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	CMS Assurance
1	Level of care is reevaluated at least annually.	CMS Assurance - Level of Care iBudget Handbook APD Memo dated 1/24/13 – Instructions for Completion of the Waiver Eligibility Work Sheet RECORD REVIEW Level of Care is to be reevaluated at least annually using the Medicaid Waiver Eligibility Worksheet. Review the Medicaid Waiver Eligibility Worksheet(s) for the Support Plan (s) effective during the review period to ensure it is complete including: • Name of the person receiving services • Support Plan effective date indicated • Social Security Number indicated o 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 B is checked, either at least one "handicapping condition" or at least three "major life activities" must be marked. o If Option C is selected, at least three "major life activities" must be marked. • Section II. Medicaid Eligibility - Option A or B is checked o If A is checked, the correct Medicaid number is documented o Option B is to be checked only if person receiving services is new to the waiver in the past year or if the individual has lost Medicaid eligibility in the past year and has had it restored. In this instance the "Eligible" box should be checked and date	1) Complete Medicaid Waiver Eligibility Worksheet is not in the record for the entire period of review. (B) 2) Complete Medicaid Waiver Eligibility Worksheet is in the record, but not for the entire period of review. (B) 3) Complete Medicaid Waiver Eligibility Worksheet is in the record, but date of signatures is greater than 365 days apart. (B) 4) Medicaid Waiver Eligibility Worksheet is not signed and dated by person receiving services/legal representative. (B) 5) Medicaid Waiver Eligibility Worksheet is not signed and dated by Support Coordinator. (B) 6) (B)Name of person receiving services is not on the Medicaid Waiver Eligibility Worksheet. (B) 7) Social Security Number of the person receiving services is not on the Medicaid Waiver Eligibility Worksheet. 8) Effective Date of the Support Plan is not on the Eligibility Worksheet. 9) Section I. Level of Care Eligibility is not completed. (B) 10) Section II. Medicaid Eligibility is not completed. 11) Section III. Eligibility determination is not completed. 12) Section IV. Choice is not completed.	Level of Care

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		of determination for restoration of Medicaid should be entered. • Section III. Eligibility Determination – Option A. is checked o WSC's dated signature and agency (if applicable) are documented • Section IV. Choice – Option A. is checked o The dated signature/mark of the person receiving services is present o The dated signature of the legal representative, if applicable, is present o If the person receiving services uses a mark for a signature, the dated signature of a witness is present o Printed name and relationship to the person receiving services, legal representative or witness is present • The Waiver Eligibility Worksheet must be completed in its entirety and **signed at intervals of no greater than 365 days.** Note: ONLY the individual should sign on the line provided for his or her signature. If the individual is a legally competent adult, he or she must sign this worksheet. If the individual is not capable of signing, they should be assisted in marking the form and the mark shall be witnessed by a caregiver or the WSC. If a legal representative has been appointed through the courts or if the individual has given authority to another person such as through a Power of Attorney, the legal representative should sign and date on the second line.		

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		Other than as a witness, at no time should the WSC sign this form. Note: Support Plan extensions **do not** apply to Medicaid Waiver Eligibility Worksheets. **This standard is subject to identification of a potential billing discrepancy**		
2	Level of care is completed accurately using the correct instrument/form.	CMS Assurance - Level of Care APD Eligibility Rules: 65G-4.014 - 017 iBudget Handbook RECORD REVIEW • Ask the WSC to describe their system for re-evaluating Level of Care. • Review the Central Record for Psychological and/or Medical Record(s) used to establish eligibility. • Review the Central Record for most recent QSI summary report. • Review the Medicaid Waiver Eligibility Worksheet and ensure: o The correct form is used for the time period; o For section I, the Option selected is consistent with IQ and/or Disability Category referenced in Psychological and/or Medical Record(s) filed in Central Record; o If Option B or C are checked, the Handicapping Condition(s) and/or Major Life Activities checked off are consistent with information in the Central Record, including the most current QSI,	1) Unable to determine - Psychological and/or Medical Record(s) used to establish eligibility were not available in the Central Record. 2) Statement from APD concerning absence of Psychological and/or Medical Records did not contain all required information. **(***Not Met but not calculated into score)** 3) Option checked under section I was not consistent with the Psychological and/or Medical Record(s) in the record. 4) Option checked under section I was not consistent with the QSI in the record. 5) Handicapping Condition(s) checked were not consistent with the Psychological and/or Medical Record(s) in the record. 6) Handicapping Condition(s) checked were not consistent with the Psychological and/or Medical Record(s) in the record. 7) Handicapping Condition(s) checked were not consistent with the QSI report in the record. 8) Major Life Activities checked were not consistent with the Psychological and/or	Level of Care

