DIVISION OF AGING ADULT DAY CARE/DAY HEALTH PROGRAMMATIC REVIEW, PARTICIPANT RECORD REVIEW AND UNIT VERIFICATION

Enter monitoring visit or review date(s) below:										
Enter the State Fiscal Year below being monitored:										
Enter the Monitor's Name, Job Title and organization below:										
Indicate the type of provider that is being monitored by checking the appropriate box below:										
☐ Community Service Provider (organization that contracts directly with AAA to receive the funding from the AAA and to directly provide a service)										
☐ Sub-contractor of a Community Service Provider (The Community Service Provider contracts with the AAA to receive the funding from the AAA, but does not directly provide a service. The Community Service Provider contracts with an organization that will directly provide a service. This organization that the Community Service Provider contracts with is referred to as the Sub-contractor).										
For Subcontractor Monitoring Only: If this tool is being completed by staff employed by a Community Service Provider and is being used to monitor a sub-contractor as defined above, the Community Service Provider staff attests that the sub-contractor requirements of the 308.2: Monitoring Plan of the AAA Policy and Procedure Manual were followed. YES NO NA										
Enter the name of the organization being monitored below:										
Indicate which services the organization being monitored receives HCCBG funding to provide by checking the appropriate box(es) below:										
☐ Adult Day Care☐ Adult Day Care Transportation☐ Adult Day Health☐ Adult Day Health										
Indicate which HCCBG funded services are being monitored with the completion of this monitoring tool by checking the appropriate box(es) below:										
Adult Day Care										
Adult Day Health Adult Day Health Transportation Indicate the type of monitoring by checking the appropriate box(es) below:										
☐ Programmatic Review ☐ Unit Verification										
Enter the Name(s) and Job Title(s) of the organization staff that were interviewed during this monitoring visit or acted as informant(s) during this review below:										
Indicate the program's current certification status that is providing the direct service by checking the appropriate boxes and entering date information below:										
The Adult Day Care/Day Health Care program is currently certified by the North Carolina Division of Aging. Yes \(\subseteq \text{No*} \subseteq *If No, Contact Glenda Artis or Terrie Deal at DA regarding next steps										
Dates of Current Certification: From (Month, Date & Year): To (Month, Date & Year):										
Current Certification: Full Certification Provisional Certification										

CLIENT RECORD REVIEW & UNIT VERIFICATION – ADULT DAY CARE - DAILY CARE (ARMS CODE 030)

* DSS-5027- only applicable for Departments of Social Services Records.

