Employer Resources & Forms

Individual & Family-Directed Supports

Trillium
HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

Trillium Health Resources

Transforming the lives of people in need
by providing them with ready access to quality care.

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144 Community College Rd.
Ahoskie, NC 27910-9320

Trillium Central Regional Office
201 W 1st Street,
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Trillium Southern Regional Office
3809 Shipyard Blvd.
Wilmington, NC 28403-6150

Member & Recipient Service Line 1.877.685.2415 | Administrative/Business Calls: 1-866-998-2597

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TIPS ON USING RESOURCES & FORMS GUIDE

The Employer Resources & Forms Guide provides information for Employers of Record and Managing Employers who are participating in Individual & Individual & Family-Directed Supports. This includes either the Agency with Choice or Employer of Record models. Most of the documents in Employment Tips & Resources Guide are not required and may be modified by the employer. Your Community Navigator will point out all forms that may not be altered due to requirements by the state.

Community Navigators assist employers in understanding when and how to use these documents. Community Navigators also can provide additional resources and documents employers may want to consider using as they begin and continue to self-direct services.

For Managing Employers, the Agency with Choice selected by the employer may use different documents or forms. Managing Employers should always consult with the Agency with Choice to make sure all policies unique to that agency are followed.

RECRUITMENT OF EMPLOYEES

APPENDIX 1. SAMPLE ADS FOR EMPLOYEES

EXAMPLES OF ADS THAT WORK WELL

Here is an example of a good ad:

- Describe what kind of qualities you seek in staff
- Describe yourself and the position you offer in a positive way
- Describe duties and tasks about the job that are enjoyable and exciting

Adventures in Inter-Personal Relationships

Wanted: An interested *and* interesting person to provide support to a 15-year-old teenager with autism in his home and during sports activities. Creativity, good problem-solving skills and a sense of humor are a must. Must be fit and ready for high levels of physical activity. Previous experience helpful, but not necessary. Paid training period for the right person. Full and part time positions available. $9 per hour to start.

CHALLENGE, OPPORTUNITY, ACCOMPLISHMENT – *"Life Is What You Make It"*

Live the Values of Community Inclusion

Bill is looking for one or two employees to assist him in his beautiful home in rural Quietville. Bill is looking for applicants who enjoy teaching someone to cook, assisting with exercising during swimming, being outdoors, doing things in the community and being *ACTIVE*. Bill prefers people who are quiet, creative, dependable, consistent, use common sense and can listen carefully. Flexible situation for the right person!

EXAMPLES OF ADS THAT MAY NOT WORK WELL

The following ad may not work well because they:

- Use language that focuses on disability and limitations
- Make the position sound like unpleasant work
- Fail to describe the intrinsic values of the job

Share your home with hyperactive 15-year-old boy with autism and intellectual/developmental disability. Training in behavior modification and managing aggressive behavior will be provided. Earn $1,000 per month.

Full time, round-the-clock caregivers needed to work in shifts providing full care for non-verbal man with developmental disabilities who uses a wheelchair for mobility. Overnight stays required and duties include assisting with meals, lifting, bathing and attending to personal care. Free immunizations will be provided. Man is Hepatitis B carrier. Earn $10.00 per hour.

APPENDIX 2. SAMPLE FLYER

Looking for someone to provide after school care for child with disabilities

JOB DESCRIPTION

- Part-time. Monday – Friday, 3:00 p.m. – 7:00 p.m.
- Assist with teaching activities in home and in the community, meal preparation, and leisure activities
- Occasional week-ends hours

Salary

- 12.00 per hour

Benefits

- Mileage
- Two weeks paid vacation

Position Requirements

- Reliable, trustworthy
- Clean driving record with less than 3 points
- Position begins August 10

Qualifications

- Experience working with children with disabilities
- High school graduate
- Excellent references
- No criminal or abuse record

If interested, please call (704) 555-1234 after 3:00 p.m.

APPENDIX 3. JOB APPLICATION FOR PROSPECTIVE EMPLOYEE

Date of Application		
Name (as it appears on your Social Security Card)		
Mailing Address: Street or P. O. Box	City	State/Zip Code
Street Address (if different)	City	State/Zip Code
Telephone Number	Alternative Telephone Number	
Are you at least 18 years old? Yes____No_____		
State/Month Moved to North Carolina	Have you lived in North Carolina continuously during the past five years?	
Date Available for Work	Days and Hours Available for Work	
Type of Work Interested In (check all that apply): ___Full Time ___Part Time ___Backup employee (substitute)	I understand that CPR and First Aid Certifications are a condition of employment. ___Yes ___No	
Are you certified in CPR? Yes ___No ____ Expires on _____	Are you certified in First Aid? Yes ___No __ Expires on _____	
Have you ever been convicted of a crime, plead guilty, or no contest to a crime, or received deferred adjudication for any offense? Yes___ No___If so, please explain on back of this form. (A criminal background check must be verified before an offer for employment is made.)		
Do you have a valid North Carolina Driver's License? Yes___ No____	Have you ever been excluded from participation in the Medicaid or Medicare Programs? Yes___ No__	
Education: List all diplomas/GED and degrees and name of school, college, or university that you received them. Use additional pages if you need additional space		
High School		
College/University		
List all the jobs you have had beginning with the most recent. Use the back additional pages if you need additional space		
Employer	Address	
Position	Dates Employed	
Supervisor	Telephone Number	
Description of Work Duties		
Reason for Leaving		

Employer	Address
Position	Dates Employed
Supervisor	Telephone Number
Description of Work Duties	
Reason for Leaving	

Employer	Address
Position	Dates Employed
Supervisor	Telephone Number
Description of Work Duties	
Reason for Leaving	
May I contact your current Employer Yes____No_____	

List two personal references (other than former Employers)

Name and Telephone Number	Address
Name and Telephone Number	Address

By signing this application I verify the information provided is true and correct to the best of my knowledge. I also acknowledge that a Background Check is required and that some convictions prevent employment. I also acknowledge that if I am hired, I must have and maintain current certification in CPR and First Aid.

Signature _____ Date _____

APPENDIX 4. SAMPLE SCREENING QUESTIONS

If someone calls because they have seen your ad, you may want to ask the person some questions to find out if the caller is someone with whom you might want to do a face-to-face interview.

YOU MIGHT WANT TO:

- Ask for name, address, and phone number.
- Give a short description of the job duties.

SOME QUESTIONS YOU MIGHT WANT TO ASK:

- Are you at least 18 years of age?
- Do you have a Social Security number? (They must have one to be paid.)
- What hours are you available?
- What days can you work?
- Do you like and/or are you allergic to animals? (If you have animals)
- Do you mind working in a smoke-free environment? (If smoking bothers you)
- Do you mind working in a smoke-filled environment? (If you are a smoker)
- Are there any reasons you would not be able to travel to my neighborhood?
- Do you have a valid driver's license? (If driving is a part of work)
- Do you have experience providing supports and services? Do you mind assisting me in bathing, toileting, and dressing?
- There might be some lifting and physical activity involved in this job. Do you have any limitations or restrictions regarding lifting weight or physical activity?

Tell the person you will contact him/her if you decide to schedule an interview. This will give you some time to think about whether you want to interview him/her in person or not. Thank him/her for calling.

If you have a telephone call from someone asking for information about your ad, you may want to complete a Screening Worksheet to help you remember your conversation with the caller. This form can also help you keep up with any interviews you scheduled.

APPENDIX 5. TIPS FOR CONDUCTING A TELEPHONE INTERVIEW

- Take notes to reference in making a hiring decision.
- Make sure the applicant's name and telephone number are recorded accurately.
- Be friendly and pleasant.
- Be honest and realistic in describing duties, salary and schedules.
- If the job requires lifting or other physical activity, ask if this would present a problem for the applicant.
- Ask the applicant to describe previous experience.
- Without giving your address, generally describe where the work location is. Ask if commuting presents a problem.
- Ask if the applicant is available for the hours and days needed.
- Discuss any special equipment that the applicant may need to be familiar with; ask if the applicant has experience in using that equipment.
- Ask open-ended questions to help get an idea of whether the experiences and attitudes will suit the needs of the individual. Open-ended questions cannot be answered with a simple yes or no.
- Ask if the applicant has questions about the job.
- Thank the applicant for his/her interest and explain when you expect to make a decision about hiring someone. If you are interested in a face-to-face interview with the applicant, indicate this and either schedule it or tell him/her that you will call them to schedule the interview.
- When scheduling a face-to-face interview, be sure to tell the applicant he/she needs to come prepared to complete a job application form, including contact information for work and personal references. Repeat the time, date and location of the interview to be sure that both the applicant and you are clear on these points.

APPENDIX 6. TELEPHONE SCREENING FORM

Date: _____ Caller's Name: _____

Caller's Phone (Day/Evening) #: _____

What kind of experience does caller have?_____

Can caller provide employment and personal references? Yes_____ No_____

Does caller have Social Security number? Yes_____ No_____

Does the caller have a valid Driver's License?

Does the caller have access to a reliable vehicle for use at work? Yes_____ No_____

How long has caller lived in area (including in state)? _____

Why is caller interested in this kind of work?_____

_____

Is caller willing to undergo background checks? Yes_____ No_____

What is caller's work availability? _____

Start work when? _____

What schedule can the caller work? _____

Does caller have any special experience and training? _____

Notes: _____

_____

_____

_____

Applicant's Name: _____ Date: _____

APPENDIX 7. SAMPLE INTERVIEW QUESTIONS

- Do you have any questions about the information in the job description or what I have explained about the job?
- Is there anything (due to health conditions, transportation availability, etc.) that would prevent you being able to perform the duties as they are outlined in the job description?
- Why are you interested in this job?
- What training and experience do you have that would make you a good choice for this position?
- What did you like least/most about pervious jobs you have held?
- How do you feel when given detailed instructions about how a task is to be done
- Do you learn best by seeing, hearing or doing?
- Can you assist and support me in the community if it means going to places you care nothing about and have no personal interest in?
- My personal appearance is very important to me. I always want to look neat and clean and expect you to keep a neat and clean appearance. Do you have any concerns about this?
- I expect you to never drink alcohol or use drugs on the job and to never arrive "under the influence." Why, as my personal employee, do you think this would be important to me?
- When you have a conflict or a disagreement with someone, how do you usually handle or resolve it?
- How long do you anticipate keeping this job?
- If you could not work when scheduled, what would you do?

APPENDIX 8. AVOIDING DISCRIMINATION: QUESTIONS NOT TO ASK

THE FOLLOWING ARE QUESTIONS ON TOPICS THAT CAN BE DISCRIMINATORY.

Avoid asking things like:

- How old are you?
- What is your native language?
- What is your marital status?
- What is the lowest salary you will accept?
- Do you have children?
- What is your height and weight?
- Have you ever been arrested?
- What church do you attend?
- Do you belong to any clubs or organizations?
- What is your credit rating?
- Do you own or rent our home?
- Do you own a car?
- What country were you born in?
- Do you have any addictions?
- What is your star sign?
- Do you have a disability or medical condition?
- What is your political affiliation?
- What are your family members' names?
- What is your race?
- Where are your family members employed?

APPENDIX 9. REFERENCE INFORMATION RELEASE

Applicant's Name _____

Position Applied For _____

Former Employer _____ Position _____

I, authorize _____, former employer, to release the following information to _____, potential employer, so they may further evaluate my qualifications for the above-mentioned position.

The information I authorize you to share is valid only for those Categories I have initialed below:

Category	Applicant's Initials
Job Performance	_____
Attendance/Punctuality	_____
Attitude	_____
Job Knowledge	_____
Reliability	_____
Trustworthiness	_____
Employment Dates	_____

Reason for Leaving Previous Employer _____

_____

_____

_____

Applicant Signature _____ Date _____

Witness Signature _____ Date _____

APPENDIX 10. SAMPLE QUESTIONS FOR REFERENCE CHECKS

FOR WORK REFERENCES

- When did the applicant work for you? (Does his/her information match the applicant's information on the job application form?)
- Did the applicant arrive on time at work?
- Was the applicant dependable?
- How often was the applicant absent without notice?
- Did the applicant do satisfactory work?
- How did the applicant deal with handling money on the job?
- Can the applicant deal with a wide range of tasks?
- What was it like to supervise this applicant?
- Were there any problems with the applicant?
- Why did the applicant leave the job?
- Would you hire this applicant again?

FOR PERSONAL REFERENCE

- What is your relationship with the applicant?
- How long have you known the applicant?
- What are the applicant's strengths and limitations?
- How does the applicant handle stressful situations?
- Would you trust the applicant to have keys to your house and car?
- Would you trust the applicant to have access to your bank account?
- Do you think the applicant is reliable?
- How well does the applicant get along with others?
- Do you think the applicant would be good at this type of work?

APPENDIX 11. PERSONAL REFERENCE WORKSHEET SAMPLE

Applicant's Name_____

Reference Name_____Phone #_____

Relationship to Applicant_____

How long have you known this person? _____

Do you feel this person is well suited to providing support and/or assistance?_____

What are this person's strongest/weakest qualities?_____

How would you describe this person's general attitude?_____

Why do you believe this person is interested in this kind of work?_____

Do you consider this person reliable/trustworthy?_____

Is there anything else I should take into consideration about this person?_____

APPENDIX 12. EMPLOYMENT REFERENCE WORKSHEET SAMPLE

Applicant's Name_____

Former Employer_____

Phone #_____

Supervisors or Other Employment Reference Name/Title _____

What was the applicant's position? (Primary duties) _____

How long did the applicant work for your organization?_____

What were the applicant's strongest/weakest points?_____

What special training did this applicant undergo while with your organization? _____

Why did the applicant leave your employment? _____

_____

If you had the chance, would you rehire this applicant? _____

Please grade the applicant's following attributes on a scale of 1 to 10, with 10 being Superior and 1 being Poor:

Job Knowledge _____
Reliability _____
Trustworthiness _____
Attitude _____
Attendance/Punctuality_____

Notes: _____

_____

_____

APPENDIX 13. RELEASE OF INFORMATION TO TRILLIUM HEALTH RESOURCES

Applicant's Name _____

Potential Employee _____ Position _____

I authorize_____ to release information about me to Trillium Health Resources so my qualifications can be reviewed to verify I have met minimum requirements to provide services in the NC Innovations Waiver. I understand as Lead Agency for the NC Innovations Waiver, Trillium Health Resources will monitor services being provided to the individual for whom I am applying to become a service provider. In addition, my qualifications are subject to review by State and Federal Auditors as well as records I keep, including records of the time I work. Trillium Health Resources and these Auditors are required by law to keep information they review confidential.

My Employer will maintain my records for at least five years.

The results of my criminal background record check will not be disclosed to Trillium Health Resources, state, or federal auditors.

A photocopy of this authorization form shall be as effective and binding as the original.

Applicant Signature _____ Date _____

APPENDIX 14. BUILDING A JOB DESCRIPTION

Job Title _____

(Write a brief description of tasks the employee will be expected to perform)

Bathing/Assistance in Bathroom

Dressing

Recreation/Leisure

Mobility

Correspondence/Mail

Shopping

Exercise

Job Description (page 2)

Transportation

Housekeeping

Laundry

Meal Preparation

Documentation Requirements

Social

Communication

Other

- Complete incident reports as required by procedure
- Complete time and billing forms by designated deadlines
- Complete reports of any injuries received on the job
- Utilize equipment provided, as needed, for mutual protection and safety to include gloves, masks, and hazardous waste container
- Satisfactory completion of required training

APPENDIX 15. JOB DESCRIPTION SAMPLE

Job Title: Personal Assistant for Child, age 12, with intellectual disability

Bathing/Assistance in Bathroom: Our child needs to be bathed each evening at 8:30 p.m. She has goals to learn to hold a washcloth and to assist in bathing that must be consistently trained. She must be assisted in the bathroom in wiping herself after using the toilet.

Dressing: Our child must be dressed by 7:30 a.m. prior to arrival of school bus. She has goals to learn to select clothing to wear and to learn to put on her clothes but requires assistance and prompting during dressing.

Recreation/Leisure: Our child enjoys playing with other neighborhood children after school. She must be supervised, and assisted in appropriate social skills in her interactions with the other children. She also attends dance classes on Tuesdays, and swim classes on Thursdays. Assistant will need to transport her to and from classes, and assist her in changing in and out of her swimsuit. She has goals to learn to interact with the other children in her classes, and requires prompting to stay on task. Her assistant will need to be with her in the swimming pool.

Mobility: Our child is able to walk independently; however, she must be supervised closely when outside our home as she does not understand danger associated with traffic. She must be escorted to the school bus stop and the personal assistant must meet her at the bus stop. It is extremely important that the assistant notify her parents or the emergency contact of any inability to meet her on time at the bus stop.

Correspondence/Mail: Parents will handle all correspondence but our child enjoys having e-mail from her grandparents and cousins read to her, and dictating replies to send to them.

Shopping: Our child does not enjoy shopping but has a goal to learn to make simple purchases, such as buying school supplies or items to include in lunch she takes to school.

Exercise: Our child enjoys going on walks and should be supervised in walking at least three times a week.

Transportation: Assistant will need to transport our child to dance and swimming classes, as well as other community outings in the assistant's personal vehicle on community activities. She is learning how to fasten her seat belt but must be assisted in this area.

Housekeeping: Our child has goals to learn how to make her bed and keep her bedroom clean. The personal assistant must assist her and is responsible for cleaning the parts of the bedroom and the bathroom that she uses. In addition, the personal assistant should clean the kitchen up after using it to prepare our child's meals.

Laundry: Our child's clothes, bed linens and towels must be washed weekly. This can be done on weekends when she is resting or watching television.

Meal preparation: Our child's breakfast must be prepared on school days. On weekends, she eats all meals with the family. Dinner meals are usually with the family, except on days when she has dance and swim classes. On those days, the personal assistant will prepare her dinner. The personal assistant will also assist her in preparing a snack after school. She does not use a knife, so her food must be cut for her. She is able to feed herself, but has goals to use a napkin. She must be supervised during all meals and snacks.

Documentation Requirements: The personal assistant must document all services provided as directed by the employer and keep other records as required by the employer or state and federal Medicaid program rules.

Social Requirements: Our child is a little shy in social situations but, when encouraged to engage, will do so. It is important to help her develop a rapport with other children so she will feel comfortable participating in play activities. Please include her in conversations and role model how she can ask questions or give her opinions.

Communication: Our child should be given choices when offering activities. She responds well when given at least three options to choose from for activities.

Other

- Complete incident reports as required
- Complete time sheets by designated deadlines
- Complete reports of any injuries received on the job
- Utilize equipment provided, as needed, for mutual protection and safety to include gloves, masks, and hazardous waste container
- Satisfactory completion of required training, including first aid and CPR
- Follow all Employee Guidelines and Rules
- Please be respectful and use People First Language when speaking to or about our child
- Implement the child's Person-Centered Plan as directed by the Employer

APPENDIX 16. EMPLOYMENT OF RELATIVE/LEGAL GUARDIAN AS PROVIDER

Following is information about Employment of Relative/Legal Guardian as outlined in the NC Innovations Waiver. Information below explains how the Employer of Record may apply for approval of certain relatives living in the home of the participant to provide services.

- Employment of Relative/Legal Guardian applies to NC Innovations participants ages 18 and older.
- A relative is defined as the individual's mother, father, step-mother, step-father, sister, brother, aunt, uncle, grandmother or grandfather.
- Excluded from providing NC Innovations services are the following relatives: biological or adoptive parents of a minor child, stepparents of a minor child or the spouse of a waiver participant.
- The following relatives may provide services (if approved under the conditions of the policy): parents of adult participants who are not the Employer of Record, and other relatives who live in the home of the individual.
- The Individual & Family-Directed services that relatives or legal guardians may provide are Community Living and Supports
- The relative must meet the provider qualifications for the service.
- Employers of Record and Managing Employers participating in the Individual Family-Directed option may not be employed to provide waiver services.
- The ISP contains documentation that the waiver participant is in agreement with the employment of the relative and has been given the opportunity to fully consider all options for employment of non-related staff for waiver service provision.
- It is recommended relatives residing in the home of the recipient provide no more than 40 hours per week of services to the person. If additional hours are requested to be provided by relatives residing in the home of the recipient, justification needs to be provided as to why other providers are not available and assurances of provider choice and that the individual will not be isolated from their community.
- The NC Innovations Waiver requires Trillium Health Resources pre-approve any relative as a service provider to make sure the conditions of the Waiver are met. The Community Navigator assists the Employer of Record with this process by providing copies of the form, teaches the Employer of Record how to complete the form, and assists the Employer of Record in sending the forms to Trillium Health Resources.
- If an Employer of Record intends to hire a relative who was previously approved through employment with a provider agency, the Relative As Provider Application process must still be completed by the Employer of Record and the employee approved by Trillium Health

Resources prior to the employee beginning to provide services to the participant under the Employer of Record Model.

- The relative or legal guardian will not be reimbursed for any activity they would ordinarily perform or are responsible to perform.
- Services delivered by relatives/legal guardians are monitored monthly.
- Care Managers monitor through on-site monitoring and documentation review to ensure payment is made only for services rendered and that the services are furnished in the best interest of the individual.
- Employers of Record monitor the relative or legal guardian's provision of the service, on site a minimum of one time per month.
- Payments are only made for service authorized by Trillium Health Resources in the Individual Support Plan.
- It is mandatory Employers of Record identify back-up staff for each employee inclusive of Employees under the Relatives/legal guardians as Provider process.
- Provider Network will monitor employment documentation by reviewing personnel files during on-site reviews or if issues arise. NC Innovations Waiver policy is based on Federal requirements.

TRAINING FOR EMPLOYEES

APPENDIX 17. EMPLOYEE QUALIFICATIONS AND TRAINING CHECKLIST

Employee _____

Employer _____

Date _____

Requirement	Hiring Requirement	Before Work Begins	When Work Starts	On-Going
A copy of a job application signed by the employee with a statement that the it is true/accurate		x		Initially one-time document
Copy of a High School Diploma/GED	x			Initially one-time document
Documentation the employee is at least 18	x			Initially one-time document
Verification the employee has not been excluded from participation in Medicaid/Medicare Programs: Question on the application or check the Office of the Inspector	x			Initially one-time document
Criminal record check shows no conviction that would present health/safety risk to Individual	x			Initially prior to working with participants. Updated as specified in ISP
Healthcare Registry checks with no substantiated findings of abuse or neglect.	x			Initially prior to working with participants
Service Specific Requirements as Specified in NC Innovations Technical Manual	x			As required
First Aid		x		Every three years

Requirement	Hiring Requirement	Before Work Begins	When Work Starts	On-Going
CPR		x		Annually or for a period of time as specified on card/ certificate
Orientation to Employer's Expectations			x	Initially upon hire
Medication Administration if employee is administering medications			x Before administering medications	Initially upon hire; updated as needed to address medication changes
1. Alternatives to Restrictive Interventions or Positive Behavior Support Training. Ex; NCI Part A; Getting it Right. 2. Restrictive Intervention Training if listed in PCP or Crisis Plan. Ex: NCI Part B; PMAB.		x		Annually following an approved curriculum
Service/Documentation			x	Initially upon hire
Client Rights			x	Initially upon hire
Confidentiality			x	Initially upon hire
Blood borne Pathogens		x		Initially upon hire and annually within 12 months from the initial/last date of Blood
Customized Needs of Individual as specified in ISP			x	Per Employers preference and Updated as specified in ISP as needs change
Employee Support Agreement		x		Initially upon hire; updated as needed

Requirement	Hiring Requirement	Before Work Begins	When Work Starts	On-Going
Supervision Plan		x Within Employee Support Agreement		Per Employer's preference and Updated annually
Documentation of Supervision			x	Consistent with frequency outlined in Supervisor Plan
Evidence of Liability Insurance if transporting participants		x		As needed based on expiration date of insurance policy

APPENDIX 18. EMPLOYEE TRAINING LOG

Employee _____ Hire Date _____

Employer or Representative _____

Training Requirement	Training Provided By/Date	Certificate or Documentation Obtained
CPR		
First Aid		
Review of the Individual's Support Plan and Goals		
Billing procedures		
Time Sheet Expectations and Due Dates		
Clinical Documentation Requirements		
Notification of Absences		
Emergency Procedures and Contacts		
Individual Needs, including physical, psychological, behavioral challenges, capabilities, preferences, support needs		
Medication Administration, if assisting Individual with medications		
Incident Reporting		
Behavioral Intervention Training		
Blood-borne Pathogens Training		
Confidentiality		
Individual Rights		

Employee Training Log (Page 2)

Training Requirement	Training Provided By/Date	Certificate or Documentation Obtained

APPENDIX 19. GENERAL TIPS FOR TRAINING EMPLOYEES

- All employees will need some training. The employee should be trained to do tasks the way the individual wants them done.
- Prepare. Before starting to train, all the equipment and supplies should be located. Training should be scheduled during times when the trainer will not be disturbed.
- Explain the individual's disability. The employee needs to know everything about the disability and how it affects the person's daily life.
- Review Employee Hire Agreement and Employee Guidelines. The employee should be told that the guidelines are important, and anything that is not clear should be explained. Any problems with the guidelines should be resolved immediately or the person may need to be terminated before further training is completed.
- Have a training plan. At the beginning of each session, there should be an overview of what will be covered. At the end of each session, there should be a summary of what has been taught. If more than one session is needed to cover a topic, the previous lessons should be reviewed before new material is covered.
- Explain the task. If a task must be done a certain way, it is important to tell this to the employee and to explain why it is important to do it this way. If the task needs to be done at a certain time, the employee needs to know this and why it is important to do it at that time. The employee must understand all parts of a task and why they fit together.
- Demonstrate new tasks. A good way for an employee to learn a new task is to have the employee watch someone else do it first. A friend, family member, or another skilled worker can show the employee how to do the new tasks. It is important for the employee to see the task done several times, and then allowed to practice it until the employee can do the task.
- Cover the steps in the task. If using a checklist, the employee should review the checklist as the each step of the task is worked through. The employee could also write down the steps as the person explains them. It is important to review the steps to make sure that the employee has written them down correctly.
- Stress safety. Stressing safety is critical. Make sure the employee knows what to do in case of emergency.
- Be patient. The employee may make mistakes when learning a task. The employee needs opportunities to ask questions and chances to learn tasks.
- Be sensitive to the employee. People learn at different rates. The employee's feelings reactions need to be considered. Thought should be given to how much new knowledge the employee can learn at one time.
- Respect the employee. The employee and how much the employee already knows should all be respected. The employee should be told that it is important to know he/she understands exactly how to do the task.

- Give the employee feedback. Giving employee's feedback during training, as well as on the job, is very important. It is important to talk about what is working and what is not working. Like most people, the employee needs both positive and corrective feedback.
- Correct mistakes. When the employee does a task differently than the way the task needs to be done, it should be pointed out with the correct way to perform the task.
- Praise good work. When an employee does tasks the way they need to be done, this should be pointed out. The employee should be praised and thanked for good work. This is a powerful motivator for employees.
- Evaluate employee's work and behavior. The employee should be informed that work and work behaviors will be evaluated regularly. Copies of evaluations should be shared with employees.

APPENDIX 20. UNIVERSAL PRECAUTION GUIDELINES

- Wash hands before you have contact with the individual and immediately if they come in direct contact with blood or any body fluids. Avoid hand to mouth contact. Wash your hands for 30 seconds after contact with blood and other body fluids that have come in contact with blood. Wash hands and outside of hands, between fingers and under fingernails.
- Wear disposable latex gloves when you encounter large amounts of blood, especially when you have open cuts or chapped skin. Wash your hands as soon as you take off your gloves.
- Avoid contamination of the person by use of waterproof or water-resistant clothing, plastic apron, etc. Wear rubber boots or plastic disposable overshoes when the floor or ground is likely to be contaminated with blood or other bodily fluids.
- Protect the eyes and mouth by means of a visor, goggles or safety spectacles and a mask whenever splashing is a possibility.
- Throw away blood-stained material in a sealed plastic bag and place it in a lined, covered garbage container. (Put gloves and paper towels in a plastic bag, tie the bag shut and dispose of the bag in a lined, covered garbage container.)
- Cover cuts and scratches with a bandage until healed. Place a clean bandage over wound prior to beginning work each day.
- Avoid use of or exposure to sharp objects when possible, but where unavoidable, take particular care in handling and disposal to ensure you do not come into contact with blood or bodily fluids.
- In emergency situations, wear gloves and use disposable absorbent materials, such as paper towels, to stop bleeding. Fold several paper towels together and apply direct pressure to a wound. Immediately wash your hands.
- Control surface contamination by blood and body fluids through containment and appropriate decontamination procedures. Immediately clean up blood-soiled surfaces and disinfect with a fresh solution of one part bleach and nine parts water.
- Dispose of all contaminated waste and linens safely. Put blood/bodily fluid-stained laundry in sealed plastic bags. Machine wash items separately in hot, soapy water.
- All procedures involving blood or other potentially infectious materials must be done in a manner that will minimize spattering, splashing or spraying.
- Do not eat, drink, smoke, apply cosmetics or lip balm, or handle contact lenses in areas where you may become in contact with blood or bodily fluids or other infectious materials.

APPENDIX 21. HEPATITIS EMPLOYEE NOTIFICATION

Hepatitis B is a serious infection involving the liver. The Hepatitis B virus can cause lifelong infection, cirrhosis of the liver, liver cancer, liver failure and/or death. Hepatitis B is spread when blood or body fluids from an infected person enters the body of a person who is not infected. Hepatitis B is a major infectious occupational hazard for healthcare. Any healthcare worker may be at risk for Hepatitis B exposure, depending on the tasks that the worker performs. Employees should be vaccinated if their tasks involve contact with blood or blood contaminated bodily fluids. OSHA Standards require that all employers make available the Hepatitis B vaccination series to all employees who have exposure.

The **Hepatitis B vaccine is available at no cost to employees**. The cost to provide vaccination is an administrative expense to the Employer, and is reimbursable through arrangements that can be made with the Financial Supports Agency.

The vaccine is administered in a prescribed series of three injections over a six-month period:

- Dose 2 is administered 30 days after Dose 1
- Dose 3 is administered five months following Dose 2

The employee is responsible for requesting from the healthcare provider administering the vaccination additional information about the efficiency, safety, benefits, method of administration and potential side effects of the Hepatitis B vaccination. The employee may elect to receive or decline the Hepatitis B vaccination.

_____I agree to receive the Hepatitis B vaccination and will be reimbursed by the Financial Supports Agency within 30 days of presenting a paid receipt for each dose. I understand I will only be reimbursed for doses received while I am an employee of this employer.

_____I agree to receive the Hepatitis B vaccination and the employer and I agree to the following arrangements related to covering the cost of the vaccination:

_____

_____

_____

_____

_____ I decline the Hepatitis B vaccination because I have previously received it.

_____ I decline the Hepatitis B vaccination. I understand, due to my occupational exposure to blood or other infectious materials, I may be at risk of acquiring Hepatitis B virus infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine. However, I decline the Hepatitis B vaccination at this time. I understand by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other vaccine, I can receive the vaccination series at no charge to me.

I further acknowledge and certify I have received information on occupational exposure to blood borne pathogens, universal precautions, Hepatitis B and Hepatitis B vaccination. I have been provided the opportunity to ask questions and to seek additional information. I have made my choice related to the Hepatitis B vaccination base on informed choice.

Employee Signature	Employer Signature
Date	Date

APPENDIX 22. CONFIDENTIALITY

Your employees may not discuss any information about the individual, including that the individual is receiving services from the employee. This information is confidential and should not be discussed with anyone other than the individual's legal guardian, Care ManagerCare Manager, or any other person the employee has received permission to talk with from the individual or the legally responsible person. You are responsible for training the employee in confidentiality rules and regulations. The employee should understand there are serious consequences for everyone involved if the rule of confidentiality is broken, including:

- The individual could be embarrassed, harmed or exploited.
- The employee could lose his/her job.
- The employee could face legal charges.

APPENDIX 23. CONFIDENTIALITY AGREEMENT SAMPLE

Confidential Information includes: Any individually identifiable information in possession or obtained due to my employment to include the person's medical history, mental/physical conditions, treatment, test results, conversations, and financial information. This information is considered private, confidential and is "protected health information".

Examples include, but are not limited to:

- Physical medical and psychiatric records including paper, photo, video, diagnostic and therapeutic reports, laboratory and pathology samples;
- Medication information
- Documentation related to goals/outcomes for the person
- Visual observation of person receiving medical care or accessing services; and
- Verbal information provided by or about the Individual I support

I understand and acknowledge:

- I shall respect and maintain the confidentiality of all discussions, documentation related to services provided, and any other information generated in connection with individual.
- It is my legal and ethical responsibility to protect the privacy, confidentiality and security of all documentation or records, and other confidential information.
- My obligation to safeguard patient confidentiality continues after my termination of employment with this employer.

I hereby acknowledge I have read and understand the information above and my signature below indicates my agreement to comply with the above terms.

I understand failure maintain confidentiality may make me subject to legal and/or consider disciplinary action up to and including my termination.

Dated: _____ Signature: _____

Print Name: _____

APPENDIX 24. POSITIVE BEHAVIORAL SUPPORTS TRAINING

In an effort to meet the training requirements, the Employer of Record (EOR) has the option of having staff attend North Carolina Interventions (NCI) Part A or Alternatives to Restrictive Intervention, following an approved curriculum.

Employers of Record can contact the Community Navigator for assistance in accessing the Positive Behavioral Supports training which can be used by the Employer of Record to meet the requirement for Alternatives to Restrictive Interventions Training. The EOR can use the material to train direct care staff and ensure documentation of training provided is maintained in the employees file. The training is not competency-based

NCI Part or Alternatives to Restrictive Intervention training should occur prior to the employee working with an individual and annually thereafter. Please note this training is not mandatory, but it is expected there is training documentation to support staff of the Employer of Record either attending NCI Part A or other form of Alternatives to Restrictive Interventions training.

If you have any questions, you can contact your Community Navigator for assistance in locating a class and requesting payment through your Financial Supports Agency.

APPENDIX 25. REIMBURSEMENT REQUEST FORM FOR MILEAGE

Employee Name: _____

Date	Destination	How Many Miles

Total Miles _____

Rate _____

Total Mileage Reimbursement Requested _____

_____ _____

Employee Signature Date

APPENDIX 26. EMERGENCY TELEPHONE NUMBERS

FOR POLICE, FIRE, MEDICAL EMERGENCIES: 911

The address of this house is _____

Major cross streets near this address are _____

The phone number is _____

	Name	Phone #
Doctor		
Doctor		
Poison Control		
Abuse, Neglect or Exploitation		
Pharmacy		
Family at Work		
Family at Work		
Neighbor		
Friend		
Other Relative		
Back-Up Provider		
Back-Up Provider		
Back-Up Provider Agency		
Crisis Services Agency		
Care Manager		
Community Navigator		

SERVICE DOCUMENTATION FORMS

APPENDIX 27. ELEMENTS OF SERVICE DOCUMENTATION

SHORT-RANGE GOALS AND STRATEGIES

The Employer of Record and/or Representative are responsible for developing and implementing short-range goals and task analyses/strategies for achieving long-range Individual Support Plan outcomes. Community Navigators train Employers of Record on development of short-range goals and task analysis/ strategies.

Short-range goals are steps taken to achieve the long-range outcomes. They are statements describing a proposed behavior, or what the participant will do. Short-range goals are based on wants/needs of the participant. They are based on the individual's preferences or needs, not staff convenience or preference.

A **strategy** is a long-term plan of action designed to achieve a particular outcome. Strategies are used to make a problem easier to understand and solve. A strategy is adaptable rather than a rigid set of instructions, for example to assist a participant with behavioral issues.

A **task analysis** is a process for determining in detail the specific behaviors required of staff to assist the individual with the implementation of an outcome. Task analysis includes a detailed description of any unique factors involved in or required for one or more people to perform a given task. For example, a task analysis would be used to assist an individual with a specific daily living skill.

Short-range goals, strategies and/or task analysis must be in place prior to service delivery. This includes having the signature of the individual and/or legally responsible person for initial plans and all updates prior to implementing the goals. If a signature page is developed for the strategies or task analysis, this signature page could serve as the signed document and therefore each page of the strategies or task analysis would not require a separate signature.

TYPES OF DOCUMENTATION

There are two types of documentation used in Individual & Family-Directed Services: Service Notes and Service Grids.

Service Notes

For Service Note requirements, the Employer of Record refers to the DMH/DD/SAS Records Management and Documentation Manual 45-2 (chapter 8 & 9). The following NC Innovations Individual & Family-Directed Service require a service note, which includes items 1 through 13, under Contents of a Service Note, Chapter 8 of the DMH/DD/SAS Records Management and Documentation Manual 45-2:

- Community Navigator
- Individual-Directed Goods and Services (required for service component)
- Natural Supports Education

Service Grid

For Service Grid requirements, the Employer of Record refers to the DMH/DD/SAS Records Management and Documentation Manual 45-2 (chapter 8 & 9). A service grid should include all elements 1 through 10, under Required Elements of a Service Grid, Chapter 8 of the Record Management and Documentation Manual.

A service grid shall be completed daily or per activity to reflect the service provided and may only be used for the following Individual & Family-Directed Services:

- Community Living and Supports
- Community Networking
- Respite Care
- Supported Employment

SIGNATURES

All entries in the service record shall be signed with a full signature. A full signature is to include the credentials, degree or licensure for professional staff or the position of the individual who provided the service for paraprofessional staff. Please refer to the DMH/DD/SAS Records Management and Documentation Manual 45-2 (chapter 9) for signature requirements.

FREQUENCY OF SERVICE DOCUMENTATION

All NC Innovations services require a daily or per activity service note or grid. The person who provided the service shall write and sign the service note or grid. The service note or grid shall be documented on the day that the service was provided or no later than the next work day. If a service or grid is not documented on the day the service was provided, it shall be considered a "late entry". The entry shall be noted as a "late entry" and, at minimum, the date documentation was made and the date for which the documentation should have been made. For example, "Late Entry made on 2/15/12 for 2/14/12." The late entry must include a dated signature. (See Corrections in the Service Record below for information about late entry timelines for billing purposes.)

Service notes shall be made at the frequency necessary to indicate significant changes in the individual's status, needs or changes in the Individual Support Plan.

CORRECTIONS IN THE SERVICE RECORD

Changes or modifications in the original documentation for the purpose of making a correction can be made at any time, when appropriate. Whenever corrections are necessary in the individual's record, the Employer of Record should refer to the procedures as noted in the DMH/DD/SAS Records Management and Documentation Manual 45-2 (chapter 9). However, for quality assurance and reimbursement purposes, all necessary documentation or corrections to support billing shall be properly completed within seven (7) working days.

Therefore, for billing purposes, corrections must be made within the prescribed timeframes.

- Date ranges the Quarterly Review covers
- Recommendations for continuation, revision or termination of an outcome
- Signature of the individual who completed the review

Specific Service Documentation

Community Navigator

Maintain service notes signed by the individual providing the service documenting the date of the service, the amount of time involved in the service and a description of the activities related to the long-range outcomes and short-range goals. A daily per event service note should be completed.

Community Networking

- Maintain service note or grid signed by the individual providing the service documenting the date of the service, the amount of time involved in the service and a description of the activities related to the long-range outcomes and the short-range goals.
- For conferences, classes, and related materials purchased in conjunction with these an invoice will be required.
- For Community Networking Transportation that is not part of the provision of a staffed service with an established per trip rate, maintain a record with a signature of a representative providing the transportation.
- For Community Networking Transportation that is not part of the provision of a staffed service with a per mile charge, maintain a record that documents the date service was provided, the specific activity that the person is being transported to/from, and the mileage related to the transportation of the person. The person providing transportation shall sign the record.

Individual Directed Goods and Services

The Financial Support Agency shall maintain an invoice from the supplier showing the date the Good was provided to the individual and the cost, including related charges (i.e., applicable delivery charges.) Services will require a service note, signed by the individual providing the service, documenting the date of the service, the amount of time involved in the service and a description of the activities related to the long-range outcomes and the short-range goals.

Community Living and Supports

Maintain service grid signed by the individual providing the service documenting the date of the service, the amount of time involved in the service and a description of the activities related to the long-range outcomes and the short-range goals.

Natural Supports Education

Maintain service note, signed by the individual providing the service, documenting the date of the service, the amount of time involved in the service and a description of the activities related to the long-range outcomes and the short-range goals. For conferences, classes and related materials purchased in conjunction with these, an invoice will be required.

Respite Services

Documentation shall be made on a daily basis and must contain the following components: name of the individual; the record number; the service provided; the date of service; duration of service; task performed including comments on any behaviors, which are considered relevant to the individual's continuity of care; that special instructions were followed; and signature of the individual providing the service (initials if the full signature is included on the page when the use of a grid is used for documenting). A grid may be used to document this service.

Supported Employment

Maintain service note documentation, signed and dated by the individual providing the service, documenting the date of the service, the amount of time involved in the service and a description of the activities related to the long- range outcomes and short-range goals, and transportation provided to the Individual. A grid may be used to document this service.

General Records Administration

Employers of Record will make service documentation available to the Care Manager, Trillium staff, DMH/DD/SAS, DMA, and/or CMS to review the documentation to support a claim for NC Innovations services rendered, when requested. Records must be accessible for inspection and must be brought to a designated location for review when requested by the Quality Management Department, State of North Carolina, and/or Federal Government.

How Long Records Must Be Kept

Employment-related documentation must be kept for at least five years after the employee ends employment with the Employer of Record, and until all outstanding lawsuits, claims, and audits are resolved. Service-specific documentation must be maintained by the NC Innovations Employer of Record for 11 years after the date of the last encounter or, for minors, 12 years from the 18th birthday. If the Employer of Record decides to not continue to self-direct services, the record or a dually-certified copy of the record would be sent to Trillium Quality Management within 60 days of self-directing service(s).

APPENDIX 28. SHORT RANGE GOALS

Short Range Goals / Interventions For: _____

Name:	DOB:	Medicaid ID#:	Record #:

ISP Meeting Date:	Effective Date:

Long	Range	Outcome:

(*use as many Short Range Goals as necessary to address Long Range Outcome)

Short Range Goal: (to be developed by EOR)	Service(s) / Support(s)	Location(s)*	Estimated Frequency**	Target Date
Intervention: (to be developed by EOR – be as detailed/specific as possible)				

*** Location Codes:** **1**-Consumer's Home **2**-Day Program **3**-Residential Facility **4**-Community **5**-Place of Employment **6**-Volunteer Site **7**-Worker's Home **8**-Other (Please specify)

****Estimated Frequency for Each Location:** (e.g. 75% of hours, 3 out of 5 days, 2 hours/day)

Long	Range	Outcome:

(*use as many Short Range Goals as necessary to address Long Range Outcome)

Short Range Goal: (to be developed by EOR)	Service(s) / Support(s)	Location(s)*	Estimated Frequency**	Target Date

Intervention: (to be developed by EOR – be as detailed/specific as possible)

*** Location Codes:** **1**-Consumer's Home **2**-Day Program **3**-Residential Facility **4**-Community **5**-Place of Employment **6**-Volunteer Site **7**-Worker's Home **8**-Other (Please specify)

****Estimated Frequency for Each Location:** (e.g. 75% of hours, 3 out of 5 days, 2 hours/day)

Name: _____ DOB: _____ Medicaid ID: _____ Record #: _____

Signature Page

_____ _____

Signature of Individual Date

_____ _____

Signature of Legally Responsible Person Date

APPENDIX 29. GRID INSTRUCTIONS

1. Complete section with person's name, Medicaid ID number (MID#), Date of Birth (DOB), Record number and Page section.
2. Insert number of hours a week the service will be provided.
3. Insert goal from the Short Range Goal form in to the goal section under Outcome.
4. Inset the Interventions and Assessments utilizing the key on the bottom of the comments portion of the grid. In the grid below you can see interventions were documented utilizing Key 1 and assessments were documented utilizing Key 7. Please see Key here.

