Service Specific Record Review – Support Coordination

#	Performance Measure/Standard	Protocol	Not Met Reasons	
1	Level of care is reevaluated at least annually and contains all required components for billing.	CMS Assurance - Level of Care 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 and includes 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. o 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. • WSC's dated signature and agency (if applicable) are documented • 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.**	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) Name of person receiving services is not on the Medicaid Waiver Eligibility Worksheet. (B) 7) Section I. Level of Care Eligibility is not completed. (B)	B

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		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. 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 a potential billing discrepancy**		
2	Level of care is reevaluated at least annually and contains all required components for compliance.	CMS Assurance - Level of Care 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 and includes the following required components for compliance: • Support Plan effective date indicated • Social Security Number indicated • 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	1) Complete Medicaid Waiver Eligibility Worksheet is not in the record for the entire period of review. 2) Social Security Number of the person receiving services is not on the Medicaid Waiver Eligibility Worksheet. 3) Effective Date of the Support Plan is not on the Eligibility Worksheet. 4) Section II. Medicaid Eligibility is not completed. 5) Section III. Eligibility determination is not completed. 6) Section IV. Choice is not completed.	C

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		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 of determination for restoration of Medicaid should be entered. • Section III. Eligibility Determination – Option A. is checked • Section IV. Choice – Option A. is checked • 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. 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.		
3	Level of care is completed accurately using the correct instrument/form.	CMS Assurance - Level of Care APD Eligibility Rules: 65G-4.014 - 017 RECORD REVIEW • Review the Central Record for Psychological and/or Medical Record(s) used to establish eligibility. • Review the Central Record for most recent QSI summary	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.	C

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		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, 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 APD memo dated Dec. 10th 2013 with the Subject line Eligibility Determination – Level of Care. o 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: o Be on official APD letterhead o Include the staff member's signature o 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. o Note: Upon receipt of the memo WSC's should immediately be addressing those records which are	(***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 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. 12) Regional office has not yet responded to WSC's request for statement regarding missing eligibility documentation. (***Not Met but not calculated into score)	

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		missing Eligibility documentation and follow the steps outlined. o If at the time of the record review the WSC can show the Delmarva reviewer in writing that at least two weeks prior to their review date they submitted a request to APD for a statement concerning missing eligibility documentation and have not yet received anything from APD, the reviewer will score this standard not met using reason #12 and it will not factor into the WSC's score.		
4	Person receiving services is given a choice of waiver services or institutional care at least annually.	CMS Assurance - Service Plan 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; • 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.	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. 5) Dated signature of the legal representative is not present. 6) Dated signature of the witness is not present.	C
5	The Support Plan is updated within 12 months of recipient's last Support Plan.	CMS Assurance - Service Plan RECORD REVIEW Review the Central Record for the Support Plan(s) effective during the entire review period. Determine if:	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 was not signed and dated by the person receiving services. (B)	B

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		• 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: o 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 events that have happened in the life of the individual for the previous year). o Personal Attributes/Future View page o Life Area page o Health Summary page o Personal Goal page o 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 a potential billing discrepancy**	4) Support Plan was not signed and dated by Support Coordinator. (B) 5) Support Plan was not signed by the legal representative and efforts to obtain signature were not documented. (B)	

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#	Performance Measure/Standard	Protocol	Not Met Reasons	
6	An Annual Summary of progress is in the record.	CMS Assurance - Service Plan November 2010 Handbook 2-85 RECORD REVIEW Review the record for the Annual Summary. • Determine if the annual summary is included in the Support Plan or a separate document and includes: o Report of the supports and service received throughout the year o Description of progress toward meeting individually determined goals and; o Any pertinent information about significant events that have happened in the life of the individual for the previous year.	1) The record did not include an Annual Summary. 2) The Annual Summary did not include a report of the supports and service received throughout the year 3) The Annual Summary did not include a description of progress toward meeting individually determined goals. 4) The Annual Summary did not include any pertinent information about significant events that have happened in the life of the individual for the previous year.	C
7	The Support Plan is updated/revised when warranted by changes in the needs of the person receiving services.	CMS Assurance - Service Plan RECORD REVIEW 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. • 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.	1) Current Support Plan is 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.	C

#	Performance Measure/Standard	Protocol	Not Met Reasons	
		○ 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. ○ 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.		
8	WSC documents the Support Plan is provided to the individual and when applicable, the legal representative, within required time frames.	CMS Assurance - Service Plan 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 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.	C
9	WSC documents the Support Plan is provided to the providers identified on the support plan within required time frames.	CMS Assurance - Service Plan 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; and	1) No documentation was available to show the Support Plan was distributed to the providers within 10 calendar days of Support Plan effective date.	C
10	Support Plan includes supports and services consistent with assessed needs.	CMS Assurance - Service Plan RECORD REVIEW	1) Current Support Plan is not in the record for the entire period of review. 2) Current Support Plan included	C

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		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, 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 indentified in the Support Plan are consistent with the assessed needs of the person receiving services.	documentation related to some, but not all of the assessed needs. 3) Current Support Plan did not include documentation related to the assessed needs.	
11	Support Plan reflects support and services necessary to address assessed risks.	CMS Assurance - Service Plan RECORD REVIEW 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 determine if the supports and services indentified in the Support Plan are consistent with	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.	C

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		the assessed risks of the person receiving services.		
12	Support Plan reflects the personal goals of the person receiving services.	CMS Assurance - Service Plan RECORD REVIEW 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 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.	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) Documentation indicates support planning process was driven primarily by circle of supports instead of the person receiving services.	C
13	The current Support Plan includes natural, generic, community and paid supports for the person receiving services.	CMS Assurance - Service Plan RECORD REVIEW NOTE: For the purposes of this standard, only the "current Support Plan" will be reviewed. This is defined as the	1) Current Support Plan did not identify non-waiver supports the person receiving services receives.	C

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		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. Home and Community Based Services Waiver, 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. • Review the current Support Plan to determine if natural, generic, community and paid resources apart from the Waiver are identified. If the Support Plan was not in the record at all, score this standard N/A.		
14	WSC documentation indicates current, accurate and approved Service Authorizations were issued to provider(s).	CMS Assurance - Service Plan RECORD REVIEW Ask the Support Coordinator about their method of documenting Service Authorizations were provided to each provider. Review Support Plan(s) and Cost Plan(s) to identify services approved for the period under review and determine if: • Service Authorization(s) are available for the entire period of review. • Service Authorization(s) are in approved status. • The correct rates are on the Service Authorizations.	1) There was no documentation indicating when/how Service Authorizations were issued for current Support Plan/Cost Plan. 2) One or more Service Authorizations were not issued for current Support Plan/Cost Plan. 3) Rates were not correct on one or more Service Authorization for current Support Plan/Cost Plan.	C

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		o Refer to the APD Provider rate table as needed. • Service Authorizations are provided quarterly or more frequently as changes dictate. Note: Hardcopies of the Service Authorizations do not need to be in the record; WSC simply needs to be able to show for each approved service on the Cost Plan that there is an accurate approved Service Authorization in the system and it is was provided to each service provider.		
15	Services are delivered in accordance with the Cost Plan, including type, scope, amount, duration, and frequency specified in the Cost Plan.	CMS Assurance - Service Plan RECORD REVIEW Since the Support Coordinator's role includes the coordination of services and supports, this standard applies to all the services identified on an approved Cost Plan. • Review the current Cost Plan & Service Authorizations to determine type scope, amount, duration and frequency of approved services. • Review record including claims to determine if services are being rendered as approved. If Applicable: • Ask the WSC about any services not being rendered as approved. • If WSC indicates service is not being provided 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 Met.	1) One or more services are not being delivered as approved. 2) WSC documentation indicates they have been unable to locate a provider but has not documented their efforts to do so. 3) WSC documentation indicates person and/or family no longer want a particular service but has not documented this.	C
16	The Support Coordinator is in compliance with billing procedures	CMS Assurance – Financial Accountability RECORD REVIEW	1) Support Coordinator billed full support coordination when only limited was	B

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	and the Medicaid provider agreement.	Provider bills the correct rate: • Limited WSC/CDC • Full WSC/CDC • Enhanced WSC/CDC **This standard is subject to a potential billing discrepancy**	approved (B)	
17	The Support Coordinator bills for services only after service is rendered	CMS Assurance – Financial Accountability RECORD REVIEW Provider is not to bill for services prior to rendering. • Review Claims data for date billed. • Review dates on Progress Notes • Determine whether or not services were rendered prior to billing for each date of service in the review period.	1) Support Coordinator billed for services prior to rendering services on one or more dates during the period under review.	C
18	Progress Notes reflect required monthly contact/activities and are in the record.	CMS Assurance – Financial Accountability RECORD REVIEW **Contact Requirements** The requirements by level are: • Full Support Coordination: at a minimum, two billable contacts with or activities on behalf of an individual each month in order to bill Medicaid. • Limited Support Coordination: at a minimum one billable contact with or activity on behalf of an individual each month in order to bill Medicaid. • Enhanced Support Coordination: at least four billable contacts monthly with or on behalf of the individual in order to bill Medicaid. The requirements for face-to-face visits in a specific location are: • **For individuals in Supported Living**, the provider must	1) Progress Notes for person residing in a licensed residential facility did not include face-to-face contact every month for one or more months. (B) 2) Progress Notes for person residing in a licensed residential facility did not include a home visit contact every three months for one or more months. (B) 3) Progress Notes for person residing in an Assisted Living Facility did not include face-to-face contact every month for one or more months. (B) 4) Progress Notes for person residing in a Supported Living setting did not include face-to-face contact every month for one or more months. (B) 5) Progress Notes for person residing in a Supported Living setting did not include a	B