DATE(S) OF MONITORING **ORGANIZATION BEING MONITORED MONTH(S) AND YEAR REVIEWED DEFINITION OF FRAIL UNIT VERIFICATION** To Meet Frail Eligibility, the participant must: **ADC PARTICIPANT NAME DAAS-101 DAAS-5027*** Use the ZGA542 to select participant sample. Review each participant's service plan for HCCBG funded & scheduled 1). be age 60 or older and days of attendance. 2). have 2 or more ADL impairments OR a Cognitive Impairment **Cognitive Impairment HCCBG Funded** Service Registration & **ADL** Impairment **Verified Service** Unverified Registration Scheduled Day(s) of **Absences** Units **ADC PARTICIPANT NAME Registration Updates** Unite **Service Units** Age Reported Attendance Is the participant's Is the Enter HCCBG funded DAAS-101 complete? participant Does participant have a Was reimbursement Does participant have days of week that the Age 60 or cognitive impairment? requested for more Enter Enter ADL impairments? participant is scheduled to Enter date of most Is the participant's older? than 10 consecutive # of ADC Enter # of ADC attend the program listed DSS-5027* recent DAAS-101 If yes, Is the cognitive scheduled days of units # of ADC units unverified units If yes, Enter # of ADL on participant's service Complete? Enter impairment indicated on the absence? reported per verified to be adjusted in impairments listed on the Is the participant's DAAS participant's medical exam ZGA542 ARMS birthdate **DAAS-101** 101 reviewed & updated listed on the report? (e.g., M, T, TH) at least every 12 months? DAAS-101 Y N $Y \square N \square$ $Y \square N \square$ $Y \square N \square$ $Y \square N \square$ $Y \square N \square$ Date: Days: # of ADL's: Birthdate: 1 $Y \square N \square$ $Y \square N \square$ N/A 🗌 N/A \square N/A/Not Yet Due $Y \square N \square$ $Y \square N \square$ Days: Date: 2 # of ADL's: Birthdate: $Y \square N \square$ N/A 🗌 $Y \square N \square$ N/A N/A/Not Yet Due $Y \square N \square$ $Y \square N \square$ Date: 3 # of ADL's: Birthdate: Days: $Y \square N \square$ N/A 🗌 $Y \square N \square$ N/A \square N/A/Not Yet Due ☐ $Y \square N \square$ $Y \square N \square$ Date: # of ADL's: Days: 4 Birthdate: $Y \square N \square$ N/A 🗌 $Y \square N \square$ N/A \square N/A/Not Yet Due ☐ $Y \square N \square$ $Y \square N \square$ Date: 5 Birthdate: # of ADL's: Days: $Y \square N \square$ N/A \square N/A $Y \square N \square$ N/A/Not Yet Due $Y \square N \square$ $Y \square N \square$ Date: Days: # of ADL's: 6 Birthdate: $Y \square N \square$ N/A 🗌 $Y \square N \square$ N/A N/A/Not Yet Due $Y \square N \square$ $Y \square N \square$ \square Y \square N $Y \square N \square$ $Y \square N \square$ $Y \square N \square$ Date: Days: # of ADL's: 7 Birthdate: $Y \square N \square$ N/A 🗌 $Y \square N \square$ N/A 🗌 N/A/Not Yet Due $Y \square N \square$ $Y \square N \square$ Days: Date: 8 Birthdate: # of ADL's: $Y \square N \square$ N/A $Y \square N \square$ N/A \square N/A/Not Yet Due ☐ $Y \square N \square$ $Y \square N \square$ Days: Date: # of ADL's: 9 Birthdate: $Y \square N \square$ N/A 🗌 $Y \square N \square$ N/A N/A/Not Yet Due $Y \square N \square$ $Y \square N \square$ Days: Date: 10 Birthdate: # of ADL's: $Y \square N \square$ N/A 🗌 $Y \square N \square$ N/A N/A/Not Yet Due TOTAL UNITS NOT VERIFIED = % OF TOTAL UNITS FOR MONTH REVIEWED. If 10% or more, expand sample and select another month to THIS REPRESENTS Total units reported for all participants in month reviewed = review.

Monitor(s) Signature

Date

Page 2 of 8

DATE OF MONITORING

ORGANIZATION BEING MONITORED

MONTH(S) AND YEAR REVIEWED

	ADC TRANSPORTATION PARTICIPANT NAME	DAAS-101	DAAS-5027*	2). have	DEFINITION OF To Meet Frail Eligibility, the p 1). be age 60 or old 2 or more ADL impairments O	participant must: ler <u>and</u>	UNIT VERIFICATION Use the ZGA542 to select participant sample. Review participant's service plan for HCCBG funded & scheduled days of attendance. HCCBG funded ADH Transportation Units can only be reimbursed on days when participant's attendance at program was HCCBG funded. Compare # of units on the ZGA542 & # of HCCBG funded days participant attended program per attendance sheets to HCCBG funded & scheduled days of attendance on participant's service plan.							
#	ADC TRANSPORTATION PARTICIPANT NAME	Registration & Registration Updates	Registration	Age	ADL Impairment	Cognitive Impairment	HCCBG Funded Scheduled Day(s) of Attendance	Ride Provided to Participant Verification	Service Units Reported	Verified Service Units	Unverified Service Units			
#		Is participant's DAAS- 101 complete? Enter date of most recent DAAS-101 Is participant's DAAS- 101 updated at least every 12 months?	Is participant's DAAS-5027* complete?	Is the Participant Age 60 or older? Enter birthdate listed on the DAAS-101	Does the participant have ADL impairments? If yes, Enter # of ADL impairments listed on the DAAS-101	Does the participant have a cognitive impairment? If yes, Is the cognitive impairment indicated on the participant medical exam report?	Enter # of HCCBG funded days participant attended per attendance sheets	Enter source documentation used to verify rides (i.e., driver's log, vendor printout of pickups & drop offs or vendor's itemized monthly bill)	Enter # of ADC transportatio n units reported on ZGA542	Enter # of ADC transportation units verified	Enter # of ADC transportation units to be adjusted in ARMS			
1		Y	Y□N □ N/A □	Y∏N ☐ Birthdate:	Y☐ N☐ # of ADL's:	Y								
2		Y	Y□N □ N/A □	Y⊡N ⊡ Birthdate:	Y☐ N☐ # of ADL's:	Y□ N□ Y□ N□								
3		Y	Y□N □ N/A □	Y∏N ∏ Birthdate:	Y☐ N☐ # of ADL's:	Y								
4		Y	Y□N □ N/A □	Y∐N ☐ Birthdate:	Y☐ N☐ # of ADL's:	Y								
5		Y	Y	Y∏N ☐ Birthdate:	Y☐ N☐ # of ADL's:	Y□ N□ Y□ N□								
6		Y	Y□N □ N/A □	Y∭N ∭ Birthdate:	Y∏ N∏ # of ADL's:	Y□ N□ Y□ N□								
7		Y	Y□N □ N/A □	Y∭N ∭ Birthdate:	Y∏ N∏ # of ADL's:	Y□ N□ Y□ N□								
8		Y	Y□N □ N/A □	Y∐N ☐ Birthdate:	Y☐ N☐ # of ADL's:	Y□ N□ Y□ N□								
9		Y	Y	Y∐N ∐ Birthdate:	Y☐ N☐ # of ADL's:	Y□ N□ Y□ N□								
10		Y	Y□N □ N/A □	Y⊡N □ Birthdate:	Y N N H of ADL's:	Y□ N□ Y□ N□								

