ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT

Virtual Communication and Monitoring (VCAM)

I. VIRTUAL COMMUNICATION AND MONITORING (VCAM) PROPOSED RATE:

Virtual Communication and Monitoring (VCAM)

a. Device Installation/Set-Up:
b. Monthly Subscription:
c. Other:

Describe any additional charges.

II. SERVICE CAPACITY

A. Describe in detail your VCAM service and how it operates.
Include Visual component, activation of device, and 24/7 capabilities.

B. What is the process of determining the location of the device in consumer's home?

   a. Describe how consumers preference for device location is determined using a person-centered approach.
   b. How is consumer informed and educated about appropriate locations for the device?
   Include a copy of consent form for VCAM location obtained from consumer/others in the home. Must be documented within consumer's record.

C. Are there any subcontracts to your proposal? If so, please describe.

D. After receiving a call from the ASAP to initiate service, describe your agency's procedures.
Include expected time frames and average time between ASAP referral and the start of service to the consumer.

E. If there is no capacity for translation, describe your procedure for serving consumers who speak a language other than English, have specific hearing or visual needs or have Alzheimer's Disease or Related Dementia (ADRD)?

F. Describe your process for testing in-home equipment.
How frequently is testing done? What is the procedure for replacing or repairing malfunctioning equipment?

G. What documentation is kept on file? Who is responsible for testing?

H. Where is the monitoring station(s) located?

Virtual Communication and Monitoring (VCAM)

I. How is consumer/representative preference implemented?

J. What is the process to have regularly scheduled check ins for consumers?
   a. How would an individual contact the consumer for a scheduled check in through the device?
   b. Describe your policy in the event the consumer does not answer, or does not respond to scheduled check in?
      i. How and when will the ASAP be made aware of a missed check in?

K. In the event of a power outage, will the VCAM continue to operate?

L. What is your agency's policy in the event that equipment has been damaged or lost?

M. Describe the process for retrieval of equipment once a consumer is terminated from the ASAP.

III. STAFF QUALIFICATIONS

A. Describe the experience and qualifications of the person responsible for service provision (the manager of the program), if different from the information provided in the Administrative Overview.

B. Describe the experience and qualifications you require for staff providing this service, including coordinators, installers, and, as applicable, monitoring station personnel.

IV. SUPERVISION

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

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

Provider employee who completed this form:

Name: _____

Date: _____

ADMINISTRATIVE OVERVIEW
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Virtual Communication and Monitoring (VCAM)

EMPLOYEE Record Review						
ASAP(s) Name & Monitor(s):						
Provider:				**Date:**		
Employee Name:						
Start Date						
Termination Date (*if applicable*)						
Number of Reference Checks						
CORI Check						
Orientation Date						
Job Description(s)						
OIG Checks: Time of Hire/ Monthly						
Annual Performance Appraisal Date						

ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT

Virtual Communication and Monitoring (VCAM)

CONSUMER Record Review						
Consumer Name:						
Service Termination Date (*if applicable*)						
Date of Unit Removal (*if applicable*)						
Emergency Responder(s) name, phone, location of keys						
Contact Info for Caregiver						
Confidentiality Notice: Yes/No						
Copy of Consent Form (Consumers / Others in Home)						
Release of Information: Yes/No						
Documentation of Contacts with MD/CM/Care Providers (as needed):						
ASAP Authorization	**Name, Address, Phone, DOB**	**Physician(s) name & phone**	**CM/RN & Phone**	**Date of Referral/ Installation**	**Date of Service Termination**	**Hospital Name & Phone**
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:						