APPENDIX C

CDC+ PARTICIPANT REVIEW FORM FOR , 20

Participant Name: **Date of This Review:**

Participant ID #: **Consultant Name:**

Monthly Contact: **Semi-annual Face to Face Visit:**

☐ **Phone** ☐ **In Person** ☐ **Home** ☐ **Community**

This form is provided as a tool to document the required monthly contact with each CDC+ consumer that you serve. You must contact the participant by phone or in person (whichever is their preference) to discuss your review. The consultant must visit the consumer in their home or community activity no less than once per six-month period. At least one face-to-face contact must be in the consumer's home. The documentation of home visits and monthly contacts must be in the consultant files for each consumer (pursuant to the 1915j State Plan Amendment).

	AREA TO BE REVIEWED	Consultant to Initial
1.	The _____statement and current approved Purchasing Plan was reviewed with the participant for the following:	
	• The monthly deposit is correct.	Y____ N____
	• Participant is spending within their monthly budget and consistent with all sections of the Purchasing Plan.	Y____ N____
	• The participant is maintaining an up-to-date account reconciliation.	Y____ N____
	• The participant is submitting claims in a timely manner (within 6 weeks).	Y____ N____
	• All of the participant's claims have cleared (none have pended).	Y____ N____
	• Services and supports purchased are consistent with the Purchasing Plan.	Y____ N____
	• Providers utilized are consistent with the Purchasing Plan.	Y____ N____
	• If the participant used an emergency back-up provider consistently (instead of or in addition to the primary), a revised Purchasing Plan is being developed to show the provider(s) as primary.	Y____ N____ N/A___
	• If use of emergency backup provider(s) resulted in 4 or more regular DHE's, participant purchased or provided proof of having purchased, Workers Compensation Insurance.	Y____ N____ N/A___
	• For items in the savings section, the participant is tracking these funds and will be able to purchase authorized items within the timeframe noted in the Purchasing Plan.	Y____ N____ N/A___
	If no to any of the above, I will:	
	1. Contact APD to initiate any possible adjustments	Y____ N____ N/A___
	2. Provide additional information, counseling, training, and assistance to address deficiencies	Y____ N____ N/A___
	3. Develop and implement a Corrective Action Plan (CAP) to address non-compliance with program requirements within 5 business days of this contact.	Y____ N____ N/A___
2.	If changes have occurred this month to the participant's waiver cost plan, I gave a copy of the new cost plan and Budget Calculation Worksheet to the participant and verified that they developed a Purchasing Plan Change, if needed.	Y____ N____ N/A___
3.	If a Purchasing Plan or Quick Update was submitted this month, the requested service(s) meet the participant's needs and goals reflected in their current Support Plan.	Y____ N____ N/A___
	• If no, I assisted the participant to make necessary revisions.	Y____ N____ N/A___

4.	Participant is currently on a CAP If yes, I have completed the monthly update for each item addressed on the CAP.	Y____ N____ Y____ N____ N/A___
5.	I have confirmed that all of the participant's information is correct in ABC (ACLM screens 1-5). I have submitted a request for changes that require a Participant Information Update form	Y____ N____ Y____ N____ N/A___
6.	The Participant is currently Medicaid eligible. I have addressed any Medicaid ineligibility issues **(please indicate below what steps were taken to address this issue)** The participant's redetermination date is _____, and I have assisted as needed.	Y____ N____ Y____ N____ N/A___ Y____ N____ N/A___
7.	**AT THE ANNUAL HOME VISIT**: Indicators of fraud, abuse, neglect, or exploitation were found. • If yes, I reported findings to the proper authorities within 24 hours of the visit.	Y____ N____ Y____ N____ N/A___
8.	The participant has disenrolled from CDC+ effective _____ **If yes, I have:** 1. Submitted the Participant Information Update form. 2. Ensured that the participant has traditional waiver services in place so that there will be no lapse in services.	N/A___ Y____ N____ N/A___ Y____ N____ N/A___

Detail All Problems/Concerns and follow-up needed:	Date and How Addressed: