

ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT
Companion

I. Service Capacity

A. Provide the number of full-time, part-time, and per-diem Companions:

1) Full-Time:

2) Part-Time:

3) Per-Diem:

B. Provide an overview of workforce capacity initiatives, recruitment initiatives, workforce adequacy evaluation, and how staffing is managed day-to-day. Include linguistic or other special capabilities, etc.

C. Provide a detailed description of scheduling for worker absences, ensuring service to Risk Level 1 and 2 as well as other high need consumers, orientation of substitutes, notifications, evening, and weekend coverage, etc.

D. What percentage of your direct care workforce is available to work the following schedules:

1) Evenings:

2) Overnights:

3) Weekends:

A. Describe your agency process for maintaining a current list of Risk Level 1 and 2 consumers that is accessible in the event of an emergency.

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- B. Describe your policy regarding the provision of Companion service outside the home.
- C. Describe your policy regarding the provision of Companion through telehealth (including telephone and live video). Include specific details on a person-centered approach with the consumer, and decision on whether an in-person or telehealth option is preferred by the consumer.
Note: Telehealth services must be approved by ASAP prior to service provision. ASAP Care Manager is consulted for approval if telehealth delivery is appropriate.
- D. If there is no capacity for translation, describe your procedure for serving consumers who speak a language other than English or have specific hearing or visual needs.

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.

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- C. Describe the supervisory support available to direct care workers during non-business hours, including how supervisors are contacted, the titles and, as applicable, licensure of available supervisors.

Provider employee who completed this form:

Name: _____

Date: _____

EMPLOYEE Record Review					
ASAP(s) Name & Monitor(s):					
Provider:			Date:		
Employee Name:					

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Start Date:					
Termination Date (if applicable):					
Number of Reference Checks:					
CORI Check:					
DPH Registry Check:					
OIG Monthly Checks:					
Orientation Date:					
Job Description(s):					
Field Visit/Supervision Dates:					
Ongoing Training Dates:					
Annual Performance Appraisal: Date					
Comments:					

CONSUMER Record Review						
ASAP(s) Name & Monitor(s):						
Provider:				Date:		
Consumer Name:						

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ASAP Authorization:						
ASAP Authorization for Telehealth (If applicable):						
ID Information Name; Address; Phone; DOB:						
Emergency Contact(s) & Phone:						
Physician(s) Name & Phone:						
Hospital Name & Phone:						
Medical/Social Diagnosis:						
Task or Preferences:						
Therapeutic Goal Noted in Service Plan:						
Consumer Feedback Solicited? Dates:						
Termination Date (If applicable):						
Comments:						
ASAP Authorization	ID Information: Name, Address, Phone, DOB	Emergency Contact(s) & Phone	Physician(s) Name & Phone	Hospital Name & Phone	Tasks or Preferences	Termination Date (if applicable)
<p>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."</p>						
Name & Position of Agency Demonstrator:						