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| cid:image002.jpg@01DA9C9B.873348C0 | **Policies & Procedures Checklist for Agency Use** |

Used by Medicaid/DDD approved agencies (Service Providers and Support Coordination Agencies) to confirm that expected elements of

required policies and procedures exist, are reviewed at least annually, and are updated as needed.

**11.1 Policies & Procedures Manual**

All approved agencies must develop, maintain, implement, and be able to produce for Division review at any time, a Policies & Procedures Manual governing their organization. These policies and procedures shall be designed in accordance with the DDD policy manuals and applicable Division Circulars.

Policies & Procedures should be internally consistent, include procedures that are specific, detailed, and include assignment of responsibilities, timeframes and other important details. They should be easy for staff members to read, understand and follow. Policies & Procedures should be reviewed at least annually and updated as needed to reflect current state and federal requirements.

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| **Agency Information** |
| Agency Name: Enter text.Contact Name: Enter text.Contact Email Address: Enter text. | New DDD Agency Submission Date:Enter a date.DDD Reviewer: Enter text. |

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| **General Guidelines**  | **Expectations****Met** | **Comments** |
| Agency Name/Title Page included | [ ]  Yes [ ]  No  | Enter text. |
| Policies include effective and review/revision dates  | [ ]  Yes [ ]  No  | Enter text. |
| Table of Contents | [ ]  Yes [ ]  No  | Enter text. |
| Pages are numbered | [ ]  Yes [ ]  No  | Enter text. |
| Policies include sequential numbering system | [ ]  Yes [ ]  No  | Enter text. |
| Policies include a descriptive title unique to permit easy reference and retrieval. | [ ]  Yes [ ]  No  | Enter text. |
| Policies include a purpose statement.  | [ ]  Yes [ ]  No  | Enter text. |
| Procedures include sequential steps, identify staff responsible for each step and identify timeframes for each step to be completed.  | [ ]  Yes [ ]  No  | Enter text. |

[Appendix S - Quick Guide to Required Content Areas for Provider Policy and Procedures Manuals](https://www.nj.gov/humanservices/ddd/assets/documents/community-care-program-policy-manual.pdf#page=234) of the DDD policy manuals provides a listing of content areas required of the agency based on the services the agency is Medicaid/DDD approved to provide. Agencies approved for multiple services must ensure their P&P Manual includes the required areas for any approved services.

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| **Required Policies and Expected Components**  | **Requirements****Met** | **Comments** |
| **Organizational Governance****Effective Date** Enter a date.**Reviewed/Revised** Enter a date.**Compliance Date/DDD Staff Initials:** Enter text. | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Introduces the agency’s mission/vision statement.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Identifies the Governing Authority and outlines responsibilities.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Includes a Table of Organization and Job Descriptions for all titles, including volunteers/interns and other unpaid staff.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Outlines procedures to demonstrate compliance with all legislation and regulations of corporate governance and financial practices as prescribed by the agency’s corporate designation (profit, non-profit).
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Outlines agency operations and oversight in such a manner as will ensure effective and ethical management and conflict free operations.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Addresses the requirement that all board members’/stock holders’ names, affiliations, and any potential conflicts of interest be disclosed and made publicly available if requested.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes public availability of board member names, if applicable, on the organization’s website.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| **Personnel** **Effective Date** Enter a date.**Reviewed/Revised** Enter a date.**Compliance Date/DDD Staff Initials:** Enter text. | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| **General Requirements** | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. For Service Providers, indicates method of informing the Division of changes to the Agency Head so the Division’s Provider Enrollment Unit can complete required background checks.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. For SCAs, indicates methods of informing the Division of all staff changes (new hires, terminations, and promotions) and updating internal processes, if required.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. If volunteers/interns are utilized within the agency, it must be outlined. A separate policy regarding volunteers/interns is recommended and should describe how and how often volunteers/interns will be used, vetted, trained and supervised.
 | [ ]  Yes [ ]  Partially [ ]  No  [ ]  N/A   | Enter text. |
| **Education & Experience Requirements** | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes method of verification of staff qualifications and who is responsible.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Identifies staff (by title) responsible to implement and perform the verifications and approvals.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes means of maintaining personnel records, and the list of records that are maintained.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |

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| **Background Check Requirements**  | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes method of verification of initial and ongoing checks and who is responsible for each of the following:
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Fingerprint check (Federal & State) at the time of hire (copy of CHRI Clearance letter available through the Fingerprint Approval Retrieval Application (FARA) portal.)
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Fingerprint archive (every two years) (copy of CHRI Clearance letter available through the Fingerprint Approval Retrieval Application (FARA) portal.)
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Central Registry Status at the time of hire (Completed Employee/Volunteer Consent for Employers to Check Form) and on-going every time a DHS notification of addition to the registry is received. Note: Because the agency does not receive documentation when the Central Registry is checked, the agency must determine its own system of documenting on-going checks. Documentation to be kept on hand must include the date of review, who completed the review and results of the review.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Child Abuse Record Info (CARI)- Per [OPIA Bulletin - Updated Employee Onboarding Requirements - 4.1.24](https://www.nj.gov/humanservices/staff/opia/OPIA%20Bulletin-%20Resume%20Onboarding%20%2004.01.24.pdf), all new employees’ completed CARI applications shall be submitted within 10 days of hire. Employees may work without restrictions while the CARI check is conducted.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Drug Testing (Providers – Upon hire, random and for cause.)
 | [ ]  Yes [ ]  Partially [ ]  No [ ]  NA  | Enter text. |
| 1. Exclusionary Checks - Upon hire and monthly (per Appendix I of DDD policy manuals)
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| * + 1. State of NJ Debarment
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| * + 1. NJ Treasury Exclusion
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| * + 1. Federal Exclusions Database
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| * + 1. NJ Division of Consumer Affairs
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| * + 1. Dept. of Health
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| g. Drivers Abstract (If applicable) | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes how all background check records will be filed and maintained.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| **Staff Training & Professional Development** | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Identifies staff (by title) responsible for oversight of training process of all staff inclusive of specifics and timeframes to provide necessary orientation/training and the timeframes.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Identifies staff (by title) responsible for providing necessary orientation/training and the timeframes.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes documentation and storage methods in staff personnel records.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Identifies required trainings and their time frames in compliance with DDD policy manuals Appendix E.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Acknowledges need to identify at least two College of Direct Support (CDS) administrators.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| **Admission (Service Providers)****Effective Date** Enter a date.**Reviewed/Revised** Enter a date.**Compliance Date/DDD Staff Initials:** Enter text. | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes criteria for admission to include time frames and who is responsible for each of the following:
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| * 1. Pre-admission (will there be a tour?)
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| * 1. Outline criteria for acceptance
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Communication of determination to prospective individual/family/guardian.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Appeal process / grievance procedure
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Waiting list process for admissions
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Method to establish level of supervision
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Identification of items (policies, procedures, agency handbook, documents, etc.) to be reviewed and provided to the individual/family/guardian.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. A detailed process and orientation of new individuals to the agency.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| **Admission (Support Coordination Agencies)****Effective Date** Enter a date.**Reviewed/Revised** Enter a date.**Compliance Date/DDD Staff Initials:** Enter text. | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes criteria for admission (enrollment) into the agency. (i.e. DDD eligible, Medicaid Eligible, etc.) timeframes and includes who is responsible for each of the following:
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes criteria for determining when to open agency capacity and county capacity.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Includes the timeframe for the SCA to identify/assign a SC.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Includes the timeframe when contact needs to be made with the individual/family/legal guardian after assignment.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Ensures the individual has access to or is provided a copy of the DDD policy manuals.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Establishes timeframe for informing the individual/family about the Participant Enrollment Agreement and obtaining a signed copy from the individual/guardian.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Outlines a detailed planning process and orientation of new individuals to the agency.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. The policy indicates that the agency will serve all individuals that meet the requirements for support coordination.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| **Suspension (Service Providers) –** Residential Providers and Support Coordination Agencies are not required to have a suspension policy, as Residential Providers cannot suspend individuals from residential sites and suspensions do not occur with SCAs.**Effective Date** Enter a date.**Reviewed/Revised** Enter a date.**Compliance Date/DDD Staff Initials:** Enter text. | [ ]  Yes [ ]  Partially [ ]  No [ ]  N/A  | Enter text. |
| 1. Describes process for making determination, the time frames and who is responsible for each of the following:
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| * 1. Reasons for suspension (examples)
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| * 1. Warning Process
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| * 1. Notification of suspension
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| * 1. Timeline to return to services
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| * 1. Appeal process
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| **Discharge (Service Providers)****Effective Date** Enter a date.**Reviewed/Revised** Enter a date.**Compliance Date/DDD Staff Initials:** Enter text. | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes process for making determinations, list timeframes and title of position responsible for each step.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| * 1. Involuntary Discharge
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Process for making determination
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Reasons for discharge (examples)
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. IDT meeting
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Communication/notification including signature
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Documentation of process
	* 1. (Discharge from residential setting if applicable)
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Appeal Process
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Readmission to program, if applicable
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| * 1. Voluntary Discharge
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Notification to agency (including timeframes)
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Roles and Responsibilities
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Process to return to services
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| **Discharge (Support Coordination Agencies)****Effective Date** Enter a date.**Reviewed/Revised** Enter a date.**Compliance Date/DDD Staff Initials:** Enter text. | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Policy includes that the agency may not discharge individuals from their Support Coordination Agency roster.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Outlines an internal process, time lines and staff responsible to assist individuals who are being discharged from DDD for any of the following:
2. They no longer meet the functional criteria necessary to be eligible for the Division.
3. They choose to no longer receive services from the Division.
4. They do not maintain Medicaid eligibility.
5. They no longer resides in the State of New Jersey.
6. They do not comply with DDD policy manuals or waiver program requirements.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Outlines an internal process, time lines and staff responsible to address if an individual is not accessing SP/CCP services other than Support Coordination for greater than 90 days and is facing Waiver disenrollment.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| **Reporting Incidents** **Effective Date** Enter a date.**Reviewed/Revised** Enter a date.**Compliance Date/DDD Staff Initials:** Enter text. | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Defines incidents and detailed descriptions regarding actions that the agency will take if an incident occurs.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Clear indication of response plan for incidents, including investigation procedures, lead responsible for investigation and reporting.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Identifies person responsible for investigation and reporting.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| **Complaint/Grievance Resolution or Appeals Process****Effective Date** Enter a date.**Reviewed/Revised** Enter a date.**Compliance Date/DDD Staff Initials:** Enter text. | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes the sequential steps for individuals/families/guardians to report/file complaint or grievance.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes flow of how the agency will review complaints/grievances indicating the staff responsible for each phase of the complaint/grievance and appeal process and time frames.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes each level of appeal available to individuals/families/guardians, including one that involves the Agency Head.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes all related documentation and the communication of the final decision.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| **Complaint Investigation** **Effective Date** Enter a date.**Reviewed/Revised** Enter a date.**Compliance Date/DDD Staff Initials:** Enter text. | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes the sequential steps for the agency to complete an investigation to include staff titles responsible, time frames, and potential disciplinary actions.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Includes that administrative staff conducting the investigation shall immediately report incidents with potential criminal nature to law enforcement authorities within 24 hours in accordance with Division Circular # 15, Section IV.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Includes that during the course of an investigation, should additional incidents or allegations be discovered, each incident shall be reported in accordance with Division Circular #14 and Administrative Order 2:05.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| **HIPAA & Protected Health information (PHI)****Effective Date** Enter a date.**Reviewed/Revised** Enter a date.**Compliance Date/DDD Staff Initials:** Enter text. | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes the process for employees to receive trainings on the policies and procedures regarding protected health information (PHI) including a receipt of a Confidentiality Statement and HIPAA Fact Sheet. Process must include staff title responsible and time lines.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Includes plan for ensuring confidentiality of individuals served.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Includes plan for ensuring access to documents is limited to appropriate staff.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Includes plan for release of information from individual/guardian prior to sharing information.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Plan for corrections to documents.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Plan includes safeguards for paper documents.
2. Deletions, erasures, and whiting out errors is not permitted;
3. Content can only be changed by the original writer;
4. Corrections must be made by the person who originally wrote the document with one line through the error including initials and date of correction.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. (**SCAs**) Includes safeguards for electronic documents.
2. Documents uploaded/entered into iRecord cannot be altered once submitted.
3. An additional case note explaining the correction must be entered into the system.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| **Emergency Procedures****Effective Date** Enter a date.**Reviewed/Revised** Enter a date.**Compliance Date/DDD Staff Initials:** Enter text. | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Outlines staff training and preparation related to handling of life threatening emergencies, including time lines and staff responsible for each action.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes actions to be taken in life threatening emergencies (refer to Division Circular #20) when with an individual and a live threatening emergency occurs.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes completion of Incident Report and denotes title/role responsible for actions as well as timelines.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes any additional documentation required by the agency, if applicable.
 | [ ]  Yes [ ]  Partially [ ]  No [ ]  NA  | Enter text. |
| 1. For **SCAs**, describes coverage and requirement for 24-hour availability and responsiveness.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. For **SCAs**, describes response plan for staffing shortages.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. For **SCA**s, outline plan for notification to the DDD Support Coordination Unit, operational issues which may have impact on agency operations and/or the individuals served, as well description of back up plans for operational breakdown. Examples include, but are not limited to, Agency Head unavailability, Supervisor absence and no back up in place, no Support Coordinator, etc.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. For **Service Providers**, describes evacuation process (if applicable); mechanism to ensure everyone is evacuated and accounted for; staff roles and responsibilities; mechanism to ensure everyone has been moved to a safe location and is accounted for (shelter in place policy, if applicable).
 | [ ]  Yes [ ]  Partially [ ]  No [ ]  N/A (SCA)  | Enter text. |
| 9. For **Service Providers** addresses: 1. Emergency Drills
2. Emergency Cards
3. Emergency Consent for Treatment
4. First Aid Kit \*if located in a facility\*
 | [ ]  Yes [ ]  Partially [ ]  No [ ]  N/A (SCA)  | Enter text. |
| **Medication Administration** – (Service Providers only, if medication is distributed while rendering service)**Effective Date** Enter a date.**Reviewed/Revised** Enter a date.**Compliance Date/DDD Staff Initials:** Enter text. | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Includes a statement of which program(s) will distribute medications.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes procedures for all of the following including the title responsible and timeframes for each:
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| * 1. Storage (include off-site storage)
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| * 1. Administration and documentation
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| * 1. OTC and PRN administration and documentation
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| * 1. Notification, if necessary, of medication and documentation errors / definition of errors / UIR completion.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| * 1. Staff training (to include practicum)
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| * 1. Quality assurance oversight
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| * 1. Medication changes and disposal
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| * 1. Self-administration
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| * 1. Medication refusals
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| **Reporting Medicaid Fraud/Waste/Abuse****Effective Date** Enter a date.**Reviewed/Revised** Enter a date.**Compliance Date/DDD Staff Initials:** Enter text. | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Policy includes a definition (from DDD materials) of Medicaid Waste/Fraud/Abuse.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes process to identify concerns.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Articulates who in the organization has the responsibility for reporting Medicaid Waste/Fraud/Abuse.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Identifies steps that should be taken when reporting Medicaid Waste/Fraud/Abuse.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Articulation of which entities should be contacted in instances of Medicaid Waste/Fraud/Abuse.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Identifies staff training.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| **Human Rights****Effective Date** Enter a date.**Reviewed/Revised** Enter a date.**Compliance Date/DDD Staff Initials:** Enter text. | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. States the responsibilities of staff (by title) and efforts to ensure the human and civil rights of individuals with developmental disabilities are protected.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Includes description of how issues that may infringe upon an individual’s rights are documented in the individual’s record. This shall include the staff responsible (by title) to document and wherein the individual’s record it shall be noted.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. States the responsibility of the staff (by title) within the agency to advocate for and protect the rights of individuals with developmental disabilities.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Indicates that all individuals/guardians shall receive a signed copy of the Participant Rights and Responsibilities [Participant Rights and Responsibilities](https://www.nj.gov/humanservices/ddd/assets/documents/services/participant-rights-responsibilities-english.pdf).
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Provides the referral process to the Human Rights Committee (HRC) and ensures any restrictions of individual’s rights are documented accordingly by staff.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. For **Providers**, outline the membership of the agency’s HRC or how agency will utilize the DDD HRC.
 | [ ]  Yes [ ]  Partially [ ]  No [ ]  N/A (SCA)  | Enter text. |
| 1. For **Providers**: Identify roles and responsibilities for HRC and how conflicts, disputes, committee functions, minutes, etc. will be documented.
 | [ ]  Yes [ ]  Partially [ ]  No [ ]  N/A (SCA)  | Enter text. |
| **Financial Management and Billing****Effective Date** Enter a date.**Reviewed/Revised** Enter a date.**Compliance Date/DDD Staff Initials:** Enter text. | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes procedural steps for conducting Internal Controls for claim submissions, billing processes, oversight of recordkeeping, monitoring expenditure controls and addressing Internal Financial controls.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Includes procedures clearly define staff roles and responsibilities.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| **Quality Management Plan****Effective Date** Enter a date.**Reviewed/Revised** Enter a date.**Compliance Date/DDD Staff Initials:** Enter text. | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes methods to a comprehensive plan to continuously evaluate, audit and develop strategies for improvement within the agency.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Identifies the staff title responsible for development of an annual quality management.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Details annual goals
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Details the evaluation of strategies.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Details indicators of systemic improvements made as a result of analysis.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Details quality improvement strategies to be used including staff training, policy updates and service improvements.
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes methods for measuring satisfaction (may include surveys, complaint and grievance resolution, or other evidence.)
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Describes customer satisfaction measures in alignment with the CMS Home & Community Based Services (HCBS) Quality Framework, which includes the following seven broad areas:
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Participant access
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Participant-centered service planning and delivery
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Agency capacity and capabilities
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Participant safeguards
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Participant rights and responsibilities
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. Participant outcomes and satisfaction
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |
| 1. System performance
 | [ ]  Yes [ ]  Partially [ ]  No  | Enter text. |