ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT

Adult Day Health

A. List the date of your most recent certification (attach copy).

B. List the total number of slots for program.

C. What is the average time between ASAP referral and the start of service to the consumer?

D. Describe your procedure for action in case of the following emergencies:
   1. Fire

   2. Loss of power (lights and/or heat)

   3. Hurricanes and snowstorms

   4. Consumer wandering away

   5. Consumer health crisis

   If emergency policies are written, attach a copy of policy(ies)

E. Describe your policy for admission to your program. Cite any restrictions. How many "slots" are available for ADH, and ADH dementia (if applicable)?

F. Describe restrictions (if any) for an elder to continue in your program.

G. How many employees have had CPR and/or Basic First Aid training?

H. In order to meet the needs of the participant, list who provides the following:
   1. Health care and supervision

   2. Counseling

   3. Restorative services

   4. Socialization Maintenance

   5. Therapy services

ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT
Adult Day Health

I. Are prescription or non-prescription medications dispensed or administered?
☐ No
☐ Yes

If Yes, who is responsible for supervising the administration of medications?

J. Describe how you assure that the required participants-to-staff ratio is maintained.

K. Who is responsible for ensuring that meals meet government standards of nutrition?

L. Are meals prepared on site?

M. List the special diets that your site can accommodate.

N. List the AM & PM snacks served during the average week.

Dementia/Related Illnesses Providers

A. List your requirements for admission.

B. Describe how activities are designed to meet the needs of high and low functioning groups.

C. If your program is combined with other programs, such as Adult Day Health or Supportive Day Care, are activities provided in separate locations?

D. Describe how you assure that the required participants-to-staff ratio is maintained.

Provider employee who completed this form
Name: Date:

SERVICE SPECIFIC ON-SITE REVIEW

Adult Day Health

Please note the documents and records which will be required for the Consumer files and/or Employee files to be reviewed at the time of On Site Evaluation

EMPLOYEE Record Review					
Provider Date Monitor					
Start Date & Termination Date, if applicable					
Number of reference checks					
CORI Check					
Orientation Date					
Job Description in file?					
License(s)/ Certificate(s) Current/expired?					
Physical: Most recent					
TB: Most recent					
CPR/First Aid: Most recent					
OIG monthly checks					
Ongoing training: dates					
Annual Performance Appraisal: Date					
Comments					

SERVICE SPECIFIC ON-SITE REVIEW

Adult Day Health

Please note the documents and records which will be required for the Consumer files and/or Employee files to be reviewed at the time of On Site Evaluation

CONSUMER Record Review					
Provider Date Monitor					
ASAP Authorization					
name; address; phone; DOB, SAMS ID					
Emergency contact(s) name and phone					
Physician(s) name and phone					
Preferred hospital name and phone					
Medical/social diagnosis					
Current CM/RN and phone					
Service start date & Termination Date, if applicable					
Service plan					
Care Plan Signed and dated					
Consumer agreement					
Comments					
NOTE: Shaded data elements are only required in the Consumer File if provider is not on Provider Direct. Otherwise the PD Demonstrator will be asked to illustrate “on screen”.					

Name and Position of Provider Direct Demonstrator	