ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT
Bill Payer/Representative Payee Services

I. Service Capacity

A. Attach copies of all policies and procedures related to the provision of Bill Payer/Rep Payee services.

B. Describe your professional qualifications to provide Bill Payer/Rep Payee Services, including a brief history of your organization's engagement in providing this service. Attach relevant designations/certifications.

C. Describe the process for matching consumers and Bill Payers/Rep Payees.

D. Describe the documentation requirements for the service.

E. How do you monitor the services provided to ensure the consumer's funds are safe and protected from misappropriation and/or financial exploitation?

F. Describe your policy for ensuring consumer choice in the provision of this service.

G. Is this service currently subject to audit by any other payer(s)? If so, provide details.

H. What is your proposed rate for Bill Payer Services? Describe any additional charges.

II. Staff Qualifications

A. What experience and qualifications are required for those providing direct service to consumers?

B. Describe in detail the screening and interviewing process.

ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT

III. Training and In-Service Education

A. Describe the initial training and orientation of Bill Payers/Rep Payees. Attach a copy of the curriculum for training Bill Payers/Rep Payees.

B. Describe the ongoing training requirements.

IV. Supervision

A. Describe the procedures for supervision, including frequency, documentation, and credentials/qualifications of supervisors.

B. Describe the procedures for reviewing bank and financial statements, including frequency and persons responsible.

Provider employee who completed this form

Name: _____ Date: _____

SERVICE SPECIFIC ON-SITE REVIEW

Bill Payer/Representative Payee Services

Please note the documents and records which will be required for the Consumer files and/or Employee files to be reviewed at the time of On Site Evaluation

CONSUMER Record Review					
Provider Date Monitor					
Authorization/referral form					
ID Info – name; address; phone; DOB					
Emergency contact(s) and phone					
Functional status/limitations					
Name of current CM/RN					
Service start date & Termination date, if applicable					
Comments					

NOTE: Shaded data elements are only required in the Consumer File if provider is not on Provider Direct. Otherwise the PD Demonstrator will be asked to illustrate “on screen”.

Name and Position of Provider Direct Demonstrator	

SERVICE SPECIFIC ON-SITE REVIEW

Bill Payer/Representative Payee Services

Please note the documents and records which will be required for the Consumer files and/or Employee files to be reviewed at the time of On Site Evaluation

EMPLOYEE Record Review					
Provider Date Monitor					
Service start date & Termination date, if applicable					
Number of reference checks					
CORI Check					
Job Description(s)					
Ongoing training dates: if applicable					
OIG monthly checks					
Annual Performance Appraisal: Date					
Comments					