^{* &}lt;u>DSS-5027</u>- only applicable for Departments of Social Services Records. Monitor(s) Signature _

PARTICIPANT RECORD REVIEW & UNIT VERIFICATION - ADULT DAY HEALTH - DAILY CARE (ARMS CODE 155)

DATE OF MONITORING **ORGANIZATION BEING MONITORED** MONTH(S) AND YEAR REVIEWED DEFINITION OF FRAIL
To Meet Frail Eligibility, the participant must: **ADDITIONAL ADH ELIGIBILITY UNIT VERIFICATION** ANH PARTICIPANT NAME

	ADH PARTICIPANT NAME	DAAS-101	& DAAS-5027*	1). be age 60 or older <u>and</u> 2). have 2 or more ADL impairments OR a Cognitive Impairment			Must have one of the be ADH eligible	below documented to	Use the ZGA542 to select participant sample. Review participant's service plan for HCCBG funded & scheduled days of attendance.				
#	ADH PARTICIPANT NAME	Registration & Registration Updates	Registration	Age	ADL Impairments	Cognitive Impairment	Medical Monitoring	Special Services	HCCBG Funded Scheduled Day(s) of Attendance	Absences	Service Units Reported	Verified Service Units	Unverified Service Units
		Is the participant's DAAS-101 complete? Enter date of most recent DAAS-101 Is the participant's DAAS-101 updated at least every 12 months?	Is the participant's DAAS-5027* complete?	Is the participant Age 60 or older? Enter birthdate listed on the DAAS-101	Does the participant have ADL impairments? If yes, Enter # of ADL impairments listed on the DAAS-101	Does the participant have a cognitive impairment? If yes, Is the cognitive impairment indicated on participant medical exam report?	Does the participant receive monitoring of a medical condition? Enter Documentation Reviewed	Enter 1,2, or 3 based on which is provided to the participant: 1. Administration of Medication, 2. Special feedings, or 3. Provision of other treatment or services related to health care needs Enter Documentation Reviewed	Enter HCCBG funded days of week that participant is scheduled to attend listed on participant's service plan (e.g., M, T, TH)	Was reimbursement requested for more than 10 consecutive scheduled days of absence?	Enter # of ADH units reported per ZGA542	Enter # of ADH units verified	Enter # of ADH unverified units to be adjusted in ARMS
1		Y□N □ Date: Y□N □ N/A/Not Yet Due□	Y□N□ N/A □	Y∐ N∐ Birthdate:	Y□ N□ # of ADL's :	Y	Y∏N ☐ Documentation Reviewed:	Service Provided Documentation Reviewed	Days:	Y□ N□ N/A □			
2		Y□N □ Date: Y□N □ N/A/Not Yet Due□	Y□N□ N/A □	☐ Y☐ N Birthdate:	Y□ N□ # of ADL's:	Y	Y∏N ☐ Documentation Reviewed:	Service Provided Documentation Reviewed	Days:	Y□ N□ N/A □			
3		Y□N □ Date: Y□N □ N/A/Not Yet Due□	Y	Y∐ N∐ Birthdate:	Y□ N□ # of ADL's :	Y	Y∏N ∏ Documentation Reviewed:	Service Provided Documentation Reviewed	Days:	Y□ N□ N/A □			
4		Y□N □ Date: Y□N □ N/A/Not Yet Due□	Y	Y∐ N∐ Birthdate:	Y□ N□ # of ADL's :	Y	Y∏N ∏ Documentation Reviewed:	Service Provided Documentation Reviewed	Days:	Y			
5		Y□N □ Date: Y□N □ N/A/Not Yet Due□	Y□N□ N/A □	Y□ N□ Birthdate:	Y□ N□ # of ADL's :	Y	Y∏N ☐ Documentation Reviewed:	Service Provided Documentation Reviewed	Days:	Y			

PARTICIPANT RECORD REVIEW & UNIT VERIFICATION - ADULT DAY HEALTH - DAILY CARE (ARMS CODE 155) DEFINITION OF FRAIL

To Meet Frail Eligibility, the participant must: 1). be age 60 or older and ADDITIONAL ADH ELIGIBILITY
Must have one of the below documented to **UNIT VERIFICATION** ADH PARTICIPANT NAME **DAAS-101** & DAAS-5027* Use the ZGA542 to select participant sample. Review participant's service plan for HCCBG

				2). have 2 or more ADL impairments OR a Cognitive be ADH eligible			be ADH eligible	funded & scheduled days of attendance.					
#	ADH PARTICIPANT NAME	Registration & Registration Updates	Registration	Age	ADL Impairments	Cognitive Impairment	Medical Monitoring	Special Services	HCCBG Funded Scheduled Day(s) of Attendance	Absences	Service Units Reported	Verified Service Units	Unverified Service Units
		Is the participant's DAAS-101 complete? Enter date of most recent DAAS-101 Is the participant's DAAS-101 updated at least every 12 months?	Is the participant's DAAS-5027* complete?	Is the participant Age 60 or older? Enter birthdate listed on the DAAS-101	Does the participant have ADL impairments? If yes, Enter # of ADL impairments listed on the DAAS-101	Does the participant have a cognitive impairment? If yes, Is the cognitive impairment indicated on participant medical exam report?	Does the participant receive monitoring of a medical condition? Enter Documentation Reviewed	Enter 1,2, or 3 based on which is provided to the participant: 1. Administration of Medication, 2. Special feedings, or 3. Provision of other treatment or services related to health care needs Enter Documentation Reviewed	Enter HCCBG funded days of week that participant is scheduled to attend listed on participant's service plan (e.g., M, T, TH)	Was reimbursement requested for more than 10 consecutive scheduled days of absence?	Enter # of ADH units reported per ZGA542	Enter # of ADH units verified	Enter # of ADH unverified units to be adjusted in ARMS
6		Y	Y□N □ N/A □	Y∐ N∐ Birthdate:	Y□ N□ # of ADL's :	Y□ N□ Y□ N□	Y∐N ☐ Documentation Reviewed:	Service Provided Documentation Reviewed	Days:	Y□ N□ N/A □			
7		Y□N □ Date: Y⊡N □ N/A/Not Yet Due□	Y□N □ N/A □	Y∐ N∐ Birthdate:	Y□ N□ # of ADL's :	Y N	Y∐N ☐ Documentation Reviewed:	Service Provided Documentation Reviewed	Days:	Y□ N□ N/A □			
8		Y□N □ Date: Y□N □ N/A/Not Yet Due□	Y□N □ N/A □	Y∐ N∐ Birthdate:	Y□ N□ # of ADL's :	Y N Y N	Y∐N ☐ Documentation Reviewed:	Service Provided Documentation Reviewed	Days:	Y□ N□ N/A □			
9		Y□N □ Date: Y□N □ N/A/Not Yet Due□	Y□N □ N/A □	Y∏ N∏ Birthdate:	Y□ N□ # of ADL's :	Y N	Y∏N ☐ Documentation Reviewed:	Service Provided Documentation Reviewed	Days:	Y□ N□ N/A □			
10		Y N Date: YN N NA/Not Yet Due	Y	Y∏ N∏ Birthdate:	Y□ N□ # of ADL's :	Y N Y N	Y∐N ☐ Documentation Reviewed:	Service Provided Documentation Reviewed	Days:	Y□ N□ N/A □			
	·	d for all participants in mo					THIS REPRESENT and select another	S % OF TOTA	AL UNITS REPORT	ED FOR THE M	ONTH REVIEWE). If 10% or more,	expand sample
* DSS-5027-	only applicable for Departments of Social Serv	ices Records. Monito	r(s) Signature			•			Date				

