ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT
Companion

I. Service Capacity

A. Provide the number of regular full- and part-time Companions:

B. Provide an overview of workforce capacity initiatives, including recent turnover rates, ratio of service requests to staffing capacity, workforce adequacy evaluation, recruitment initiatives, linguistic or other special capabilities, etc.

C. Provide a detailed, concrete description of how staffing is managed day-to-day, including scheduled and unscheduled worker absences, ensuring service to Risk Level 1 and 2 and 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.

B. Describe your policy regarding the provision of Companion service outside the home.

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 the experience and qualifications you require for Companions.

III. Training and In-service Education

A. Describe your requirements for job specific training prior to placement, including ensuring worker sensitivity to elders, recognition of and reporting requirements regarding elder abuse and neglect, other emergency response issues, etc.

B. Describe the on-going training program for Companions.

IV. Supervision

A. Describe the procedures for supervision, including frequency, documentation, and credentials/qualifications of supervisors for each position (direct care, coordinators, supervisors, etc.).

B. Describe the systems and procedures employed to ensure that services are delivered to consumers as authorized, including telephony, unannounced field visits, quality assurance calls, etc.

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: _____

ESMV REQUEST FOR RESPONSES
RATE SHEET

COMPLETE FOR EACH SERVICE RESPONDENT IS REQUESTING TO PROVIDE.

Provider Name: _____
Service Type:_____

Calculation of Average Hourly Employee Compensation

Base Wage		Training Wages	
Travel Stipend		Transportation Expense	
Holiday Pay		Bereavement Pay	
Sick Pay		Annuity/Pension	
Personal Day Pay		Day Care	
Vacation Pay		Other (define)	
Health Insurance		Other (define)	

Total Hourly Average: $_____

Hourly Administrative Overhead: $_____

*Hourly Profit: $ _____

Hourly Unit Rate: $ _____

_____
Provider Authorized signature

_____
Title

_____
Printed Name

_____
Date

* Non-profit corporations do not complete this line.

SERVICE SPECIFIC ON-SITE REVIEW

Companion

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					
DPH Registry Check					
Orientation Date					
Job Description(s)					
Field visit/Supervision dates					
OIG monthly checks					
Ongoing training dates					
Comments					

SERVICE SPECIFIC ON-SITE REVIEW

Companion

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					
Task/preferences					
Therapeutic goal noted in Service Plan					
Consumer feedback solicited? Dates:					
Termination date, if applicable					
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	