Key 1 HH	I	G	#VP	X	M	PP	N/A	R
Hand over Hand	Independent	Gesture	#Verbal Prompt(s)	Not run daily	Model	Physical Prompt	Not Applicable	Refused

Key 7 1	2	3	4
Goal Met	Intervention Effective-Progress Noted	Intervention Effective-NO progress noted	Goal Not Run

Key 2 Y	N	X	N/A	R
Yes	No	Not run daily	Not Applicable	Refused

5. Complete Time In/Time Out, Duration, Date and Initials section.
6. Sign on Support Professional Signature line

COMMENTS INSTRUCTIONS

1. Complete Person's Name, Date of Birth (DOB), Medicaid ID number (MID), and Record number.
2. Insert appropriate dates under date section
3. Write in comments for the session from that date. Be as specific as possible in recapping the session including the interventions you provided, the assessment of how effective the interventions were and how they were received by the consumer. Remember, "If it isn't documented it didn't happen". Give yourself credit for the work you do with the person you support.
4. Print your name, sign and add your initials at the bottom of the form where indicated.
5. Make sure to have your Employer signs where indicated.

See Sample Grid on the following Page:

INDIVIDUAL'S NAME:	MID#:	DOB:	RECORD #:	Page 1 of 1
SERVICE: ______________________	hrs./wks.	MCO: Trillium	SERVICE PROVIDER: EOR	

OUTCOME					KEY	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Goal					1							
Assessment					7							
Goal					1							
Assessment					7							
Goal					1							
Assessment					7							
Goal					1							
Assessment					7							
Goal					1							
Assessment					7							
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Goal					1							
Assessment					7							
Goal					1							
Assessment					7							
Goal					1							
Assessment					7							
Goal					1							
Assessment					7							
TIME IN/TIME OUT					X							
DURATION					X							
DATE					X							
INITIALS (SEE ON BACK)					X							

INDIVIDUAL/RESPONSIBLE PERSON SIGNATURE (REQUIRED):______________________________
DATE:

EOR SIGNATURE:______________________________

Support Professional SIGNATURE: ______________________________

APPENDIX 30. COMMUNITY LIVING AND SUPPORTS CHECK LIST

Comments

INDIVIDUAL'S NAME: _____ Month/Year_____

Specify Service: _____ LME-MCO Trillium Health Resources

EOR: _____ RECORD #: _____ MID#: _____

Insert PC Goal # Check when Complete					Comments for Community Living and Supports Services
Date					
Duration					

All Staff Persons Working with this person must fill in information below.

Staff Name (Please Print)	Staff Signature (full signature required	Initials

APPENDIX 31. SERVICE NOTE A

Name: **Medicaid ID Number:** **Record Number:**	1. Date of Service 2. Identification of Person receiving services if different from person receiving services 3. Purpose of Contact 4. Description of Interaction(s) 5. Effectiveness of Intervention(s) 6. Duration of Service – All periodic, as required by the specific service, or as otherwise required 7. Professional's Signature – Degree, credentials, or licensure Paraprofessional Signature/Position

APPENDIX 32. SERVICE NOTE B

Name: **Medicaid ID Number:** **Record Number:**	1. Date of Service 2. Identification of Person receiving services if different from person receiving services 3. Purpose of Contact 4. Description of Interaction(s) 5. Effectiveness of Intervention(s) 6. Duration of Service – All periodic, as required by the specific service, or as otherwise required 7. Professional's Signature – Degree, credentials, or licensure Paraprofessional Signature/Position

APPENDIX 33. SERVICE NOTE C

Individual:	Medication ID#:	Record Number:
Date:	Duration of Service:	
Purpose of Contact		
Intervention(s) [What you did]		
Effectiveness of the Intervention(s)		
Full Signature Required		
Date:	Duration of Service:	
Purpose of Contact		
Intervention(s) [What you did]		
Effectiveness of the Intervention(s)		
Full Signature Required		
Date:	Duration of Service:	
Purpose of Contact		
Intervention(s) [What you did]		
Effectiveness of the Intervention(s)		
Full Signature Required		

MANAGING EMPLOYEES

APPENDIX 34. EMPLOYEE SUPPORT AGREEMENT

Employee _____

Employer of Record _____

Date of Agreement_____

The Employee agrees to:

1. Perform the duties in this Agreement and any attachments to this Agreement.
2. Maintain required documentation, and agrees all matters regarding the Individual or matters discussed with my Employer are confidential. Information will not be disclosed to other persons without authorization from my Employer.
3. Complete all necessary paperwork to secure payroll deductions from my pay. This includes keeping a time and billing forms that must be signed by the Employer and employee, and incident and accident reports. Submission of false information on timesheets, clinical documentation, or other reports could result in criminal prosecution.
4. All records are the property of the Employer of Record and must be returned to the Employer of Record at the time that the employment relationship ends. Records will not be taken from the work site unless authorized by the Employer of Record.
5. To notify _____or their designee, _____,of any medical emergency or illness. The employee will notify one of them before taking the Individual to the physician, except in case of an emergency.
6. To participate in any meetings requested by the Employer.
7. The employee acknowledges receipt of the employee's job description and employee guidelines, and agrees to abide by all rules. The Employee agrees to comply with all policies and procedures of the federal and state Department of Health and Human Services related to the provision of Medicaid Services. These policies can be changed by the state or federal government at any time, including reimbursement rates for services that could change employment or salary terms.
8. The first 30 days of employment are a trial period to determine if the relationship is working for both parties. I understand this is an employment "at will relationship," which can be terminated by either party, at any time. I agree to give a 10-day written notice to my Employer if this Agreement is to be terminated. My Employer will immediately terminate this agreement and employment if I habitually neglect duties or if my actions present a threat to the health or

welfare of the Individual. My Employer may give me 10 days written notice of termination unless it is determined my continued employment will pose a risk to the Individual.

9. As compensation for services rendered, I will receive a salary of $_____per hour as gross wages, which shall be paid_____ (frequency). Payment of wages will be made _____days after the close of the pay period. The Financial Support Service provider will withhold and remit the appropriate federal and state required taxes. Other deductions include FICA, FUTA, SUTA, Workers Compensation and _____. A W-2 statement for the previous calendar year will be supplied to the employee no later than January 31.

10. I understand a Financial Support Agency will process my paycheck. Only my Employer has the authority to authorize my paycheck. If I am overpaid, I must reimburse the Financial Support Agency for the overpayment.

11. The first 30 days of employment are a trial basis and employment may not continue after this time period.

12. I understand I will be paid time and a half for any hours worked over 40 per week. The time is calculated from hours worked from Sunday thru Saturday. My Employer or their representative must specifically authorize overtime pay.

13. No gifts may be made or accepted from the individual supported, the family of that individual or the individual's guardian or Representative.

14. Performance reviews will be given once each _____.

15. I agree to reimbursement of _____ per mile when asked to use my personal vehicle to perform job duties as directed by my Employer. I agree to keep an accurate record of mileage incurred, and to abide by all traffic and driving-related laws of the State of North Carolina, including proper use of seat belts at all time. I will provide adequate insurance on my vehicle. (If the Employer supplies a vehicle, the Employer will provide adequate auto insurance for vehicle to be used; furthermore, the Employer will provide proof of such insurance on the vehicle.) I must maintain a valid NC Driver's License to keep my job. Travel from home to work and back again or to other assignments not related to work for Employer will not be reimbursed. I understand that meals or admission tickets will not be reimbursed.

16. I recognize employment is conditional on my Employer's participation in NC Innovations Waiver, Individual and Family Supports Option. If the Employer no longer participates in the Option, I may no longer be employed.

17. My Employer has authorized _____ to act on all supervisory matters in his/her absence.

Employee Support Agreement *(continued)*

The Employer of Record agrees to the following:

1. Keep all information about my employee confidential, and to release it only upon the consent of my employee.
2. Pay the employee (through the Financial Support Agency) the salary and benefits described in this Agreement.
3. Provide or arrange required and appropriate training to/for the employee.
4. Evaluate the performance of the employee and provide appropriate feedback to assure the Individual being supported receives quality services.

If there are disputes about this Agreement, they must be addressed by the Employer of Record. A complaint may also be filed by the Employee with Trillium Health Resources. However Trillium Health Resources is not the Employer. We agree to the terms of this agreement.

Employer of Record's Signature_____ Date_____

Employee's Signature_____ Date_____

Representative's Signature, if applicable_____ Date_____

APPENDIX 35. EMPLOYEE SCHEDULE SAMPLE

Employee Schedule

Employee Name:

_____

Start Date: _____, 20_____.

Days/Hours of Employment: The employee shall work the following schedule:

Sunday	_____ to _____	Thursday	_____to _____
Monday	_____ to _____	Friday	_____to_____
Tuesday	_____ to _____	Saturday	_____ to_____
Wednesday	_____ to _____		

Total hours / week _____

Absences/Tardiness: In the event the employee is unable to work at a scheduled time due to illness or other legitimate reason, employee shall give Employer ___ hours advance notice. In case of an emergency or tardiness, employee shall notify Employer as soon as possible.

Scheduled Holidays I will not be expected to work

_____

_____

Vacation Days with Pay: _____ Vacation Days without Pay: _____

Sick Days with Pay: _____ Holiday Days with Pay: _____

Holiday Pay Rate: (specify holidays):

_____

APPENDIX 36. EMPLOYEE SUPERVISION PLAN

Employee Training and Supervision Plan

Training that must be completed before the employee provides services to the individual the individual is supporting:

- ☐ CPR
- ☐ First Aid
- ☐ Blood borne Pathogens

Other training that must be completed with expected completion date:

- ☐ _____ Date _____
- ☐ _____ Date _____
- ☐ _____ Date _____
- ☐ _____ Date _____
- ☐ _____ Date _____

The above training will be arranged by the Employer of Record at no cost to the employee. The employee will be paid during the actual hours of training attendance (minus any time off for lunch).