PARTICIPANT RECORD REVIEW & UNIT VERIFICATION - ADULT DAY HEALTH - TRANSPORTATION (ARMS CODE 156)

DATE OF MONITORING ORGANIZATION BEING MONITORED MONTH(S) AND YEAR REVIEWED

	DATE OF MONITORING ORGANIZATION BEING MONITORED									MONTH(S) AND YEAR REVIEWED						
	ADH PARTICIPANT NAME	DAAS-101 & DAAS-5027*	DAAS-5027*	To Meet Frail Elig or older, have	NITION OF FR ibility, Participant either 2 ADL Impa gnitive Impairme	must be age 60 irments OR a	_	ADH ELIGIBILITY to be below documented to	UNIT VERIFICATION Use the ZGA542 to select participant sample. Review participant's service plan for HCCBG funded & scheduled days of attendance. HCCBG funded ADH Transportation Units can only be reimbursed on days when participant's attendance at program was HCCBG funded. Compare # of units on the ZGA542 & # of HCCBG funded days participant attended program per attendance sheets to HCCBG funded & scheduled days of attendance on participant's service plan.							
#	ADH PARTICIPANT NAME	Registration & Registration Updates	Registration	Age	ADL Impairments	Cognitive Impairment	Medical Monitoring	Special Services	HCCBG Funded Scheduled Day(s) of Attendance	Ride Provided to Participant Verification	Service Units Reported		Unverified Service Units			
		Is participant's DAAS- 101 complete? Enter date of most recent DAAS-101 Is participant's DAAS-101 updated at least every 12 months?	Is participant's DAAS-5027* complete?	Is the participant Age 60 or older? Enter birthdate listed on the DAAS-101	Does the participant have ADL impairments? Enter # of ADL impairments listed on the DAAS-101	Does the participant have a cognitive impairment? Is the cognitive impairment indicated on participant medical exam report?	Does the participant receive monitoring of a medical condition? Enter Documentation Reviewed	Enter 1,2, or 3 based on Which is provided: 1. Administration of Medication, 2. Special feedings, or 3. Provision of other treatment or services related to health care needs	Enter # of HCCBG funded days participant attended per attendance sheets	Enter source documentation used to verify rides (i.e., driver's log, vendor printout of pickups & drop offs or vendor's itemized monthly bill)	Enter # of ADH transportation units reported	Enter # of ADH transportation units verified	Enter # of ADH transportation units to be adjusted in ARMS			
								Enter Documentation Reviewed								
1		Y ☐ N ☐ Date: Y☐N ☐ N/A/Not Yet Due ☐	Y	Y□ N□ Birthdate:	Y□ N□ # of ADL's :	Y N N N	Y∏N ☐ Documentation Reviewed:	Service Provided Documentation Reviewed								
2		Y	Y□N □ N/A □	Y∏ N∏ Birthdate:	Y□ N□ # of ADL's :	Y	Y∐N ☐ Documentation Reviewed:	Service Provided Documentation Reviewed								
3		Y ☐ N ☐ Date: Y☐N ☐ N/A/Not Yet Due ☐	Y□N □ N/A □	Y∏ N∏ Birthdate:	Y□ N□ # of ADL's :	Y N N N	Y∏N ☐ Documentation Reviewed:	Service Provided Documentation Reviewed								
4		Y N N Date: Y N N N	Y	Y□ N□ Birthdate:	Y□ N□ # of ADL's :	Y N N N	Y∏N ☐ Documentation Reviewed:	Service Provided Documentation Reviewed								
5		Y ☐ N ☐ Date: Y☐N ☐ N/A/Not Yet Due ☐	Y	Y□ N□ Birthdate:	Y□ N□ # of ADL's :	Y N N N	Y∐N ☐ Documentation Reviewed:	Service Provided Documentation Reviewed								

