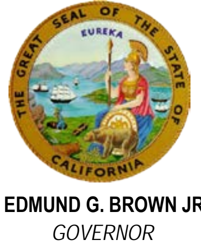
JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

Home and Community Based Alternatives Waiver Initial Provider Application

Congregate Living Health Facility

Type only. Handwritten applications will not be accepted.

Date:

Facility Legal Name: **doing business as:**

Facility Street Address:

City, Zip Code:

County:

Facility Telephone: **FAX:**

Facility Website:

Facility Capacity:

Number of participant beds requested:

National Provider Identification (NPI) number (required):

How many staff members are awake at night, including weekends?

Contact Information
(***Information provided will be used to communicate with the applicant regarding the status of this submission.)***

Name:

Title:

Telephone number:

Email Address:

Please provide detailed responses to the following questions. Inadequate responses will result in delay and/or denial of application.

➔ ***This electronic document will expand to accommodate your responses.***

1. Explain the availability of RN or LVN staffing for your facility. Is the RN or LVN a staff member or are they contracted with the facility?
   - If they are contracted, provide the name and contact information for that group or person and work schedule
   - If the RN/LVN is an employee, provide the RN/LVN's name, license number, and work schedule.

2. Are the RNs available on-call to residents? Yes No
   - If yes, what is the response time in minutes? _______________minutes

3. Continuous Nursing and Supportive Services (CNSS) are a collection of services included in a per diem rate based on the waiver participant's level of care. Are there at a minimum a Certified Nurse Assistant (CNA) and Licensed Vocational Nurse (LVN) awake, alert, and on duty at all times to provide for the residents of the Home and Community-Based setting?

   Yes No

4. Does the RN visit each waiver participant for a minimum of two hours, twice a week, or longer as necessary to meet the participant's care needs? Yes No

5. Is there an LVN in the setting and "on duty" at any time that an RN is not onsite?

   Yes No

6. Is there an CNA or persons with similar training and experience available in the facility to assist the RN and LVN to meet the requirement of at least two staff members awake, alert, and on duty? Yes No

7. What are your policies regarding in-service training?
   - What training do you require of your staff?
   - How frequent is the training?
   - What method is used to keep record of all training?

8. Facilities are required to have an emergency response system that enables an individual to secure immediate assistance from his/her caregiver.
For privacy consideration, the use of baby monitors will not be accepted.
   - Fully explain the individualized response system in your facility.
   - How do participants alert staff for assistance?
   - Where are call buttons or pull cords located?

9. What actions are taken by facility staff in the event of an emergency involving a participant?
   - Explain the procedures used in the event of a natural disaster.
   - How are residents advised and prepared for emergency action?

10. What process do you use to obtain feedback from participants and their families?
    - Are records kept of the requests and the follow-up action?

11. How do you track participant critical incidents (example: an injury, death, any form of abuse) and/or complaints?
    - How are they recorded?
    - How is the information used?
    - Give an example of the facility's method of resolving issues of these types.

12. With regard to a "person-centered service plan", please explain how the participant is included in the assessment process and how person-centered care plans are developed to ensure the participant's goals, preferences and needs are addressed.
    a. What is the facility's policy on the documentation of participant's inclusion with assessments and reassessments?

13. **Please include the following documents with this initial application:**

- Copy of the CMS/National Plan and Provider Enumeration System (NPPES) confirmation
- A facility floor plan with designated purpose (i.e. bathrooms (full or half), bedrooms (including private unit), kitchen, dining, etc.)
- Copies of the last two facility Licensing Reports

- A sample monthly meal plan, including snacks
- A sample activity schedule
- A sample of community activities – these are activities made available and located outside of the facility
- A list of course topics used in staff training
- Evacuation Plan
- Copy of Facility License
- For more information see IHO Provider Enrollment Web page

Submit completed application and attachments requested above to:

Department of Health Care Services
Long-Term Care Division
In-Home Operations
1501 Capitol Avenue, MS 4503
PO Box 997437
Sacramento, CA 95899-7437

- ***Incomplete applications will be returned without processing***
- ***Do not submit the non-refundable application fee with this form***.

When the review of this submission has been completed, you will be contacted regarding the status of your application. If this application is approved, a site review will be performed by IHO staff to verify applicant and facility qualifications.

Contact's Signature ____Date __________________

Reviewed by

____Date__________________
DHCS LTCD Representative