ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT

Alzheimer's/Dementia Coaching (Habilitation Therapy)

I. Service Capacity

A. What is your proposed rate for Alzheimer's/Dementia Coaching (Habilitation Therapy)?

B. Provide the number of Alzheimer's/Dementia (Habilitation Therapy) Coaches.
   1) Full Time:
   2) Part Time:
   3) Per-Diem:

C. Are coaches available during non-business hours for urgent consultations? If so, provide details or any other avenues of communication.

D. Describe the process and tools used to assess the consumer and family. Attach copies of any tools referenced.

E. Describe the process and tools used to create a comprehensive habilitative therapeutic plan of care. Attach copies of any tools referenced.

F. Describe the process for care plan evaluation and modification.

G. Describe your agency's protocols for communication. Include an outline of coordination between the consumer/family; care managers and RNs; and direct care workers, including Supportive Home Care Aides.

H. Describe your agencies process, and/or ability to provide Alzheimer's/Dementia Coaching (Habilitation Therapy) to a consumer and caregiver via telehealth (including telephone and live video).
   Note: Telehealth services must be approved by ASAP prior to service provision. ASAP Care Manager will be consulted for approval of telehealth delivery from qualified agency.

I. If there is no capacity for translation, describe your procedure for serving consumers who speak a language other than English, or have specific hearing or visual needs.

II. Staff Qualifications

A. Describe the experience and qualifications for the person responsible for programmatic service oversight.

B. Describe qualifications of Alzheimer's/Dementia (Habilitation Therapy) Coaches to perform this service. Include a list of all persons at your agency who will provide Alzheimer's Coaching, their experience, their licensure, and attach copies of training certificates from the Alzheimer's Association.

III. Training and In-Service Education

A. Describe in detail any initial and on-going training provided to Alzheimer's/Dementia (Habilitation Therapy) Coaches.

ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT

Alzheimer's/Dementia Coaching (Habilitation Therapy)

IV. Supervision

A. Describe the procedures for supervision, including frequency, documentation, and credentials/qualifications of supervisors for Alzheimer's/Dementia (Habilitation Therapy) Coaches.

B. Describe the systems and procedures employed to ensure that services are delivered to consumers as authorized.

C. Describe how Alzheimer's/Dementia (Habilitation Therapy) Coaches will access supervision and consultation. Whom do they consult for guidance and direction when their own skills are challenged?

Provider employee who completed this form:

Name: _____ Date: _____

ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT

Alzheimer's/Dementia Coaching (Habilitation Therapy)

EMPLOYEE Record Review					
ASAP(s) Name & Monitor(s):					
Provider:			**Date:**		
Employee Name:					
Start Date:					
Termination Date (*if applicable*):					
Number of Reference Checks:					
CORI Check:					
OIG Monthly Checks:					
Job Description(s):					
Alzheimer's Association Training Date(s):					
Licenses, if appropriate **(RN, LICSW, LCSW, OT, Waiver Based or other Professional Qualifications)**					
Annual Performance Appraisal: Date					
Comments:					

ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT

Alzheimer's/Dementia Coaching (Habilitation Therapy)

CONSUMER Record Review						
ASAP(s) Name & Monitor(s):						
Provider:				**Date:**		
ASAP Authorization:						
ASAP Authorization for Telehealth *(If applicable)*:						
ID Information (Name; Address; Phone; DOB)						
Emergency Contact(s) & Phone:						
Physician(s) Name & Phone:						
Hospital Name & Phone:						
Medical/Social Diagnosis:						
Current CM/RN & Phone Numbers:						
Start Date:						
Termination Date *(If applicable)*:						
A.C. Assessment:						
A.C. Care Plan: *Includes 5 Domains**						
Comments:						

ASAP Authorization	**ID Information: Name, Address, Phone, DOB**	**Emergency Contact(s) & Phone**	**Physician(s) Name & Phone**	**Hospital Name & Phone**	**Current CM/RN & Phone Numbers**	**Start Date & Termination Date *(If Applicable)***

Note: Shaded data elements are only required in the Consumer file if provider is not on Service Delivery Manager (Provider Direct). Otherwise, the agency demonstrator will be asked to illustrate "on screen."

Name & Position of Agency Demonstrator:	

5 Domains Include: Communication, Physical Environment, Approach to Personal Care, Purposeful Engagement, Behavior as Communication