The employee will not be paid mileage for driving to the training, as this will be the employee's assigned work site for the day.

Failure to attend training will be grounds for dismissal.

A training certificate must be returned to the Employer of Record to verify attendance.

Other training may be required by the Employer of Record to keep CPR and First Aid certifications current, or as needed in order for the employee to perform job duties.

The plan for supervising the employee is:

- ☐ Observing the work of the employee at least monthly
- ☐ Reviewing the Time and Billing Sheet completed by the employee at least twice per month
- ☐ Reviewing the employee's documentation at least monthly
- ☐ Meeting with the employee at least monthly
- ☐ _____
- ☐ _____

Documenting the supervision in the Supervision Log in the employee's file.

cc: Employer and Employee

APPENDIX 37. SUPERVISION LOG SAMPLE

Name: _____ Date: _____

Individual Supervision: _____

Topic(s)

Employee Action Needed *(Measurable Action Item)*	Time Frame

Supervisory Action Needed *(Measurable Action Item)*	Time Frame

Comments/Notes

Employee Signature: _____

Employer Signature: _____

APPENDIX 38. AREAS TO THINK ABOUT IN DEVELOPING EMPLOYEE GUIDELINES

An employer or representative will want to think about the following areas when developing Employee Guidelines:

- **Personal Property**—Employees will respect the individual's personal property, and ask permission if they want to use it.
- **Food and Beverages**—Consider allowing employees to help themselves to water and keep food that they bring to work for lunch or breaks in the refrigerator. Remind employees they cannot eat or drink items in the house unless invited specifically to do so. They must bring their own lunch or dinner to work. Consider if they will be given a break allowing them to leave the home and go out to lunch or dinner.
- **Personal Phone Calls**—Employees must ask to make a phone call, either on the phone in the house or on the employee's personal cell phone. Calls made at work must be time limited unless there is an emergency. Employees must reimburse for long distance phone calls that are made on the individual's phone.
- **Internet Access**—Employees should not use smart phone, tablets and/or computers for personal use while on the job, including sending text messages and e-mails.
- **Smoking**—Employees may or may not smoke at the individual's home. Consider if there will be a designated smoking area and if the individual can be left alone while the employee uses the designated smoking area.
- **Visitors**—Employees may not have visitors on the job. The services provided by Medicaid funding in Individual and Family Services require a 1:1 staffing ratio; therefore when the employee is providing them, the employee cannot work with or visit with anyone else. This includes the employee's own children or family members of the individual.
- **Dress**—Dress should be appropriate to the type of work. The employer or representative should describe any attire that would be considered inappropriate.
- **Handling the Individual's money**—Employees should be careful with the individual's money. The employer or representative should describe expectations around helping the individual keep receipts, clip coupons, make shopping lists, watch utility usage and help select activities that are inexpensive.
- **Relating to others who live in the individual's home**—Employees are employed to provide services only to the individual. The employer or representative should make the employee aware of other individuals who live in the home and any special information that might be helpful in relating to those individuals.
- **How the employee should act during social activities**—The employer should clarify any special issues if the employee is a friend or relative. Boundaries between work and non-work time should be clarified so there is no question about when the employee is to be paid.

APPENDIX 39. SAMPLE EMPLOYEE EVALUATION

- The property of our child and our family must be respected. You must request permission to use any other item in our home unless you have been instructed that you may use it.
  - You should bring your own meals and snacks, including beverages you wish to drink. You can keep them in the refrigerator. You may help yourself to water and coffee.
  - You can eat your meals and snacks when our child has hers. You may only eat food or drink beverages in the kitchen or dining room. Because you are responsible for supervising her at all times, you may not leave the house for lunch or breaks. If you need time off, you should schedule this with us.
- You should not make phone calls while at work. If there is an urgent need for you to make a phone call, you may do so as long as you use your own cell phone or request permission to use our phone. These phone calls should be brief, unless there is an emergency. If the phone call is long distance, you must reimburse us for the charges. Please keep your personal cell phone turned off or on vibrate while you our working with our child.
- You may not send text messages or personal e-mails while working with our child.
- You may not smoke at our home, either inside or outside our home. You may not smoke anytime our child is present in your car or while you are with her in the community.
- You may not have visitors at work, either while you are working in our home or in the community. Because Medicaid services are to be provided with one staff person to one participant (our child), we will not ask you to care for our other children. Interactions with others in the community should be directly related to the services you are providing to our child. Encounters with individuals you know in the community should be brief, and you should not tell them any information about our family or our child.
- You should dress appropriately for the work schedule. You will need a swimsuit and towel for the days that our child participates in her swimming class. We ask that you not wear shorts to work unless there are plans for an outside outing on a hot summer day. Jeans are fine but we ask that you not wear t-shirts with slogans on them that could be considered offensive to our family or others in the community. Please do not wear open toe shoes or flip flops, except at the pool. Please wear sturdy shoes or sneakers that will help protect you from falling.
- We will not expect you to handle our child's money except for small amounts of cash that she will need for community outings. Please obtain a receipt of any purchase made, and return the receipt with leftover money to us.
- Our other two children are our responsibility. They will be present in our home, and may play with our child at times that she is not working on goals or other activities. Please notify us if they require any direction or discipline, or if they are interfering with scheduled training activities.
- We will only pay you for when you are on duty. If you encounter our family in the community, it is fine for you to greet us but we do not expect you to assist us with our child during non-working hours.

APPENDIX 40. COMMONLY ASKED EMPLOYEE EVALUATION QUESTIONS

Attendance

Does the employee report to work when scheduled?

_____ Always ___ Usually _____ Sometimes ____ Rarely _____Never

When the employee is late or absent, does he or she give enough notice?

_____ Always ___ Usually _____ Sometimes ____ Rarely _____Never

Does he or she give a good reason for being late or absent?

_____ Always ___ Usually _____ Sometimes ____ Rarely _____Never

Performance

Does the employee do the work to my satisfaction?

_____ Always ___ Usually _____ Sometimes ____ Rarely _____Never

Does the employee follow my instructions well?

_____ Always ___ Usually _____ Sometimes ____ Rarely _____Never

How would I rate the employee on the following tasks? The list will be unique to your situation.

_____Great _____Very Good _____OK _____Not So Good _____Poor

How much supervision does the employee need for the following tasks? *(Giving medication, shopping, etc. The list will be unique to your situation.)*

_____Nearly None_____Very Little _____Some _____Lots _____Total

Next steps

Does the employee need more training?

_____No _____Yes In what areas? *(List)*_____

_____

Do there need to be changes in the Employee Procedures?

_____No _____Yes In what areas? *(List, for example: scheduling, task, etc.)*_____

_____

Does the employee need to make changes in his/her performance?

_____No _____Yes In what areas? *(Be prepared to discuss. For example, showing up and on time)*

APPENDIX 41. SAMPLE EMPLOYEE EVALUATION

Date of Review_____

Employee Name_____

Attendance

Evaluation Area	Poor	Below Average	Average	Above Average	Superior
Follows Work Schedule					
Reports to Work on Time					
No Excessive Absences					
Gives Prior Notice for Absences					

Comments

_____

_____

_____

_____

_____

Performance

Evaluation Area	Poor	Below Average	Average	Above Average	Superior
Performs Duties Satisfactorily					
Follows Instruction					
Needs Minimal Supervision					
Job Knowledge					

Comments

_____

_____

_____

_____

_____

Behavior

Evaluation Area	Poor	Below Average	Average	Above Average	Superior
Trustworthy					
Open to Suggestions					
Communicates Well					
Willing to Learn					
Positive Attitude					

Comments_____

_____

_____

_____

_____

_____ _____

Employee Signature/Date Employer Signature/Date

Employee Evaluation (Sample 2)

Employee Name _____

Date _____

Evaluation Factor	Yes	No
Calls me by the name I want to be called		
Talks to me in a nice way		
Looks at me when talking to me		
Asks me about my feelings and ideas		
Gives me extra time to communicate if I need it		
Gives me extra time to do things if I need extra time without making me feel hurried		
Asks me if I need help before giving me help		
Includes me in conversation when other people are in the room and they are talking about me		
Shows up at the time and day he/she told me he/she would		
Dresses and grooms in a way that makes me feel good about going out with him/her in the community		
Calls me if he/she are going to be late		
If he/she cannot come when scheduled to, he/she calls in time for me to make other plans		
Returns my phone call quickly or by the time I have asked him/her to call me back		
Knocks on my door before entering		
Asks permission before using personal things like my phone or stereo, eating my food, touching personal items		
Respects my privacy		
Supports/helps me to select goals that I want to work on		
Knows what my personal goals are on my support plan		
Helps me to work on things that are part of my goals		
Helps me find better or other ways to reach my goals when I am having a hard time reaching a goal		

Evaluation Factor	Yes	No
Helps me change my goals and helps me to work on my new goals		
Asks me what I want to work on or where I want to go		
Takes time in doing the things I want to do when we go into the community		
When I am with him/her, I feel we are really having a good time, learning things and enjoying out time together		
If I have a problem with what he/she is dong, I feel he/she listens to me and fixes the problem quickly		
Overall, I feel good, safe, and happy when I am with this person		

Employee Signature/Date

Employer Signature/Date

APPENDIX 42. NOTICE OF UNSATISFACTORY PERFORMANCE

To: _____

From: _____

Date: _____

Subject: Unsatisfactory Performance

As we discussed in our meeting on _____, there are issues related to your recent work performance and/or behavior on the job that must change for you to continue as an employee. Below are items we discussed including issues of concern that require improvement and the steps you will take to make those improvements.

