MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

COMMUNITY FIRST CHOICE Policy Manual	Section: FORMS
	Subject: Agency Based Recertification Documentation SLTC-210

PURPOSE: The recertification form documents the effort on the part of the agency and the member to ensure required steps have been taken to assure continued program compliance.

DEFINITIONS: Agency Representative is identified as the program Oversight Representative for providers of self-directed services. For Agency based providers, the Agency Representative is identified as the Nurse Supervisor.

PROCEDURE: The Recertification Form is completed by the provider agency every 6 months or when significant change occurs and recertification is necessary. The completed form is signed by the member/personal representative (PR) and the agency representative.

INSTRUCTIONS:

1. Check one of the boxes at the top of the form to indicate which program your member is currently receives services through.
2. Enter the member name and Medicaid ID number.
3. If the member has a PR (Self-Direct only) enter that name under Contact Person.
4. Enter the date of the home visit.
5. Enter the average biweekly (biweekly = two week) utilization in units (1 unit = 15 minutes) for the previous two months.
6. Enter the current biweekly authorization in units.

7. Review the member's Functional Need Assessment, Service Profile, and Service Plan with the member/PR. Place mark in the check box indicating that this has been done. In the event this was not completed, indicate circumstances under the comment and address in the action plan.

8. Review Service Delivery Records (SDRs) for the two months prior to the 180-day visit. Determine whether the SDRs reflect the Service Plan. If so, place a check mark in the box indicating such. If the SDRs do not reflect the Service Plan, indicate (under comments) in what way they fail to reflect the Service Plan. Be specific. Address corrective action in the action plan.

9. Review current profile and the service plan to determine whether they are meeting the member's needs, place a check mark in the appropriate box. In the event the profile/plan does not meet the member needs, please address corrective action in the action plan.

10. Enter corrective action plan for issues identified above, and/or any other compliance issues. Be specific.

11. For CFC/PAS Self-Direct only: A Compliance Form (SLTC 167) must be completed (In addition to the agency action plan).

12. Enter additional comments to address issues not previously identified or that may be relevant to the 180-day visit.

13. Evaluation of the care attendant. Please indicate yes or no for each statement.

14. Each "No" answer (with the exception of Care Attendant present at visit) requires that the Provider Agency address the issue in the action plan, above.

15. Agency Representative signs, enters their Agency Name, and enters the visit date.

16. Member/PR is offered training on the management of personal care attendants by Provider Agency. Member (Agency Based) or PR (Self-Direct) signature validates the offer of training and all information contained on the form. Visit date is entered.

DISTRIBUTION:

White copy – Provider Agency
Yellow copy - Member