ADMINISTRATIVE OVERVIEW

Revised 05/02/2017

RESPONSES MUST BE TYPED. HAND-WRITTEN RESPONSES WILL BE RETURNED.

Before completing this form, download and review the following documents posted on 800ageinfo.com For Professionals corridor/Document Library:

Elder Affairs Documents:

- PI-97-55 Privacy and Confidentiality
- PI-03-17 Elder Rights Review Committee
- PI-07-03 Requirements of Prevention, Reporting, and Investigation of Abuse by Homemakers and Home Health Aides (For Homemaker and Home Health Agencies only)
- PI-09-19 Revised CORI Regulations
- PI-11-06 Risk Management
- PI-11-07 Prohibition on Non-Compete Agreements
- Provider Network Quality Assurance Manual
- Provider Agreement
- Attachment A Service Descriptions (for applicable services)
- Homemaker Standards (For Homemaker Agencies)
- Personal Care Guidelines (For Homemaker Agencies)
- Executive Order 504 Provider Certification and Data Security Addendum

Commonwealth of Massachusetts Documents:

- 105 CMR 155.00 (For Homemaker and Home Health Agencies)
- 201 CMR 17.00
- 808 CMR 1.00
- Commonwealth Terms and Conditions for Human and Social Service Providers
- Executive Order 526 Regarding Non-Discrimination, Diversity, Equal Opportunity, and Affirmative Action
- MassHealth All Provider Bulletin 196

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I. CORPORATE INFORMATION

☐ New Applicant ☐ Existing Provider

1. Legal Name: _____
2. d/b/a, if different: _____
3. Address: _____

   _____

   _____
4. List any satellite offices and indicate whether employee, consumer, or financial records are kept at each site:

   _____

   _____

   _____
5. Telephone number(s) _____
6. Fax number(s) _____
7. Website url: _____
8. Agency Contact (Name, title, and email address of person completing this tool):

   _____
9. Nine-digit Federal Employer Identification Number: _____
10. If your agency is a non-profit organization, submit a current original "Short Form Certificate of Legal Existence," which Massachusetts's corporations may obtain for a nominal fee. Order online at http://corp.sec.state.ma.us/corp/corpsearch/corpsearchinput.asp. Or write,

    Secretary of State's Office
    Corporate Division
    One Ashburton Place – Room 1715
    Boston, MA 02108
11. If your agency is a for profit corporation, submit an original "Short Form Certificate of Legal Existence with Officers," which Massachusetts corporations may obtain for a nominal fee from the Secretary of State's Office at the website or address listed above.

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12. List all ASAPs with which you currently contract and list services provided.

_____

_____

13. If your company does not now contract with any ASAPs, list 3-5 business references, two of which must be entities for which you provide services similar to those proposed in this application.

    1. _____
    2. _____
    3. _____
    4. _____
    5. _____

14. As of today's date, the Commonwealth of Massachusetts Supplier Diversity Office (formerly SOMWBA) has certified your company as a (check all that apply)

    ☐ Minority-owned business or non-profit organization (MBE)

    ☐ Woman-owned business or non-profit organization (WBE)

    ☐ N/A

15. Attach a copy of the MBE and/or WBE Certification.

16. Is or has your company been the subject of state or federal debarment, suspension, or investigation?

    ☐ No

    ☐ Yes (please explain)

    _____

17. Is or has any other revenue source (private or public) required a corrective action plan within the previous five years?

    ☐ No

    ☐ Yes (please explain)

    _____

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18. Describe the mission and history of your organization. Include information relevant to the application, such as the number of years providing services, types of services, number of persons served and their characteristics, and other contracts and lines of business.

_____

19. The Uniform Financial Statements and Independent Auditor's Report (UFR) is the set of financial statements and schedules required of human and social service organizations who deliver services to the Commonwealth's vulnerable consumers via contracts with state departments. Please state the date of your organization's most recent filing. If you have not filed a UFR, please state the exemption that your organization claims. For details, see http://www.mass.gov/anf/budget-taxes-and-procurement/procurement-info-and-res/conduct-a-procurement/human-soc-serv-policies/information-and-resources-on-the-uniform.html
    Date of UFR filing: _____

    Exemption: _____

20. Are any of your services subcontracted to other companies or individuals? Please note that the *Provider Agreement* requires the Provider to secure written approval from an ASAP prior to subcontracting any services delivered pursuant to the Agreement.
    ☐ No ☐ Yes

