KEPRO - WV I/DD Waiver Self Review Tool

Health, Human Resources BUREAU FOR MEDICAL SERVICES	
I/DD Provider Agency:	
I/DD Contact Person:	
Date Self-Review is Due:	
Assigned Provider Educator:	
# of Employee Files in 100% Sample Who Delivered I/DD Waiver Services During Assigned Review Period:	

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	./55	KEPRO											
		Provider Self-Revie											
	100% Staff	Review for Submis	ssion										l
	tions for Completion - ate names of ALL staff mem												
	ite names of ALL staff mem I Review Period in columns	•	rvices during only the										
			er number; (P) followed by										l
			P38. Create additional pages										
as neces	sary.												
	umn C, indicate which serv	• •											
	umn D, inidcate the date o												
5. Indica		n columns E - M. Any laps	es should be highlighted in										İ
	ems N - T indicate Yes, No,	or N/A if it does not apply											l
7. For ite	em U. enter anv applicable	provider comments.											İ
Assigned Re	eview Period:	1/1/16	5-12/31/16										
Review Due	Date:		1										
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C+-ff			C. I/DD Service(s) billed by staff		Date of	E. Current CPR Certification	Current CPR	Previous CPR Certification	Previous CPR	F. Current First Aid Certification	Current First Aid Expiration	Previous First Aid Certification	Previous First Aid Expiration
Staff Identifier	A. Staff Last Name	B. Staff First Name	during the review period (i.e. SC, BSP I or II, RN, LPN)	D . Date of Hire	Separation	Date	Expiration Date	Date	Expiration Date	Date	Date	Date	Date
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G. Current Infectious Disease Control Training Date	Current Infectious Disease Control Training Expiration Date	Disease Control	Previous Infectious Disease Control Training Expiration Date	Abuse / Neglect	Current Recognition of Abuse / Neglect Training Expiration Date	Abuse / Neglect	Previous Recognition of Abuse / Neglect Training Expiration Date	Member Rights	Current Member Rights Training Expiration Date	Previous Member Rights Training Date	Previous Member Rights Training Expiration Date	J. Current Confidentiality Training Date	Current Confidentiality Training Expiration Date	Previous Confidentiality Training Date	Previous Confidentiality Training Expiration Date	K. Current Conflict Free Service Coordination Training Date (n/a if Provider Only Agency)
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					M. Facilitated								
					WV APBS Overview of	N. Monthly Documentation			Q. BEHAVIOR SUPPORT	R. BEHAVIOR SUPPORT	S. LICENSED REGISTERED NURSE	T. LICENSED PRACTICAL	
Current Conflict	Previous Conflict	Provious Conflict			Positive Behavior Support or	Indicating staff person is not on	O. There is documentation to	P. SERVICE COORDINATION ONLY	PROFESSIONAL I ONLY	PROFESSIONAL II ONLY	ONLY There is evidence	NURSE ONLY There is evidence	
Free Service	Free Service	Free Service			WVUCED Positive	OIG lists of	verify the staff	There is evidence that	There is evidence the	There is evidence the	the RN meets	the LPN meets	
Coordination Expiration Date	Coordination Training Date	Coordination Expiration Date	L. Current CIB eligibility	Previous CIB eligibility	Behavior Support Direct Care	excluded persons?	person is at least 18 years of age?	the SC meets degree and experience	experience	experience	requirements.	licensing requirements.	
(n/a if Provider Only Agency)	(n/a if Provider Only Agency)	(n/a if Provider Only Agency)	determination Date	determination Date	Overview Training Date	Indicate Yes or No.	Indicate Yes or No.	requirements. Indicate Yes or No.	requirements. Indicate Yes or No.	requirements. Indicate Yes or No.	Indicate Yes or No.	Indicate Yes or No.	

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	I/DD Waive																			
	100% Sta	aff Review for Subm	ission																	
	s for Completion - DIRI																			
		who provided IDD services	during only the Assigned Review																	
	umns A and B. ional lines if necessary and :	assign a Staff Identifier num	ber; (P) followed by the next																	
number in th	e consecutive sequence; i.e	P57, P58, P59. Create add	ditional pages as necessary.							i										
3. In column	C, indicate which service(s)) that staff provided. , and, if applicable, the date	- of																	
			ould be highlighted in yellow.																	
6. For items	N-O, indicate Yes or No.																			
7. For item P	, enter any applicable provi	ider comments.																		
Assigned Rev		1/1	/16-12/31/16																	
Review Due [Date:		l .												Current		Previous		Current	
			C. I/DD Service(s) billed by staff											G. Current	Infectious	Previous	Infectious	H. Current	Recognition of	Previous
6. "			during the review period (i.e. F-PCS,		Date of	E. Current CPR Certification	Current CPR	Previous CPR Certification	Previous CPR	F. Current First	Current First Aid	Previous First Aid Certification		Infectious Disease Control	Disease Control Training	Infectious Disease Control	Disease Control Training	Recognition of Abuse/Neglect	Abuse/Neglect	Recognition of Abuse/Neglect
Staff Identifier	A. Staff Last Name	B. Staff First Name	HB-PCS, In Home Respite, Out of Home Respite, SE, JD, Pre-Voc)	D. Date of Hire	Separation	Date	Expiration Date	Date	Expiration Date	Date	Expiration Date	Date	Date	Training Date	Expiration Date		Expiration Date	Training Date	Training Expiration Date	Training Date
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P56																				

Previous													L. Facilitated WV APBS Overview of Positive Behavior Support or WUCED Positive			N. Monthly Documentation Indicating staff person is not on	O. There is documentation to verify the staff	
Recognition of Abuse/Neglect Training	I. Current Member Rights	Current Member Rights Training	Previous Member Rights	Previous Member Rights Training	J. Current Confidentiality	Current Confidentiality Training	Previous Confidentiality	Previous Confidentiality Training	K. Current Direct Care Ethics	Current Direct Care Ethics	Previous Direct Care		Behavior Support Direct Care Overview Training	M. Current CIB eligibility determination	Previous eligibility CIB determination	OIG lists of excluded persons? Indicate	person is at least 18 years of age? Indicate	
Expiration Date	Training Date	Expiration Date	Training Date	Expiration Date	Training Date	Expiration Date	Training Date	Expiration Date	Training Date	Expiration Date	Ethics Training Date	Date	Date	Date	Date	Yes or No.	Yes or No.	
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P. PROVIDER COMMENTS