

ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT
Aide Assisted Transportation

I. AIDE ASSISTED TRANSPORTATION PROPOSED RATE:

- a. Companion:
- b. Homemaker:
- c. Personal Care/Homemaker:
- d. Home Health Aide:
- e. Supportive Home Care Aide:

Describe any additional charges:

II. SERVICE CAPACITY

A. Provide the number of staff relating to care level match for consumer & aide:

	Full-Time	Part-Time	Per-Diem
Companion			
Homemaker			
Personal Care/Homemaker			
Home Health Aide			
Supportive Home Care Aide			

B. Describe in detail your Aide Assisted Transportation service and how it operates.

C. Are there any subcontracts to your proposal? *If so, please describe.*

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- F. Have there been any legal proceedings or claims against employees, alleging negligence or failure to observe transportation or motor vehicle rules that are open, pending, or closed within the past 10 years?

- G. 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.

IV. GENERAL POLICIES & PROCEDURES

- A. Describe your policy for notifying the ASAP about circumstances encountered that affect completion of authorized services (such as no answer at the door, etc.).

V. SUPERVISION

- A. Describe the procedures for supervision, including frequency, documentation, and credentials/qualifications of supervisors for each position.

- B. Describe the systems and procedures employed to ensure that services are delivered to consumers as authorized, including documentation of trips.

Provider employee who completed this form:

Name: _____ Date: _____

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EMPLOYEE Record Review						
ASAP(s) Name & Monitor(s):						
Provider:					Date:	
Employee Name:						
Start Date: Orientation Date:						
Termination Date (if applicable):						
Number of Reference Checks:						
Job Description(s):						
OIG Checks: Time of Hire/Monthly						
Driver's License (Class & Date of Expiration)						
DMV Registry Check: Active Insurance Confirmed:						
Supervision: Dates						
Annual Performance Appraisal Date:						

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Comments:						
CONSUMER Record Review						
ASAP(s) Name & Monitor(s):						
Provider:				Date:		
Consumer Name:						
ASAP Authorization:						
ID Information: Name; Address; Phone; DOB:						
Emergency Contact(s) & Phone:						
Physician(s) Name & Phone:						
Medical/Social Diagnosis (If applicable):						
Name of Current CM:						
Date of Referral:						
Service Start Date:						
Termination Date (If applicable):						
ASAP Authorization	Name, Address, Phone, DOB	Emergency Contact(s) & Phone	CM/RN & Phone	Physician(s) Name & Phone	Date of Service Termination	
Note: Shaded data elements are only required in the Consumer file if provider is not on Service Delivery Manager (Provider Direct). Otherwise, the agency demonstrator will be asked to illustrate "on screen."						
Name & Position of Agency Demonstrator:						