21. If yes, please respond to the following:
    a) Identify subcontractor (s) by name, address, service(s) and percentage of ASAP business referred to each:

    _____

    _____

    _____

    b) Describe how you monitor subcontractors for quality assurance:

    _____

c) Describe how you ensure that subcontractors for the provision of Home Health Aide Services comply with PI-07-03, Prevention, Reporting and Investigation of Abuse by Homemakers and Home Health Aides under DPH Regulations:

_____

II. LICENSES, CERTIFICATIONS, ACCREDITATIONS, PERMITS, and INSURANCE

1. Please list and provide copies of all of the above that pertain to your provision of services to the ASAP. This would include local, state, county, and federal requirements, as well as association accreditations.

_____

2. Before issuing any contract, the ASAP will require a copy of a Certificate of Insurance-verifying that you have procured and maintain appropriate liability insurance issued by a company authorized to do business in the Commonwealth and certified by the Massachusetts Commissioner of Insurance. The ASAP must be described as a Certificate Holder and be provided a minimum of 10 days written notice of cancellation.

III. ORGANIZATION AND STAFFING

1. Describe in detail the qualifications (professional experience, education, licensure, etc.) for the following key staff:

    a) Executive Director/Owner _____

    b) Program Director (person responsible for service delivery) _____

    c) Clinical Manager/Nurse Supervisor (if different from above) _____

    d) Chief Financial Officer _____

2. Provide a narrative overview of your organization, including number of FTEs, unit/department divisions, number of supervisors, reporting structures, etc.

_____

3. Does the applicant use contract employees (not regular full or part time employees) for the services provided under this contract? If yes, provide details such as the number of contract employees, hours per week, supervisory structure, etc.

_____

4. For organizations with more than 50 employees, attach an organizational chart that includes titles and FTEs.

5. Describe the process for recruitment, screening, and hiring of qualified direct care, supervisory, and coordinator staff.

_____

6. List the non-statutory fringe benefits offered to your employees. Specify the categories of employees eligible for each of the benefits. In addition, provide the following:

_____

   a) # of eligible employees in each category:

   b) # of employees receiving each benefit:

7. Describe your procedure to ensure licenses (including driver's licenses) and certifications of employees are current.

8. Attach a copy of your hiring checklist and the list of topics for orientation.

9. Describe your initial and on-going training program(s) for supervisors, coordinators, and staff/direct care workers. Include a list of topics for orientation.

_____

10. Describe the tracking system for ensuring mandatory training is complete and up-to-date, including the persons responsible for this.

_____

11. Describe how training is documented and where training documentation is maintained.

_____

12. Attach a copy of your in-service training calendar for the current calendar year and the previous calendar year.

IV. SERVICE CAPABILITY

1. List the ASAP areas that you are able to serve. For each ASAP area that you are unable to fully serve, list the specific cities and towns or areas that you are able to serve within that ASAP area.

_____

2. Provide a detailed description of your agency's ability to serve people with disabilities, elders, and persons from diverse ethnic, linguistic, and socio-economic backgrounds.

_____

List the Days and Hours of Operation of:

	Main Office	***Satellite(s)***	***Other***
A.M.			
P.M.			
Days			

3. Describe in detail the after-hours back up for both routine and urgent consumer needs. As necessary, include information specific to each service provided.

_____

4. Describe your procedures for responding to weather-related emergencies, including closings, notifications, and triage due to staff shortages. As necessary, include information specific to each service provided.

_____

5. Indicate your agency's in-house capacity to communicate with consumers in languages other than English when needed:

	Administrative Staff Language/# of Staff	***Direct Care Staff*** Language/# of Staff	***Other Staff*** Language/# of Staff
Office			
Main			
Satellite			
Other			

6. Describe in detail your guidelines for service coordination, including communication protocols between the consumer and the ASAP, mandatory notifications, service starts, and service suspensions.

_____

7. Indicate whether you have one or both of the following:
   a) Continuity of Operations Plan (COOP): ☐ Yes ☐ No
   b) Emergency Management Plan: ☐ Yes ☐ No

V. POLICIES AND PROCEDURES

Attach copies of the policies and procedures for the following requirements:

1. Personnel Policies, including supervision, annual performance evaluation, work rules, etc.
2. Conflict of Interest
3. Privacy and Confidentiality
4. Non-discrimination in employment and service delivery
5. 105 CMR 155.00, including the procedure on the required DPH registry check (Homemaker Agencies, Home Health Agencies, and Skilled Nursing Facilities only)
6. MassHealth All Provider Bulletin 196: The Office of the Inspector General's List of Excluded Individuals and Entities
7. Tuberculosis Testing (Homemaker Agencies, Home Health Agencies, Adult Day Health Providers, and Skilled Nursing Facilities only)
8. CORI (PI-09-19)
9. Infection Control Plan (Homemaker Agencies, Home Health Agencies, Adult Day Health Providers, and Skilled Nursing Facilities only)
10. Reportable Incidents
11. Consumer Not at Home Policy
12. Emergencies in the Home
13. Theft, Loss, or Damage to Consumer Property
14. Shopping/Money Handling (Homemaker and Home Health Agencies, Companion Providers, Grocery Shopping Providers)
15. Service Priority for High Risk Consumers (PI-11-06) (Homemaker and Home Health Agencies only)
16. Prohibitions on Fees and Gratuities

Attach copies of job descriptions for all positions related to the contract.

In addition, ASAPs that receive more than $5 million annually in Medicaid (MassHealth) funds and their subcontractors must have policies on the prevention and detection of fraud, waste, and abuse.

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VI. RECORD KEEPING

1. Describe your consumer record keeping system, including whether you maintain electronic files in addition to paper files, what information is kept in each, and how organized.

_____

2. Describe the procedures to keep consumer information current, including persons responsible.

_____

3. How do you ensure that consumer files are maintained for the required seven years after the last day of service provided?

_____

4. Describe your employee record keeping system, including whether you maintain electronic files in addition to paper files, what information is kept in each, and how organized.

_____

5. Describe the procedures to keep employee information current, including persons responsible.

_____

6. The Provider Direct Business Rules attached to the Provider Agreement outline the technical specifications for the electronic system of record. Describe how you meet the requirements for viewing and monitoring authorizations using Provider Direct, including persons responsible.

VII. PRIVACY AND CONFIDENTIALITY

1. Is your company a "Covered Entity" under the HIPAA Privacy Rule? _____

2. Provide a brief description of your instructions to staff regarding the confidentiality of consumer information.

_____

3. How do you ensure that information concerning a consumer's HIV status is accorded additional security and confidentiality, in accordance with Massachusetts state law?

_____

4. List by title the staff who have access to consumer data:

_____

5. How do you ensure the physical security of electronic and paper records?

_____

6. Is consumer data ever removed from the office(s)? If yes, describe the circumstances (such as direct care workers taking a list of consumers and their addresses to the field), and the procedures to ensure such information is returned to your office(s).

_____

7. How do you dispose of material that contains consumer data, including electronic data?

_____

VIII. BILLING VERIFICATION

1. Describe in detail the process for generating a monthly invoice. Include the titles of persons involved in the process, what steps they are responsible for, what documentation or information they use and how service delivery is verified, what equipment or software programs are used, the review process – including how errors are detected and corrected, the documentation maintained to support invoices, and how the invoice is delivered to the ASAP.

_____

IX. QUALITY ASSURANCE

1. Describe your approach to ensuring quality in service delivery.

_____

2. Describe how complaints are handled, including the titles of persons responsible for resolution and how complaints are tracked.

_____

3. Describe how your organization receives or solicits consumer feedback regarding service, how that information is reviewed, and how it is used to improve service delivery. Provide concrete examples.

_____

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PLEASE FILL OUT THIS FORM COMPLETELY. USE AS MUCH SPACE AS NECESSARY.

CONTACT INFORMATION

Provider Name: _____

President/Executive Director/Owner
Name and Title: _____
Phone: _____
Fax: _____
Email: _____

CFO
Name and Title: _____
Phone: _____
Fax: _____
Email: _____

Program Manager (Person in charge of service delivery)
Name and Title: _____
Phone: _____
Fax: _____
Email: _____

Personal Care Supervisor(s)
Name and Title: _____
Phone: _____
Fax: _____
Email: _____

Contract Manager
Name and Title: _____
Phone: _____
Fax: _____
Email: _____

Service Coordinator(s) (Please include back-up and specify service area if needed.)
Name(s) and Title(s): _____
Phone: _____
Fax: _____
Email: _____

Billing Coordinator
Name and Title: _____
Phone: _____

Fax: _____
Email: _____