ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT

Alzheimer's Coaching (Habilitation Therapy)

I. Service Capacity

A. What is your proposed rate for Habilitation Therapy?

B. Provide the number of regular full- and part-time Alzheimer's Coaches.

C. Provide the number of per diem contract Alzheimer's Coaches.

D. Are coaches available during non-business hours for urgent consultations? If so, provide details.

E. Describe the process and tools used to assess the consumer and family. Attach copies of any tools referenced.

F. Describe the process and tools used to create a comprehensive habilitative plan of care. Attach copies of any tools referenced.

G. Describe the process for care plan evaluation and modification.

H. Describe your agency's protocols for communication. Include an outline of coordination between the consumer/family; care managers and RNs; and direct care workers, including Supportive Home Care Aides

II. Staff Qualifications

A. Describe the experience and qualifications of the person responsible for service provision (the manager of the program), if different from the information provided in the Administrative Overview.

B. Describe qualifications of Alzheimer's Coaches to perform this service. Include a list of all persons at your agency who will provide Alzheimer's Coaching, their experience, their licensure, and attach copies of training certificates from the Alzheimer's Association.

III. Training and In-Service Education

A. Describe in detail any initial and on-going training provided to Alzheimer's Coaches.

IV. Supervision

A. Describe the procedures for supervision, including frequency, documentation, and credentials/qualifications of supervisors for Alzheimer's Coaches.

B. Describe the systems and procedures employed to ensure that services are delivered to consumers as authorized.

C. Describe how Alzheimer's Coaches will access supervision and consultation. Whom do they consult for guidance and direction when their own skills are challenged?

Provider employee who completed this form
Name: _____ Date: _____

SERVICE SPECIFIC ON-SITE REVIEW

Alzheimer's Coaching (Habilitation Therapy)

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 Records Review					
Provider Date Monitor					
Start Date & Termination Date, if applicable					
Number of reference checks					
CORI Check					
Job Description(s)					
Alzheimer's Association Training Date(s)					
Licenses, if appropriate (RN, LICSW, LCSW, OT, or Waiver based on other professional qualifications)					
OIG monthly checks					
Annual Performance Appraisal: Date					
Comments					

SERVICE SPECIFIC ON-SITE REVIEW

Alzheimer's Coaching (Habilitation Therapy)

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 Records Review					
Provider Date Monitor					
ASAP authorization					
ID Info – name; address; phone; DOB					
Emergency contact(s) and phone					
Physician(s) name and phone					
Hospital name and phone					
Medical/social diagnosis					
Current CM/RN and phone #s					
Start Date & Termination Date, if applicable					
A.C. assessment					
A.C. Care Plan: includes 5 domains*					
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	

***5 Domains**: Communication, Physical Environment, Approach to Personal Care, Purposeful Engagement, Behavior as Communication*