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		Psychological and/or Medical Record(s). If the Psychological and/or Medical Record(s) used to establish eligibility are not available in the Central Record the WSC must follow steps as outlined in AHCA memo dated Dec. 4th 2013 with the Subject line Eligibility Determination – Level of Care. Per this memo: The WSC and APD staff must use due diligence in searching all files associated with the client. After an exhaustive review of all client files, an ABC screen shot of the diagnosis combined with a statement from APD Regional staff may be accepted as a substitute for original documentation. The statement must: • Be on official APD letterhead • Include the staff member's signature • Indicate that the individual has been receiving services through APD for many years and documentation of the diagnosis was present in the file when eligibility was originally determined.	Medical Record(s) in the record. 9) Major Life Activities checked were not consistent with the QSI report in the record. 10) Incorrect or out of date Medicaid Waiver Eligibility Worksheet was in the record. 11) Complete Medicaid Waiver Eligibility Worksheet was not in the record.	
3	Person receiving services is given a choice of waiver services or institutional care at least annually.	CMS Assurance - Service Plan iBudget Handbook RECORD REVIEW Review the Medicaid Waiver Eligibility Worksheet(s) for Support Plan(s) effective during the review period to ensure Section IV is complete including: • A mark indicating the choice of the person receiving services;	1) Complete Medicaid Waiver Eligibility Worksheet is not in the record for the entire period of review. 2) Complete Medicaid Waiver Eligibility Worksheet is in the record but not for the entire period of review. 3) Section IV. Choice is not marked. 4) Dated signature of person receiving services is not present.	Service Plan

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		• The dated signature/mark of the person receiving services; • The dated signature of the legal representative, if applicable; • If the person receiving services uses a mark for a signature, the dated signature of a witness; and • Printed name and relationship to the person if signed by the legal representative or witness.	5) Dated signature of the legal representative is not present. 6) Dated signature of the witness is not present.	
4	The Support Plan is updated within 12 months of recipient's last Support Plan.	CMS Assurance - Service Plan iBudget Handbook RECORD REVIEW Review the Central Record for the Support Plan(s) effective during the entire review period. Determine if: • The Support Plan was completed prior to the annual Support Plan effective date and present for each month billed by the WSC for the entire period of review. • The Support Plan is present and directions on the APD Support Plan form are followed for each section. • Support Plan must include: • Annual Summary (In accordance with s. 393.0651, F.S., complete an annual report of the supports and service received throughout the year, description of progress toward meeting individually determined goals and any pertinent information about significant	1) Complete Support Plan was not in the record for entire period of review. (B) 2) Complete Support Plan was in the record, but was not completed prior to the annual effective date. (B) 3) Support Plan did not include an Annual Summary. (B) 4) Support Plan was not signed and dated by the person receiving services. (B) 5) Support Plan was not signed and dated by Support Coordinator. (B) 6) Support Plan was not signed by the legal representative and efforts to obtain signature were not documented. (B) 7) Support Coordinator indicated the person receiving services is unable to sign but did not document this on the Support Plan. (B) 8) Person receiving services was unable to sign, but a witness did not sign. (B)	Service Plan

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		events that have happened in the life of the individual for the previous year). • Personal Attributes/Future View page • Life Area page • Health Summary page • Personal Goal page • The signature page which must include: ▪ Dated signature of the person receiving services; ▪ Dated signature of the parent/legal representative if the person receiving services is a minor; ▪ Dated signature of the legal representative /Guardian Advocate if the person has one(Verify via Probate Court documents); ▪ Dated signature of a witness if the person receiving services was unable to sign or signed using a mark; and ▪ Dated signature of the WSC. **This standard is subject to identification of a potential billing discrepancy**		
5	The Support Plan is updated/revised when warranted by changes in the needs of the person receiving services.	CMS Assurance - Service Plan iBudget Handbook RECORD REVIEW/PROVIDER INTERVIEW 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	1) Complete Support Plan was not in the record for entire period of review. 2) Support Plan did not include updates or revisions when needs of the person receiving services changed.	Service Plan

