liaison as needed.	CONSUMER-DIRECTED CARE PLUS - October 2015 • Determine if there has been any change to Participant e-mail address and/or alternate phone numbers that are not available in ABC/iConnect database. • Determine if there has been any change in Representative. • Determine if there has been any change in CDC+ Consultant. • Determine if there has been any disenrollment or reinstatement of budget. • For any one or more changes noted above determine that a Participant Update Information from has been completed by CDC+ Consultant. • Determine form has been submitted to the Regional/Area office and signed by Regional/Area Liaison.	1) Participant's Information Update form was not signed by CDC+ Consultant. 2) Participant's Information Update Form was not signed by Regional/Area Liaison. 3) A Participant's Information Update form was not completed and submitted for a change in e-mail address and/or alternate phone numbers. 4) A Participant's Information Update form was not completed and submitted for a change in Representative or Representative's information. 5) A Participant's Information Update form was not completed and submitted for a change in CDC+ Consultant or CDC+ Consultant's information. 6) A Participant's Information Update form was not completed and submitted for a change in enrollment status.
39	When correctly completed/submitted by the Participant/CDC+ Representative, Consultant	CONSUMER-DIRECTED CARE PLUS - October 2015 • Review Purchasing Plan(s) and determine CDC+ Consultant signature is on or before the 10th of the month prior to the Purchasing Plan effective date.	1) Purchasing Plan was not in the record. 2) The date of CDC+ Consultant's signature on approved Purchasing Plan in record was after the 10th of the month prior to the month it was to be effective.

#	Performance Measure/Standard	Protocol	Not Met Reasons
	submits Purchasing Plans by the 10th of the month.	• Review documentation to ensure plan was submitted to Regional/Area office. Note: Emergency situations could warrant a Purchasing Plan being submitted after the 10th of the month.	3) Purchasing Plan had not been submitted to the Regional/Area office.
40	CDC+ Consultant provides technical assistance to Participant as necessary to meet Participant's and Representative's needs.	CONSUMER-DIRECTED CARE PLUS - October 2015 • Look for indications in Progress Notes and other documentation the Consultant has provided technical assistance when needed to address the Participant's needs. • Consultants can provide supports with choosing a different support/service, suggestions on how to select, train and supervise workers. • Consultant can answer questions, discuss ideas, provided information about community resources and peer support activities in the community. • Consultant is also responsible to provide technical support in the writing of the Purchasing Plan. • Review documentation to see if Participant is in a negative balance and if technical assistance has been provided to assist.	1) Documentation did not indicate CDC+ Consultant's effort to provide technical assistance when requested and/or needed. 2) Participant and/or Representative indicated CDC+ Consultant had not provided needed technical assistance. 3) Participant has had a negative balance during the review period and there was no documentation to show Consultant provided technical assistance.
41	CDC+ Consultant has taken action to correct any overspending by the Participant.	CONSUMER-DIRECTED CARE PLUS - October 2015 • Review documentation to show unexpended balance at the end of the statement is positive and sufficient for the Participant to pay for the remaining services provided during the statement month. • If overspending has occurred, ensure the Consultant is addressing it in Progress Notes.	1) Progress Note(s) did not clearly identify actions taken by CDC+ Consultant to correct overspending by the Participant.

Service Specific Record Review – CDC+ Consultant

(Note: The Term WSC and CDC+ Consultant are used interchangeably in this tool)

#	Performance Measure/Standard	Protocol	Not Met Reasons
42	If applicable, CDC+ Consultant initiates Corrective Action.	CONSUMER-DIRECTED CARE PLUS - October 2015. Determine CDC+ Consultant has initiated a Corrective Action Plan, if necessary. A Corrective Action Plan may be required if: ○ A Representative is not available, but is necessary for participation; ○ The Participant or Representative has been unable to manage the CDC+ budget or services; ○ The Participant's health or safety is at risk; ○ The Participant or Representative can no longer be served safely in the community; ○ The Participant or Representative has failed to properly screen providers; and ○ The Participant or Representative has failed to comply with the requirements of the CDC+ program. • Note: APD will provide number and dates of applicable Corrective Action Plans.	1) A problem had occurred and the CDC+ Consultant had not initiated a Corrective Action Plan. 2) Corrective Action Plan was not initiated by CDC+ Consultant when appropriate.
43	Completed/signed Corrective Action Plan is in the record.	CONSUMER-DIRECTED CARE PLUS - October 2015 Ask the CDC+ Consultant if they have initiated a Corrective Action Plan. Determine: • Copy of Corrective Action Plan is in the record and complete; and • Corrective Action Plan is signed by Participant/Representative, CDC+ Consultant, Regional/Area APD office Liaison and State APD office.	1) Corrective Action Plan was not in the record. 2) Corrective Action Plan was not signed and dated by the Participant/ Representative. 3) Corrective Action Plan was not signed and dated by CDC+ Consultant. 4) Corrective Action Plan was not signed and dated by Regional/Area APD office. 5) Corrective Action Plan was not signed and dates by APD State office.

#	Performance Measure/Standard	Protocol	Not Met Reasons
		Note: The current Corrective Action Plan form revision date is 11/15/2010. If no Corrective Action plan has been initiated, score this standard as N/A	
44	If applicable, an approved Corrective Action Plan is being followed.	CONSUMER-DIRECTED CARE PLUS - October 2015 • Review the Corrective Action Plan in the Record. • Based on steps outlined in the plan determine if Corrective Action Plan is being followed. • Determine if the CDC+ Consultant has notified the APD Regional/Area Office within three business days if the CDC+ Consultant is aware the Corrective Action Plan is not being followed. If no Corrective Acton Plan has been initiated score this standard as N/A	1) Corrective Action Plan was not in the record. 2) Corrective Action Plan is not being followed. 3) Consultant has knowledge the Corrective Action Plan is not being followed and has not notified the Regional/Area Office.
45	The Emergency Backup Plan is in the record and reviewed annually.	CONSUMER-DIRECTED CARE PLUS - October 2015 Page 3-3 • Determine Emergency Backup is identified on the Purchasing Plan. • Determine Emergency Backup Plan is in the record and complete. • Discuss with the CDC+ Consultant the backup providers to ensure they are currently viable. • Determine Emergency Backup Plan is updated for critical services as needed. • Each CDC+ Participant is required to develop an emergency back-up plan before starting to manage a budget on CDC+, and	1) The Emergency Backup Plan was not in the record. 2) The Emergency Backup Plan was in the record but was not complete. 3) The Emergency Backup Plan was not reviewed annually and updated, if necessary.

#	Performance Measure/Standard	Protocol	Not Met Reasons
		the plan must be reviewed and updated, if necessary, during the annual support planning process. Note: The Emergency Backup Plan is a document separate and apart from the Purchasing Plan. The Emergency Backup Plan must be reviewed and updated, if necessary, during the annual support planning process. Review can be through signature or initialing by the CDC+ Consultant and date the review took place. CDC+ Consultant should also indicate the plan was reviewed within their Progress Notes and remains reflective of what the Participant would do/require in the event of an emergency.	