WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

Acentra HEALTH

 I/DD Provider Agency: _____

I/DD Waiver Contact Person: _____

Assigned Provider Educator: _____

# of Employees Providing
I/DD Waiver Services During
the Review Period: _____

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I/DD Waiver Provider Self-Review
100% Review of I/DD Waiver Staff

Assigned Review Period: _____

Review Due Date: _____

Instructions for Completion:

Professional Staff

1. Indicate names of ALL professional staff members who **provided I/DD Waiver services** during the assigned review period in columns C (First Name) and D (Last Name). This includes Case Managers, Behavior Support Professionals, Registered Nurses, Licensed Practical Nurses, and agency-employed Therapists.

2. Assign a Staff Identifier number (P) in increasing sequential order in column B (Staff Identifier), i.e. P1, P2, P3, P4…

3. Indicate requested information as described in columns E - G.

4. Enter any applicable provider comments in column H.

Direct Care Staff

1. Indicate names of ALL direct-care staff members who **provided I/DD Waiver services** during the assigned review period in columns C (First Name) and D (Last Name). This includes all PCS staff, day service staff, and respite staff.

2. Assign a Staff Identifier number (P) in increasing sequential order in column B (Staff Identifier), i.e. P1, P2, P3, P4…

3. Indicate requested information as described in columns E - H.

4. For all staff, indicate which type of service(s) they provide in column F: 24 hour (URPCS/LGHPCS), NF/HBPCS/Respite (FPCS, HBPCS, IH Respite, OOH Respite), Day Services (FBDH, PV, JD, SE), or a combination. If staff provide a combination of services, please specify all service types in column I.

5. For any staff providing transportation services, indicate which type of vehicle(s) - personal, company, or both - the staff utilizes to provide the service(s), if applicable in column G.

6. Enter any applicable provider comments in column I.

Extended Professional Staff

1. Indicate names of ALL contracted staff members who **provided I/DD Waiver services** during the assigned review period in columns B (First Name) and C (Last Name). This includes any contracted Registered Nurses, Licensed Practical Nurses, and Therapists.

2. Assign a Staff Identifier number (P) in increasing sequential order in column A (Staff Identifier), i.e. P1, P2, P3, P4…

3. Enter any applicable provider comments in column F.

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Professional Staff

Staff Identifier	First Name	Last Name	Professional Role (CM, RN, Etc)	Date of Hire	Termination Date (if applicable)	Provider Comments

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Direct-Care Staff

Staff Identifier	First Name	Last Name	Services Provided (Select from List)	Date of Hire	Termination Date (if applicable)	Provides Transportation (Select from List)	Provider Comments

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Extended Professional Staff

Staff Identifier	First Name	Last Name	Contracted Role (RN, OT, etc)	Provider Comments