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		review. • Ask the Support Coordinator to describe the process used to update/revise the Support Plan and how discussions are held to determine if the person receiving services has had a change in needs. • Review Support Plan, QSI, 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: o Activities, supports and contacts contain information about changes in the needs of the person receiving services. o When the person receiving services does not have a functional means of communication, look for documentation the Support Coordinator has obtained information and recommendations from the circle of supports of the person receiving services. o If any changes in the needs of the person receiving services 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. If PCR, ask the person receiving services to describe needs. Ask how the Support Coordinator has provided support to identify the needs.		

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6	The Support Plan is provided to the individual and when applicable, the legal representative, within required time frames.	CMS Assurance - Service Plan iBudget Handbook RECORD REVIEW 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 receiving services/legal representative within 10 calendar days of the Support Plan effective date	1) No documentation was available to show the Support Plan was distributed to the person receiving services within 10 calendar days of Support Plan effective date. 2) No documentation was available to show the Support Plan was distributed to the legal representative within 10 calendar days of Support Plan effective date.	Service Plan
7	The Support Plan is provided to the providers identified on the support plan within required time frames.	CMS Assurance - Service Plan iBudget Handbook RECORD REVIEW 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 service provider(s) within 10 calendar days of the Support Plan effective date	1) No documentation was available to show the Support Plan was distributed to the providers within 10 calendar days of Support Plan effective date.	Service Plan
8	Support Plan includes supports and services consistent with assessed needs.	CMS Assurance - Service Plan iBudget Handbook RECORD REVIEW/PROVIDER INTERVIEW 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. • Review the current Support Plan to identify the supports and services.	1) Current Support Plan is not in the record for the entire period of review. 2) Current Support Plan included documentation related to some, but not all of the assessed needs. 3) Current Support Plan did not include documentation related to the assessed needs.	Service Plan

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		• Review the Support Plan, QSI report, Progress Notes, Behavioral Assessments & Functional Community Assessments (if applicable) and any other applicable supporting documentation in the central record to determine the assessed needs of the person receiving services. • Conduct a comparative review of documentation to determine if the supports and services identified in the Support Plan are consistent with the assessed needs of the person receiving services. If PCR, ask the person receiving services to describe needs. Ask how the Support Coordinator has provided support to identify the needs.		
9	Support Plan reflects support and services necessary to address assessed risks.	CMS Assurance - Service Plan iBudget Handbook RECORD REVIEW/PROVIDER INTERVIEW 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. • Review the current Support Plan to identify the supports and services. • Review the Support Plan, QSI report, Progress Notes, and any other applicable supporting documentation in the Central Record to determine the assessed risks of the person receiving services. • Conduct a comparative review of documentation to	1) Current Support Plan is not in the record for the entire period of review. 2) Current Support Plan included documentation related to some, but not all of the assessed risks. 3) Current Support Plan did not include documentation related to the assessed risks.	Service Plan

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		determine if the supports and services identified in the Support Plan are consistent with the assessed risks of the person receiving services. If PCR, ask the person receiving services to describe risks. Ask how the Support Coordinator has provided support to identify the risks.		
10	Support Plan reflects the personal goals of the person receiving services.	CMS Assurance - Service Plan iBudget Handbook RECORD REVIEW/PROVIDER INTERVIEW 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. • Review the current Support Plan to identify the goals. • Review 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: o Activities, supports and contacts contain information about working with the person receiving services to identify and define his/her goals. o When the person receiving services does not have a functional means of communication, look for documentation the Support Coordinator has obtained information and recommendations from the circle of supports	1) Current Support Plan did not reflect the person's goals. 2) Documentation did not reflect use of a Person Centered approach to determine the personal goals of the person receiving services. 3) Documentation did not reflect use of circle of supports in identifying the personal goals of the person receiving services. 4) Support planning process was driven primarily by circle of supports instead of the person receiving services.	Service Plan

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		of the person receiving services. • 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 receiving services. If PCR, ask the person receiving services to describe goals. Ask how the Support Coordinator has provided support to identify the goals.		
11	The current Support Plan includes natural, generic, community and paid supports for the person receiving services.	CMS Assurance - Service Plan iBudget Handbook RECORD REVIEW/PROVIDER INTERVIEW 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: 1. Natural and community supports; 2. Third Party Payer, such as private insurance; 3. Medicare; 4. Other Medicaid programs; and 5. iBudget Florida, which is the payer of last resort. • Ask the Support Coordinator to describe natural, generic, community, and paid resources that are included in the circle of support for the person receiving services.	1) Current Support Plan did not identify non-waiver supports the person receiving services receives.	Service Plan

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		• Review the current Support Plan to determine if natural, generic, community and paid resources apart from the iBudget Waiver are identified. If PCR, ask the person receiving services about supports received that are not paid for through the iBudget Waiver. If the Support Plan was not in the record at all, score this standard N/A.		
12	Services are delivered in accordance with the Cost Plan.	CMS Assurance - Service Plan iBudget Handbook RECORD REVIEW 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 Determine if the services on the Purchasing Plan are comparable with the services outlined in the Cost Plan. If Applicable: • Ask the WSC about any services from the Cost Plan not being utilized under CDC+. • If WSC indicates service is not being utilized due to lack of available providers or choice of individual/family review for documentation in the record showing WSC's efforts to address. • If documentation supports WSC's reasons for service(s) not being rendered as approved, score as	1) Services on the Purchasing Plan were not comparable to services identified in the Cost Plan. 2) Current Cost Plan was not in the record. 3) Purchasing Plan was not in the record.	Service Plan

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		Met. If PCR, ask the person receiving services if they are receiving all services approved on their Purchasing Plan. If any services are not being received/used inquire about reason.		
13	The Support Coordinator is in compliance with billing procedures and the Medicaid provider agreement.	CMS Assurance – Financial Accountability iBudget Handbook RECORD REVIEW Support Coordinator is not to bill for services prior to rendering • Review Claims data for date billed • Review dates on Progress Notes • Determine whether or not required minimum contacts were completed prior to billing for each month of service the review period. Provider bills the correct rate: • Limited WSC/CDC • Full WSC/CDC • Enhanced WSC/CDC **This standard is subject to identification of a potential billing discrepancy**	1) Support Coordinator billed for services prior to completing/documenting minimum contacts for one or more months during the period of review. 2) Support Coordinator billed an incorrect rate. (B)	Financial Account.
14	Participant Monthly Review forms & Progress Notes reflecting required monthly contact/activities are filed in the	CMS Assurance – Financial Accountability iBudget Handbook RECORD REVIEW • The Consultant is required to have a minimum of 1	1) Participant Monthly Review Forms were not present for one or more months. (B) 2) Monthly Review Form and/or Progress Notes did not demonstrate a bi-annual face to face. (B)	Financial Account.

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	Participant's record prior to billing each month.	monthly contact every month • 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 • Look for the Participant Monthly Review forms to be completed on a monthly basis for these contacts. • Consultant can choose not to use the Monthly Review but the form or Progress Note they use in its place must contain the following: o Documentation the Consultant has reviewed the Participant's monthly statement with the Participant or Representative and has determined whether the Participant or Representative has complied with the Purchasing Plan; o Verification the Participant or Representative has submitted all provider timesheets and invoices in a timely manner; o Identification of any budget management problems o Identification of any circumstances that require a Corrective Action Plan or disenrollment from CDC+. Look for Progress Notes and/or written narrative on the Monthly Review form to support contact/visits. **This standard is subject to identification of a potential billing discrepancy**	3) Monthly Review Form and/or Progress Notes did not demonstrate an annual Home Visit. (B) 4) Consultant chose to document monthly contacts using a format other than the Participant Monthly Review form and it did not include all required components. (B)	

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15	The provider has evidence of assisting individual/legal representative to know about rights.	CMS Assurance - Service Plan iBudget Handbook RECORD REVIEW/PROVIDER INTERVIEW • Ask the provider how they inform individuals and their families or guardians of their rights and responsibilities and how frequently. • Ask the provider for examples of how they have assisted individuals to fully exercise their rights and make informed choices. • Interactively, with the provider, review documentation supporting discussion. • Ask the provider for examples of how they observe the rights and responsibilities of individuals.	1) Provider could not describe efforts and documentation did not reflect evidence of assisting the individual/legal representative to know about rights. 2) Provider was able to describe efforts to assist the individual/legal representative to know about rights, but had not documented the information.	Service Plan
16	The Support Coordinator monitors to ensure the person's health and health care needs are addressed.	CMS Assurance - Health and Welfare iBudget Handbook RECORD REVIEW/PROVIDER INTERVIEW • Ask the Support Coordinator to describe the method used to gain knowledge of person's health needs. • Review file for documentation of gaining knowledge of person's health needs. • Ask the Support Coordinator about person's individualized heath needs. • Ask the Support Coordinator how the person's health and health care needs have been addressed. • Look for the Support Coordinators method for gathering information concerning doctor visits for preventative, annual and specific health care needs. • Review Progress Notes and other related health care	1) Documentation indicated Support Coordinator was not aware of the person's individualized health and health care needs. 2) Documentation indicated Support Coordinator was aware of but had not addressed the person's health and health care needs. 3) Support Coordinator had not advocated for the person to receive annual physicals and/or needed specialists visits. 4) Support Coordinator did not document follow up on medical doctor visits, results, medication changes, etc. 5) The Support Coordinator addresses the individual's health and health care needs but has not documented knowledge and efforts.	Health & Welfare

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		documentation to determine if the health and healthcare needs of the person receiving services are being addressed. If PCR, ask person receiving services how the Support Coordinator has assisted in addressing personal health care needs.		
17	The Support Coordinator monitors to ensure person's safety needs are addressed.	CMS Assurance - Health and Welfare iBudget Handbook RECORD REVIEW/PROVIDER INTERVIEW • Ask the Support Coordinator to describe the method used to gain knowledge of person's safety needs. • Review file for documentation of gaining knowledge of person's safety needs. • Ask the Support Coordinator for person individualized safety needs. • Ask the Support Coordinator how she/he has addressed the person's safety needs. • Look to see if safety issues arose and how they were addressed. Was there follow through? • Review Progress Notes and Support Coordinator's documentation of safety needs to determine if the person's safety needs are being addressed. If PCR, ask person receiving services how the Support Coordinator has provided education on safety needs in relation to natural disasters, community safety and home safety.	1) Documentation indicated Support Coordinator was not aware of the person's individualized safety needs. 2) Documentation indicated Support Coordinator was aware of but had not addressed the person's individualized safety needs. 3) Support Coordinator had not advocated for the person to receive additional education/training in the area of safety. 4) Support Coordinator did not document follow up on safety issues. 5) The Support Coordinator addresses the individual's safety needs and safety skills but has not documented knowledge and efforts.	Health & Welfare

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18	The Support Coordinator is aware of the person's history regarding abuse, neglect, and/or exploitation.	CMS Assurance - Health and Welfare iBudget Handbook RECORD REVIEW/PROVIDER INTERVIEW • Ask the Support Coordinator about the person's history in regards to abuse, neglect and/or exploitation. • Ask the Support Coordinator about method of documenting this information. • Look for documentation in the record about past abuse or lack thereof. If PCR, ask the person about any history regarding abuse, neglect and/or exploitation. Ask person if the Support Coordinator has ever discussed history.	1) Support Coordinator had no knowledge of the individual's history regarding abuse, neglect, and/or exploitation. 2) Support Coordinator was aware of the individual's history regarding abuse, neglect, and/or exploitation, but had not documented knowledge and/or efforts to gather this information. 3) Documentation did not demonstrate the Support Coordination had addressed issues related to abuse, neglect, and exploitation that continue to impact and cause distress for the individual.	Health & Welfare
19	The Support Coordinator assists the person receiving services to define abuse, neglect, and exploitation including how the person receiving services would report any incidents.	CMS Assurance - Health and Welfare iBudget Handbook RECORD REVIEW/PROVIDER INTERVIEW • Ask the Support Coordinator to describe the process used to gather information on how the person receiving services defines abuse. • Ask the Support Coordinator how the person receiving services would report abuse if it were to occur. • Ask the Support Coordinator how the person receiving services has been educated on the definition of abuse neglect and/or exploitation. • Review the Support Plan, Progress Notes and other documentation for documentation on the person's	1) Support Coordinator had no knowledge of how the person receiving services would define abuse, neglect, and/or exploitation. 2) Support Coordinator had no knowledge of how the person receiving services would report any incidents of abuse, neglect, and exploitation. 3) Documentation did not indicate efforts to provide education to the person receiving services in this area. 4) Documentation indicates only limited attempts to provide education on abuse, neglect, and exploitation to the person receiving services in the past 12 months, other than a sign off at the annual Support	Health & Welfare

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		definition of abuse. • Review the Support Plan, Progress Notes and other documentation for documentation on education the Support Coordinator has provided regarding abuse, neglect and/or exploitation. If PCR, ask the person receiving services for a definition of abuse, neglect, and exploitation, how it would be reported, and if the Support Coordinator has provided education and discussion on the topic.	Plan meeting. 5) The Support Coordinator is aware of the individual's definition of abuse, neglect, and exploitation and how the individual would report any incidents but has not documented knowledge and efforts.	
20	Completed/signed Participant-Consultant Agreement is in the record.	CDC+ Rule Handbook 2-6. RECORD REVIEW • Determine Participant-Consultant Agreement is in the record. • Determine Agreement is signed and dated by Consultant and Participant/Guardian.	1) The 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 Consultant.	
21	Completed/signed CDC+ Consent Form is in the record.	1915j (p17); CDC+ Rule Handbook 1-20. RECORD REVIEW • Determine CDC+ Consent form is in the record • Determine Consent form is complete & signed by Participant/Guardian, Representative and 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 Consultant. 4) The CDC+ Consent Form was in the record and signed but it was not complete.	
22	Completed/signed Participant-Representative Agreement is in the	CDC+ Rule Handbook 1-20, 2-4. RECORD REVIEW • Determine Participant-Representative Agreement is	1) The Participant-Representative Agreement was not present in the record. 2) The Participant-Representative Agreement was not signed and dated by the	

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	record.	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".	Participant/legal guardian. 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 Representative.	
23	All applicable completed/signed Purchasing Plans are in the record.	1915j (p20); CDC+ Rule Handbook 2-8, 3-4 – 3-10. RECORD REVIEW • 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, 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 Representative. 4) Purchasing Plan was not signed and dated by Consultant. 5) Purchasing Plan was not signed and dated by Regional/Area CDC+ Liaison.	
24	The Purchasing Plan reflects the goals/needs outlined in Participant's Support Plan.	1915j (p20); CDC+ Rule Handbook 2-6, 2-8, 3-4 – 3-10. RECORD REVIEW • Review goals identified on the current Support Plan. • Review needs section of current Purchasing Plan. • Verify information in the Purchasing Plan is consistent with goals/needs outlined in the Support Plan.	1) Services listed in the Purchasing Plan were not consistent with the Participant's needs. 2) Goals on the Support Plan were not consistent with needs and services in the Purchasing Plan. 3) Current Support Plan was not in the record. 4) Purchasing Plan was not in the record.	
25	All applicable completed/signed Quick Updates are in the Record.	CDC+ Rule Handbook 3-10. RECORD REVIEW • 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.	

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		• Determine Quick Update(s) is signed by Participant and/or Representative, Consultant and local Regional/Area office CDC+ Liaison. Note: if no Quick Updates required/done, score N/A.	3) Quick Update form (s) was not signed by Consultant. 4) Quick Update form (s) was not signed by Regional/Area CDC+ Liaison.	
26	Participant's Information Update form is completed and submitted to Regional/Area CDC+ liaison as needed.	CDC+ Rule Handbook 2.7. RECORD REVIEW • Determine if there has been any change to Participant address/contact information. • Determine if there has been any change in Representative. • Determine if there has been any change in legal Status of the Participant. • Determine if there has been any change in 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 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 Consultant. 2) Participant's Information Update Form was not signed by Regional/Area Liaison. 3) There was a change in address/contact information but Participant Information Update form was not completed and submitted to Regional/Area CDC+ Liaison. 4) There was a change in Representative or Representative's information but Participant Information Update form was not completed and submitted to Regional/Area CDC+ Liaison. 5) There was a change in Participant's Legal Status but Participant Information Update form was not completed and submitted to Regional/Area CDC+ Liaison. 6) There was a change in Consultant or Consultant's information but Participant Information Update form was not completed and submitted to Regional/Area CDC+ Liaison. 7) There was a change in enrollment status but Participant Information Update form was not completed and submitted to Regional/Area CDC+ Liaison.	

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#	Performance Measure/Standard	Protocol	Not Met Reasons	CMS Assurance
27	When correctly completed/submitted by the Participant/CDC+ Representative, Consultant submits Purchasing Plans by the 10th of the month.	CDC+ Rule Handbook 2-8, 3.5 – 3-10. RECORD REVIEW • Review Purchasing Plan(s) and determine Consultant signature is on or before the 10th of the month prior to the Purchasing Plan effective date. • 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.	1) Purchasing Plan was not in the record. 2) The date of 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. 3) Purchasing Plan had not been submitted to the Regional/Area office.	
28	Consultant provides technical assistance to Participant as necessary to meet Participant's and Representative's needs.	1915j (p20); CDC+ Rule Handbook 2-5, 2-9. RECORD REVIEW • Look for indications in documentation & monthly review forms the consultant has provided support 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. • If PCR, ask Participant and/or Representative if Consultant has addressed requests for technical assistance. • 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 Consultant's effort to provide technical assistance when requested and/or needed. 2) Participant and/or Representative indicated 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.	

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	CMS Assurance
29	Consultant has taken action to correct any overspending by the Participant.	1915j (p12); CDC+ Rule Handbook 2-5 – 2-9. RECORD REVIEW • Determine Monthly Review Forms 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. • Look to make sure the Participant is not overspending the budget. • If overspending has occurred, ensure that the Consultant is addressing it by reviewing the Monthly Review forms & notes in the Central Record.	1) Participant Monthly Review Form(s) did not clearly identify actions taken by Consultant to correct overspending by the Participant.	
30	If applicable, Consultant initiates Corrective Action.	1915j (p12); CDC+ Rule Handbook 1-23 – 1-24, 2-6, 2-8, 2-9. RECORD REVIEW • Determine Consultant has initiated a Corrective Action Plan, if necessary. A Corrective Action Plan may be required if: o A Representative is not available, but is necessary for participation; o The Consumer or Representative has been unable to manage the CDC+ budget or services; o The Consumer's health or safety is at risk; o The Consumer or Representative can no longer be served safely in the community; o The Consumer or Representative has failed to properly screen providers; and o The Consumer or Representative has failed to comply with the requirements of the CDC+ program.	1) A problem had occurred and the Consultant had not initiated a Corrective Action Plan. 2) Corrective Action Plan was not initiated by Consultant when appropriate.	

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	CMS Assurance
31	Completed/signed Corrective Action Plan is in the record.	1915j (p12); CDC+ Rule Handbook 1-23 – 1-24, 2-6, 2-8, 2-9. RECORD REVIEW & PROVIDER INTERVIEW • Ask the Consultant if they have initiated a Corrective Action Plan Determine: • Copy of Corrective Action Plan is in the record and complete • Corrective Action Plan is signed by Participant/representative, CDC+ Consultant, Area APD office Liaison and Central APD office Note: Corrective Action Plan form was revised 11/15/2010. This is the current form that should be used. If no Corrective Action plan has been initiated score this standard as N/A	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 Consultant. 4) Corrective Action Plan was not signed and dated by Regional APD office. 5) Corrective Action Plan was not signed and dates by APD State office.	
32	If applicable, an approved Corrective Action Plan is being followed.	1915j (p12); CDC+ Rule Handbook1-23 – 1-24, 2-6, 2-8, 2-9. RECORD REVIEW & PROVIDER INTERVIEW • 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 consultant has notified the APD Area Office within 3 business days if the consultant is aware that 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) The consultant has knowledge that the Corrective Action Plan is not being followed and has not notified the Area Office.	

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	CMS Assurance
33	The Emergency Backup Plan is in the record and is reviewed annually.	1915j (p18); CDC+ Rule Handbook 1-20, 2-7, 3-3. RECORD REVIEW • Determine Emergency Backup is identified on the Purchasing Plan. • Determine Emergency Backup Plan is in the record and complete. • Discuss with the Consultant the backup providers to ensure they are currently viable. • Determine Emergency Backup Plan is updated for critical services as needed. Note: Emergency Backup Plan is a document separate and apart from the Purchasing Plan.	1) The Emergency Backup Plan was not in the record. 2) The Emergency Backup Plan was in the record but it was not complete. 4)	
34	How many DHE/Vendor changes for the Participant? (not scored just data collected)			
35	How many WSC/Consultant changes for the Participant? (not scored just data collected)			