

APPENDIX C

CDC+ PARTICIPANT REVIEW FORM for _____, 20____

Participant Name: _____ Participant ID #: _____
 Consultant Name: _____ Full _____ Limited _____
 Date of This Review: _____ Phone: Y ___ N ___ Annual In-Home Visit _____

If you provide full or limited consultant services, complete this form every month as soon as you have reviewed your copy of the participant's monthly statement. If you provide full consultant services, you must contact the participant by phone each month to discuss your review. If you provide limited consultant services, you must contact the participant whenever you identify problems. If the participant receives a cash check, you must complete items #3 & 4 every month when you receive copies of the cash receipts and the cash receipt log, even if no phone call is made. Maintain your standard case notes.

AREA TO BE REVIEWED	CONSULTANT TO INITIAL
1. A review of the statement referenced above indicates all services in the Services section of the participant's approved Purchasing Plan are being provided.	YES ___ NO ___
<ul style="list-style-type: none"> If no, this was discussed with the participant, an explanation is provided below, and if Corrective Action Plan was indicated, the Area Liaison for CDC+ has been advised. 	YES ___ NO ___
2. If participant has items in the Savings section, the participant is tracking these funds and is on schedule to purchase the approved items.	N/A ___ YES ___ NO ___
<ul style="list-style-type: none"> If no, or if the purchase has been made, the participant is developing a Purchasing Plan to show a revised estimated date of purchase or date purchased. (Estimated date of purchase is the END of the authorization.) 	YES ___ NO ___
3. The unexpended balance at the end of the statement is <u>positive</u> and <u>sufficient</u> for the participant to pay for the remaining services provided during the statement month.	YES ___ NO ___
<ul style="list-style-type: none"> If no, I discussed this with the participant and if Corrective Action Plan was indicated, a Corrective Action Plan has been written and a copy has been provided to the Area Liaison for CDC+. (Corrective Action Plan is REQUIRED if unexpended balance, adjusted for OTE/STE and restricted services funding, will be negative after all payroll documents have been submitted for services provided through the end of the month named on the statement.) 	YES ___ NO ___
4. Complete this item if participant receives a cash check each month.	N/A ___
<ul style="list-style-type: none"> Participant has all receipts for cash purchases made during month. The amount of cash received is \$_____. The amount spent for the month is \$_____. The amount of cash the participant has on hand is \$_____. The participant's cash on hand has not exceeded 20% of the monthly cash check for two months in a row. 	YES ___ NO ___
<ul style="list-style-type: none"> If no, I discussed this with the participant, who has developed a new Purchasing Plan to reduce the cash amount to \$_____ so the cash on hand will be reduced. 	YES ___ NO ___

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5. A review of cash receipts documents that all cash purchases were for items approved on the participant's Purchasing Plan.	N/A ____ YES ____ NO ____
<ul style="list-style-type: none"> If no, I discussed this with the participant, an explanation is provided below, and a Corrective Action Plan has been written; a copy has been provided to the Area Liaison for CDC+. 	YES ____ NO ____
6. During the statement month, the participant had to use an emergency backup provider for the following service and reason: _____ _____ _____	N/A ____ YES ____ NO ____
<ul style="list-style-type: none"> If the participant has been using an emergency backup provider for other than backing up the identified primary provider (e.g., consistent use in addition to the primary provider), I advised the participant a revised Purchasing Plan must be submitted immediately to show the provider(s) as primary. If use of emergency backup provider(s) has resulted in 4 or more regular directly hired employees, I advised the participant he/she must purchase or provide proof of having purchased Workers Compensation Insurance by _____ or he/she will be placed on Corrective Action. 	N/A ____ YES ____ NO ____
7. There are no changes in either the participant's or representative's registration information or the participant's legal status or CDC+ status.	YES ____ NO ____
<ul style="list-style-type: none"> If no, I completed a Participant Information Update Form to update the information and submitted it to the Area CDC+ Liaison on _____. 	YES ____ NO ____
8. Neither the participant nor I have received notice of the participant's annual Medicaid eligibility redetermination meeting.	YES ____ NO ____
<ul style="list-style-type: none"> If no, I have assisted the participant with this process and made sure the participant went to the redetermination meeting. 	YES ____ NO ____
9. AT ANNUAL HOME VISIT: The participant is living in a safe, clean environment and there are no indications of abuse or neglect.	YES ____ NO ____
<ul style="list-style-type: none"> If no, this is explained below and I have taken the necessary steps to ensure the participant's safety. 	YES ____ NO ____
10. CONSUMER HAS DISENROLLED FROM CDC+: All timesheets and invoices for services provided while the participant was on CDC+ have been submitted for payment and the account is ready for close-out.	YES ____ NO ____
<ul style="list-style-type: none"> If no, I will address this issue every week from this point forward until this item is complete, even after the participant has returned to the DD/HCBS Waiver. 	YES ____ NO ____
Detail all Problems/Concerns and follow-up needed:	Date and How Addressed: