|  |  |
| --- | --- |
| 1 | **Instructions for both CARES and HCCBG monitoring:**   * These instructions apply to all FY 2021 programmatic monitoring and/or unit verifications for adult day services. * Complete this introductory section for all monitoring. * Complete the attached 4 client review and unit verification worksheets per Exhibit 14 and COVID Exhibit 14 monitoring plans, as modified by allowable flexibilities (see row 7 for additional guidance).   + Adult Day Care Daily Care monitoring – complete page 3 if appropriate to funding source.   + Adult Day Care Transportation monitoring – complete page 4 if appropriate to funding source.   + Adult Day Health Daily Care monitoring – complete page 5 if appropriate to funding source.   + Adult Day Health Transportation monitoring – complete page 6 if appropriate to funding source. * For each worksheet, insert the service code in the column next to the participant’s name to indicate the CARES funding source for units of service. * Attach copies of the ZGA-542 Units of Service Verification reports from which client samples were drawn. * As part of the special flexibilities allowed for FY21 monitoring during the pandemic, the required client sample for CARES monitoring may be divided proportionally between allocations for like services. For Adult Day Services, the required client sample may be split between Adult Day Care (CARES code 930) and Adult Day Health (CARES code 955).  For Adult Day Services Transportation, the required sample may be split between ADC Transportation (CARES code 931) and ADH Transportation (CARES code 956). See row 7 for additional guidance. |
| 2 | **Enter monitoring visit or review date(s):** |
| 3 | **Enter the State Fiscal Year being monitored:** |
| 4 | **Enter the monitor’s name, job title, and organization:** |
| 5 | **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)*  Subcontractor 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 Subcontractor).*  **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 subcontractor as defined above, the Community Service Provider staff attests that the sub-contractor requirements in Sec. 308.2: Monitoring Plan of the AAA Policy & Procedure Manual were followed.  YES  NO  N/A |
| 6 | **Enter the name of the organization being monitored below:** |
| 7 | **Check √ which funding source(s) and services are being monitored using this tool:**  **HCCBG:**  030 (ADC)  155 (ADH)  031 (ADC Trans)  156 (ADH Trans)  Per FY21 monitoring flexibilities, unit verifications are waived for HCCBG services. Complete this introductory section for high risk only, including documentation of certification status in row 10 below. For Adult Day Services, certification represents the programmatic review process by which a determination is made that a provider has met all the specifications for program operations and service delivery.  **CARES:**  930 (CARES-ADC)  955 (CARES-ADH)  931 (CARES-ADC Trans)  956 (CARES-ADH Trans)  Complete this introductory chart for all levels of risk being monitored. Complete the appropriate worksheet(s) for record reviews and unit verifications.  **CARES NON-UNIT COVID:**  932 (CARES-ADC)  957 (CARES-ADH)  933 (CARES-ADC Trans)  958 (CARES-ADH Trans)  Complete the separate worksheet posted for FY21 ADC-ADH CARES Non-Unit Fiscal Verification. |
| 8 | **The provider attests that use of CARES Act funding was for pandemic recovery and future emergency preparedness of this service.**  YES  NO  N/A |
| 9 | **The provider attests that use of CARES Act funding for daily care billing and reimbursements complies with the requirements of Administrative Letters No. 20-05, 20-12, and 20-20.**  YES  NO  N/A |
| 10 | **Indicate the current certification status of the program 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 and Adult Services. Yes  No\*  *\*If no, contact Glenda Artis or Heather Carter at DAAS regarding next steps.*  Dates of Current Certification: From (Month, Date & Year):       To (Month, Date & Year):  Current Certification:  Full Certification  Provisional Certification |
| 11 | **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:** |

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | **ADC PARTICIPANT NAME** | | **Service**  **Code** | **DAAS-101** | **DAAS-5027\*** | | **DEFINITION OF FRAIL**  ***To Meet Frail Eligibility, the participant must: 1) be age 60 or older and 2) have 2 or more ADL impairments OR a Cognitive Impairment*** | | | **UNIT VERIFICATION**  ***Use the ZGA542 to select participant sample. Review each participant’s service plan for HCCBG funded & scheduled days of attendance.*** | | | | |
| **#** | **ADC PARTICIPANT NAME** | |  | **Registration & Registration Updates** | **Registration** | | **Age** | **ADL Impairment** | **Cognitive Impairment** | **HCCBG Funded & Scheduled Day(s) of Attendance** | **Daily Well Checks** | **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 reviewed & updated at least every 12 months? | Is the participant’s DSS-5027\* complete? | | Is the participant Age 60 or older?  Enter birthdate listed on the DAAS-101 | Does participant have ADL impairments?  If yes, enter # of ADL impairments listed on the DAAS-101 | Does participant have a cognitive impairment?  If yes, is the cognitive impairment indicated on the participant’s medical exam report? | Enter HCCBG funded days of week that the participant is scheduled to attend the program as listed on participant’s service plan per DAAS Admin Letters 20-05, 20-12, 20-20  (e.g., M, T, TH) | Were daily well check calls performed as required?  If no, Explain | Enter  # of ADC units reported per ZGA542 | Enter  # of ADC units verified | Enter  # of ADC 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  N  Y  N | Days (as of 3-10-20)  If applicable  Days: (as of 10-1-20) | Y  N |  |  |  |
| 2 | |  |  | 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 | Days: (as of 3-10-20)  If applicable  Days: (as of 10-1-20) | Y  N |  |  |  |
| 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  Y  N | Days: (as of 3-10-20)  If applicable  Days: (as of 10-1-20) | Y  N |  |  |  |
| 4 | |  |  | 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 | Days: (as of 3-10-20)  If applicable  Days: (as of 10-1-20) | Y  N |  |  |  |
| TOTAL UNITS NOT VERIFIED =  Total units reported for all participants in month reviewed = | | | | | | THIS REPRESENTS      % OF TOTAL UNITS FOR MONTH REVIEWED. If 10% or more, expand sample & select another month to review. | | | | | | | | |

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

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|  | **ADC PARTICIPANT NAME** | | **Service**  **Code** | **DAAS-101** | **DAAS-5027\*** | | **DEFINITION OF FRAIL**  ***To Meet Frail Eligibility, the participant must: 1) be age 60 or older and 2) have 2 or more ADL impairments OR a Cognitive Impairment*** | | | **UNIT VERIFICATION**  ***Use the ZGA542 to select participant sample. Review participant’s service plan for HCCBG funded & scheduled days of attendance. HCCBG funded ADC 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 PARTICIPANT NAME** | |  | **Registration & Registration Updates** | **Registration** | | **Age** | **ADL Impairment** | **Cognitive Impairment** | **HCCBG Funded & Scheduled Day(s) of Attendance** | **Rides Provided to Participant Verification** | **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 reviewed & updated at least every 12 months? | Is the participant’s DSS-5027\* complete? | | Is the participant age 60 or older?  Enter birthdate listed on the DAAS-101 | Does participant have ADL impairments?  If yes, Enter # of ADL impairments listed on the DAAS-101 | Does participant have a cognitive impairment?  If yes, Is the cognitive impairment indicated on the participant’s medical exam report? | Enter # of HCCBG funded days participant attended per attendance sheets | Enter source documentation used to verify rides (e.g., driver’s log, vendor printout of pick-ups & drop offs, or vendor’s itemized monthly bill) | Enter  # of ADC trans units reported on ZGA542 | Enter  # of ADC trans units verified | Enter  # of ADC 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  N  Y  N |  |  |  |  |  |
| 2 | |  |  | 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 |  |  |  |  |  |
| 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  Y  N |  |  |  |  |  |
| 4 | |  |  | 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 |  |  |  |  |  |
| TOTAL UNITS NOT VERIFIED =  Total units reported for all participants in month reviewed = | | | | | | THIS REPRESENTS      % OF TOTAL UNITS FOR MONTH REVIEWED. If 10% or more, expand sample & select another month to review. | | | | | | | | | |

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

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|  | | **ADH PARTICIPANT NAME** | | **Service Code** | | **DAAS-101** | | **DAAS-5027\*** | | **DEFINITION OF FRAIL**  ***To Meet Frail Eligibility, Participant must be age 60 or older, have either 2 ADL Impairments OR a Cognitive Impairment*** | | | | **ADDITIONAL ADH ELIGIBILITY**  ***Must have one of the below documented to be ADH eligible*** | | | **UNIT VERIFICATION**  ***Use the ZGA542 to select participant sample. Review participant’s service plan for HCCBG funded & scheduled days of attendance.*** | | | | | |
| **#** | |  | |  | | **Registration & Registration Updates** | | **Registration** | | **Age** | **ADL Impairments** | **Cognitive Impairment** | | **Medical Monitoring** | **Special Services** | | **HCCBG Funded & Scheduled Day(s) of Attendance** | **Daily Well Checks** | **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 reviewed & 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?  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 service is provided to the participant:  1. Administration of medication, 2. Special feedings, or 3. Provision of other treatment or services related to health careneeds.  Enter documentation reviewed. | | Enter HCCBG funded days of week that the participant is scheduled to attend the program as listed on participant’s service plan per DAAS Admin Letters 20-05, 20-12, 20-20 (e.g., M, T, TH). | Were daily well check calls performed as required?  If no, explain. | 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  N  Y  N | | Y  N  Documentation Reviewed: | Service Provided:  Documentation Reviewed: | | Days: (as of  3-10-20)  If applicable  Days: (as of  10-1-20) | Y  N |  |  |  | |
| 2 | |  | |  | | 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: (as of  3-10-20)  If applicable  Days: (as of  10-1-20) | Y  N |  |  |  | |
| 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  Y  N | | Y  N  Documentation Reviewed: | Service Provided:  Documentation Reviewed: | | Days: (as of  3-10-20)  If applicable  Days: (as of  10-1-20) | Y  N |  |  |  | |
| 4 | |  | |  | | 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: (as of  3-10-20)  If applicable  Days: (as of  10-1-20) | Y  N |  |  |  | |

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

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|  | | **ADH PARTICIPANT NAME** | | **Service Code** | | **DAAS-101** | | **DAAS-5027\*** | | **DEFINITION OF FRAIL**  ***To meet frail eligibility, participant must be age 60 or older, have either 2 ADL impairments OR a cognitive impairment*** | | | | **ADDITIONAL ADH ELIGIBILITY**  ***Must have one of the below documented to be ADH eligible*** | | | **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 and # of HCCBG funded days participant attended program per attendance sheets to HCCBG funded & scheduled days of attendance on participant’s service plan.*** | | | | | |
| **#** | |  | |  | | **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 careneeds  Enter documentation reviewed | | Enter # of HCCBG funded days participant attended per attendance sheets | Enter source documentation used to verify rides (e.g., driver’s log, vendor printout of pick-ups & drop offs, or vendor’s itemized monthly bill) | Enter # of ADH trans units reported | Enter # of ADH trans units verified | Enter # of ADH trans 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  N  Y  N | | Y  N  Documentation Reviewed: | Service Provided:  Documentation Reviewed: | |  |  |  |  |  | |
| 2 | |  | |  | | 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: | |  |  |  |  |  | |
| 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  Y  N | | Y  N  Documentation Reviewed: | Service Provided:  Documentation Reviewed: | |  |  |  |  |  | |
| 4 | |  | |  | | 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: | |  |  |  |  |  | |

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