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		conduct monthly face-to-face visits with a face-to-face visit being in the in the individual's home at least once every three months. This face-to-face visit will include a supported living quarterly review. The WSC will also conduct at least one other billable activity on behalf of the individual each month. Individuals receiving supported living services must receive at least Full Support Coordination. • **For individuals living in an Assisted Living Facility (ALF)**, WSCs must conduct monthly face-to-face visits with a face-to-face visit with the individual in his or her place of residence every three months. Individuals residing in licensed residential facilities must receive Full Support Coordination. • **For individuals residing in a licensed residential facility**, WSCs must conduct monthly face-to-face visits with a face-to-face visit with the individual in his or her place of residence every three months. Individuals residing in licensed residential facilities must receive Full Support Coordination. • **For individuals living in the family home**, the face-to-face contact with the individual in the residence is required every six months for Full Support Coordination and once a year for Limited Support Coordination. The individual's family may not waive the required visit in the home. For Full Support Coordination, the provider must conduct a face-to-face visit every three months and have at least one other billable activity. For Limited Support Coordination, the provider must conduct two face-to-face visits annually and at least one billable contact per month. The need for more frequent face-to-face visits may be determined by the individual, family or primary caregiver. The WSCs shall document this preference in the	home visit contact every three months for one or more months. (B) 6) Progress Notes for person residing in a Supported Living setting did not document if the Support Coordinator scheduled and conducted the Supported Living Quarterly meeting for one or more quarters. (B) 7) Progress Notes for person living in his/her own home did not include a home visit contact every six months for one or more months. (B) 8) Progress Notes for person living in his/her own home did not include a face to face visit contact every three months for one or more months. (B) 9) Progress Notes for person residing in a family home did not include face-to-face contact at least once every three months. (B) 10) Progress Notes for person residing in a family home did not include a home visit contact at least once every six months for one or more times. (B) 11) Progress Notes for person receiving Full Support Coordination did not document at least one other contact or activity per month for one or more months. (B) 12) Progress Notes for person receiving Limited Support Coordination did not document at least one contact or activity per month for one or more months. (B) 13) Progress Notes for person receiving Limited Support Coordination did not	

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		individual's Support Plan; however, if this results in a number of contacts beyond the minimum for Limited Support Coordination, the individual may need to move to a different level of support coordination. • **For individuals residing in their own home** and considered to be in an independent living situation, the provider must conduct face-to-face visits every three months in a variety of settings, with a face-to-face visit in the individual's place of residence at least every six months. For individuals receiving Enhanced Support Coordination, the reason for this level of support coordination must be specified in the Support Plan. The individual will receive two face-to-face visits monthly, at least one that will be at the recipient's residence and at least two additional billable activities. For persons requiring Enhanced Support Coordination for transition purposes, the individual will receive weekly face to face contact visits for the first month after transition to community-based services with one other billable contact. After that month, the visits will be two face to face visits monthly along with at least two other billable contacts monthly. This service delivery format will continue as long as Enhanced Support Coordination is needed but at a minimum of three months following transition. The purpose of the face to face visit is to discuss progress/changes to the individual's goals, status of any resolved issues and satisfaction with current supports received. Each visit should be viewed as an opportunity to give or receive meaningful information that can be used to more effectively assist the individual with achieving goals. Face to face contacts shall relate to or accomplish one or	include at least two face-to-face contacts per year, with a minimum of one contact being in the person's home. (B) 14) Progress Notes for person receiving Enhanced Support Coordination did not include at least weekly face-to-face contacts for first 30 days following discharge. (B) 15) Progress Notes for person receiving Enhanced Support Coordination did not include at least one visit in the person's residence per month. (B) 16) The Support Coordinator billed for services that were not billable (i.e. leaving messages, scheduling meetings or contacts) for one or more months. (B) 17) Progress Notes for person receiving Enhanced Support Coordination did not indicate all required contacts/activities. (B)	

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		more of the following: 1. Assist the individual to reach individually determined goals on the Support Plan, including gathering information to identify outcomes; 2. Monitor the health and well-being of the individual; 3. Obtain, develop and maintain resources needed or requested by the individual to include natural supports, generic community supports and other types of resources; 4. Increase the individual's involvement in the community; 5. Promote advocacy or informed choice for the individual and/or; 6. Follow up on unresolved concerns or conflicts. **Allowable Activities for Billing** WSCs must conduct at least one other contact or activity on behalf of the individual each month. These contacts or activities are not merely incidental, but are planned and shall related to or accomplish those items listed in 1-6 above. These contacts may be with the individual or with persons important to his or her life including family members, legal representatives, service providers, community members, etc. and can be via telephone, letter writing or email transmission. Any contact or activity on behalf of the individual must be documented in the support coordination notes. The contacts must be individualized and related to services and benefits specific to the person receiving services. **Administrative activities such as typing letters, filing, mailing or leaving messages shall not qualify as contacts or activities.** In addition activities including telephone calls to schedule meetings, setting up face-to-face visits or scheduling meetings with the individual's employer, family, providers, do not qualify as contacts.		

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		At times, APD issues memos waiving face-to-face contact requirements for Support Coordinators for one or more months to accommodate specific assignments. If a home visit or Supported Living Quarterly is required in the waived month, the Support Coordinator does not need to make this up immediately following the end of the extension. The contact should be made based on when it would be due again had the Support Coordinator completed it in the month waived. The Support Coordinator is still expected to make face to face contact with the person if it is needed for health or safety reasons. **This standard is subject to a potential billing discrepancy**		
19	The Support Coordinator documents efforts to support the person receiving services to make informed decisions regarding choice of waiver services & supports.	CMS Assurance - Service Plan RECORD REVIEW • Ask the Support Coordinator to describe method used to educate, solicit and document how the person receiving services makes the choice of waiver services & supports. • Ask the Support Coordinator for examples of how the person receiving services made informed decisions regarding choice of waiver services & supports. • Review file for documentation reflecting the Support Coordinator's efforts.	1) There was no documentation or documentation did not reflect efforts to support/assist the person receiving services to make informed decisions regarding choice of waiver services & supports. 2) Documentation indicated Support Coordinator was making decisions about waiver services and supports with little to no input from the person receiving services.	C
20	The Support Coordinator documents efforts to support the person receiving services to make informed decisions regarding choice among waiver service providers.	CMS Assurance - Service Plan RECORD REVIEW • Ask the Support Coordinator to describe method used to educate, solicit and document how the person receiving services makes the choice among waiver service	1) There was no documentation reflecting efforts to support/assist the person receiving services to make informed decisions regarding choice among waiver service providers. 2) Documentation indicated Support	C

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		providers. • Ask the Support Coordinator for examples of how they supported the person receiving services to make informed decisions regarding choice among waiver service providers. • Review file for documentation reflecting the Support Coordinator's efforts.	Coordinator was making decisions about waiver service providers with little to no input from the person receiving services.	
21	The Support Coordinator documents efforts to assist the individual/legal representative to know about rights.	CMS Assurance - Service Plan RECORD REVIEW • 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) Documentation did not reflect Support Coordinator efforts to assist the individual/legal representative to know about rights.	C
22	The Support Coordinator documents efforts to ensure the person's health and health care needs are addressed.	CMS Assurance - Health and Welfare RECORD REVIEW • 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	1) Documentation did not indicate the Support Coordinator was 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) Documentation did not indicate the Support Coordinator had advocated for the person to receive annual physicals and/or needed specialists visits.	C

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		information concerning doctor visits for preventative, annual and specific health care needs. • Review Progress Notes and other related health care documentation to determine if the health and healthcare needs of the person receiving services are being addressed.	4) Support Coordinator did not document follow up on medical doctor visits, results, medication changes, etc.	
23	The Support Coordinator documents efforts to ensure person's safety needs are addressed.	CMS Assurance - Health and Welfare RECORD REVIEW • 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.	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) Documentation indicated the 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.	C
24	The Support Coordinator has a method in place to document information about the individual's history regarding abuse, neglect, and/or exploitation..	CMS Assurance - Health and Welfare RECORD REVIEW • 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.	1) Support Coordinator had no knowledge of the individual's history regarding abuse, neglect, and/or exploitation. 2) Documentation did not demonstrate the Support Coordinator had addressed issues related to abuse, neglect, and exploitation that continue to impact and cause distress for the individual.	C

Service Specific Record Review – Support Coordination

#	Performance Measure/Standard	Protocol	Not Met Reasons	
25	The Support Coordinator documents efforts to assist 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 RECORD REVIEW • 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 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.	1) Documentation indicated the Support Coordinator had no knowledge of how the person receiving services would define abuse, neglect, and/or exploitation. 2) Documentation indicated the 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.	C
26	How many provider changes for the individual? (not scored just data collected)			
27	How many WSC changes for the individual? (not scored just data collected)			