Monitor(s) Signature	Da
MONITORS) Signature	Da

		DAAS-101 &	DAAS-5027*	To Meet Frail Elig or older, have	NITION OF FR ibility, Participant either 2 ADL Impa gnitive Impairmen	must be age 60 irments OR a		ADH ELIGIBILITY e below documented to	UNIT VERIFICATION Use the ZGA542 to select participant sample. Review participant's service plan for HCCBG funded & scheduled days of attendance. HCCBG funded ADH Transportation Units can only be reimbursed on days when participant's attendance at program was HCCBG funded. Compare # of units on the ZGA542 & # of HCCBG funded days participant attended program per attendance sheets to HCCBG funded & scheduled days of attendance on participant's service plan.					
#	ADH PARTICIPANT NAME	Registration & Registration Updates	Registration	Age	ADL Impairments	Cognitive Impairment	Medical Monitoring	Special Services	HCCBG Funded Scheduled Day(s) of Attendance	Ride Provided to Participant Verification	Service Units Reported	Verified Service Units	Unverified Service Units	
		Is participant's DAAS- 101 complete? Enter date of most recent DAAS-101 Is participant's DAAS- 101 updated at least every 12 months?	Is participant's DAAS-5027* complete?	Is the participant Age 60 or older? Enter birthdate listed on the DAAS-101	Does the participant have ADL impairments? Enter # of ADL impairments listed on the DAAS-101	Does the participant have a cognitive impairment? Is the cognitive impairment indicated on participant medical exam report?	Does the participant receive monitoring of a medical condition? Enter Documentation Reviewed	Enter 1,2, or 3 based on Which is provided: 1. Administration of Medication, 2. Special feedings, or 3. Provision of other treatment or services related to health care needs Enter Documentation Reviewed	Enter # of days of attendance indicated on attendance sheets	Enter source documentation used to verify rides (i.e., driver's log, vendor printout of pickups & drop offs or vendor's itemized monthly bill)	Enter # of ADH transportation units reported	Enter # of ADH transportation units verified	Enter # ofADH transportation units to be adjusted in ARMS	
6		Y	Y□N □ N/A □	Y∏ N∏ Birthdate:	Y□ N□ # of ADL's :	Y	Y∐N ☐ Documentation Reviewed:	Service Provided Documentation Reviewed						
7		Y	Y□N □ N/A □	Y∏ N∏ Birthdate:	Y□ N□ # of ADL's :	Y N	Y∐N ☐ Documentation Reviewed:	Service Provided Documentation Reviewed						
8		Y	Y□N □ N/A □	Y∏ N∏ Birthdate:	Y□ N□ # of ADL's :	Y N	Y∐N ☐ Documentation Reviewed:	Service Provided Documentation Reviewed						
9		Y	Y□N □ N/A □	Y∏ N∏ Birthdate:	Y□ N□ # of ADL's :	Y	Y∐N ☐ Documentation Reviewed:	Service Provided Documentation Reviewed						
10		Y	Y	Y∏ N∏ Birthdate:	Y□ N□ # of ADL's :	Y N Y N	Y∐N ☐ Documentation Reviewed:	Service Provided Documentation Reviewed						
	TS NOT VERIFIED = reported for all participants in month rev							THIS REPRE REVIEWED. If 10% or mo	SENTS % re, expand samp		JNITS REPORT		MONTH	

TOTAL UNITS NOT VERIF Total units reported for all բ		iewed =					THIS REPRE REVIEWED. If 10% or mo		UNITS REPORtains	JONTH
* <u>DSS-5027</u> - only applicable fo	r Departments of Social Ser	vices Records.	Мо	onitor(s) Signati	re				Date	

DIVISION OF AGING PARTICIPANT RECORD REVIEW & UNIT VERIFICATION

Your comment and/or note section:

e.g., any corrections needed, what documentation were reviewed, any TA provided, any follow-up needed. Please provide an explanation below if you answered n/a, no or left an answer blank: