

RECERTIFICATION DOCUMENTATION
 CFC-AB CFC-SD PAS-AB PAS-SD

Member Name: _____ Medicaid ID#: _____

Contact Person (if applicable): _____ Date of Visit: _____

Member average biweekly utilization in units (1 unit = 15 minutes) for the previous two months: _____

Current Authorization _____

“No” Answers require an action plan. All issues identified through this review process require an action plan.

Member overview, Profile and Service Plan have been reviewed with the member/PR: Yes No

Comments:

Service Delivery Records appropriately reflect the Service Plan Yes No

Comments:

Current profile and service plan are meeting member’s needs Yes No

Comments:

AGENCY ACTION PLAN (*address issues identified above as well as identified compliance issues*):

Self-Direct Only: Compliance Form Completed. Refer to attached document.

Additional Comments:

Member/PR (self-direct) or Agency (agency based) evaluation of attendants

Displays competence and safety in performing tasks:

Attendant present at visit Yes No (doesn’t require action plan)

Performs tasks according to duty guide and policy:

Yes No

Attendant name:

Interaction and performance is satisfactory:

Yes No

Additional training need identified:

Agency Signature: _____ Agency: _____ Date: _____

My signature below indicates that I have been offered voluntary training on the management of personal care attendants.

Member/PR Signature: _____ Date: _____