Issue _____

Steps toward improvement _____

Issue_____

Steps toward improvement_____

Issue_____

Steps toward improvement_____

Issue_____

Steps toward improvement_____

Please know you are a valuable employee. I hope by addressing the above issues, your performance will improve and no further corrective measures will be necessary.

Employee Signature_____ Date_____

Employer Signature_____ Date_____

APPENDIX 43. SAMPLE PROCESS FOR HANDLING CONFLICT

Because the employment relationship involves such close and frequent contact, there are many opportunities to address conflicts--or even potential ones--early. These opportunities can occur any time or any place, from the informal conversations that take place during daily routines to the times when you review the Performance Checklist with your employee.

In order to have a good relationship with your employee, you need to find a way to be at ease with each other while still respecting each other's rights to express needs and opinions openly and honestly. When issues or conflicts come up, try to address them as soon as you can rather than letting them build up or linger unresolved.

Use the following points to help you prepare yourself for addressing conflict with your employee.

- Talk about one thing at a time. Few of us can handle more than one conflict or complaint at a time. Always show respect and concern for the other person.
- Provide privacy. To keep the complaint between two persons, avoid an audience. Even one person can equal an audience.
- Allow space. Allow the other person the physical space, time and the emotional space to deal with what you have presented. When confronted, you want time to think. Give the same to others when you confront them. In other words, talking with your employee near the end of his or her shift is probably better than raising an issue as soon as they arrive.
- Be concise. Think through what you plan to say thoroughly so that you do not lose your focus.
- Be very specific in naming both the events and behaviors that are the source of the problem and the changes that you think would solve or lessen the problem. If you do not have suggestions for changes and need help from the other person in finding a solution, be very clear in stating that as well. Do not leave the other person guessing what you want done differently.
- Take responsibility for yourself. If you are raising an issue with someone else, it is your issue. Express this to the other person by using "I" rather than "you" statements. For example, say, "I feel..." rather than "You make me…."
- End with appreciation. You do not need to shower the other person with insincere compliments, but try to end on a positive note. At the very least, you could thank them for their willingness to listen or talk with you openly.

Once you have brought an issue up with your employee, it is your responsibility to monitor, or follow-up on the situation. If the suggestions or requests made in your initial discussion were well received, thank the other person for their cooperation and occasionally, over time, continue to do so as reinforcement. If your initial discussion was partially well received, thank the person for the good part of their response, and repeat your request about the part that still needs improving.

If things still do not get better, you should ask yourself if the request is "doable" by your employee. Second, did the employee understand the request? if repeating the request does not prompt your employee to try to accommodate the changes you have requested, you will have to make a decision as to whether or not this is someone who you want to continue to employ.

If it appears that you are not going to be able to resolve the issue, it is a good idea to take some notes for your records. These notes can be helpful if a fired employee files for unemployment compensation.

You want to make sure you are firing your employee for good reason. If you have fired a couple of employees, a good idea is to ask members of your team to help you think about why that might be happening. You want to stop going through advertising, interviewing and training new people over and over again if you can avoid doing so.

APPENDIX 44. WORKERS' COMPENSATION INSURANCE INFORMATION

Workers' Compensation Insurance provides coverage to employees for financial compensation, in particular compensation of lost wages and sometimes for medical costs if they are injured or disabled while performing the job duties. Employers of Record are required to have Workers' Compensation Insurance. The Financial Support Agency facilitates the application for Workers' compensation Insurance.

The following Frequently Asked Questions provide further information about Workers' Compensation Insurance:

- **Why do I need Workers' Compensation Insurance?**

  You as Employer of Record are responsible for any injuries that may occur while your employees are working. Worker's Compensation also covers worktime related to attending training and providing services outside of your home. Having this coverage relieves you of financial liability which would put your home or personal assets at risk.

- **What happens if I terminate from the Employer of Record Model?**

  If you terminate from the Employer of Record Model, you need to contact the Financial Support Agency who will complete a "Cancellation Request" on your behalf. Once the signed request is received by the insurance carrier, they will complete a final audit.

- **Who do I contact if I have inquires or need assistance with a claim?**

  If you need to report a claim, you contact the Financial Support Agency for assistance.

- **As the Employer of Record, am I insured under the Workers' Compensation Policy?**

  No, this coverage is only for your employees. If you designate a Representative, the Representative is not covered.

EMPLOYER OF RECORD PERSONNEL FILE

APPENDIX 45. EMPLOYER PERSONNEL FILE

Below are suggestions for organizing Employee Files. Please see sample documents in Employer Resources and Forms.

EMPLOYEE FILE

- Status Payroll Form
- Emergency Contact Form
- Application
- Screening Notes
- Interview Notes
- Release to Obtain References (Signed)
- References
- Job Description (Signed)
- Employee Guidelines (Signed)
- Hepatitis Employee Notification
- Employer Support Agreement (Signed)

TRAINING

- Employee Training Log
- Confidentiality Statement (Signed)
- Training Certificates
- Employee Schedule

SUPERVISION

- Employee Supervision Plan
- Supervision Form
- Performance Related Letters
- Performance Reviews
- Performance Evaluations

Note:

I-9 documentation should be kept separate from Main Employee File & Supporting Documentation (all in one folder)

Criminal Background Reports should be kept separate from main Employee File (all in one folder)

APPENDIX 46. EMPLOYEE STATUS FORM

Employee Full Name:		
SECTION 1 – EMPLOYEE		
Date of Hire:	Birth Date:	Gender (M or F):
Email Address:	Phone Number:	
SECTION 2 – WAGE / SALARY		
Effective Date: M/D/Y	Position Title:	
Current Wage / Salary:$ per/hour	New Wage / Salary:$ per/hour	
REASON FOR CHANGE ☐New Hire/Rehire ☐Termination/Resignation ☐Wage / salary increase		
Effective Date: M/D/Y	Position Title:	
Current Wage / Salary:$ per/hour	New Wage / Salary:$ per/hour	
REASON FOR CHANGE ☐New Hire/Rehire ☐Termination/Resignation ☐Wage / salary increase		
Effective Date: M/D/Y	Position Title:	
Current Wage / Salary:$ per/hour	New Wage / Salary: $ per/hour	
REASON FOR CHANGE ☐New Hire/Rehire ☐Termination/Resignation ☐Wage / salary increase		
Effective Date: M/D/Y	Position Title:	
Current Wage / Salary:$ per/hour	New Wage / Salary: $ per/hour	
REASON FOR CHANGE ☐New Hire/Rehire ☐Termination/Resignation ☐Wage / salary increase		

APPENDIX 47. EMPLOYEE EMERGENCY CONTACT INFORMATION SHEET

This sheet is to be updated annually or sooner if changes are to be made.

Employee Name:_____

Street Address _____

City _____ State _____ Zip _____

Preferred contact after work hours: Home Cell (circle one)

Home Phone Number:_____ Cell Phone Number:_____

Personal email: _____

Emergency Contact

Name:_____

Relationship:_____

Daytime Phone Number:_____

Evening Phone Number:_____

Cell Phone Number:_____

***Optional**

Medical Information to be disclosed to emergency personnel:

Conditions:_____

_____

Allergies:_____

_____

Medications:_____

_____

_____

I acknowledge that my medical information as above may be released

_____ (initials) to emergency personnel

_____ (initials) to emergency contact person

Employee Signature _____ Date:_____

EMPLOYER OF RECORD CHECKLISTS & FORMS

APPENDIX 48. MATERIALS IN THE EMPLOYER OF RECORD NOTEBOOK

Orientation Materials (assist participant in placing these materials in the notebook; Care Manager responsible for distribution)

- Individual & Family-Directed Supports Employer Brochure
- Fact Sheet: Community Navigator
- Fact Sheet: Individual & Family-Directed Supports
- Fact Sheet: Representative
- Fact Sheet: Individual Goods and Services

Training Materials

- Individual & Family-Directed Supports Overview
- Red Cross Disaster Preparedness Manual
- All Individual & Family-Directed Supports Handbooks

Employer Handbooks

- Individual & Family-Directed Supports Employer Handbook
- Individual & Family-Directed Supports Employer of Record Handbook Supplement
- Individual & Family-Directed Supports Resources and Forms Supplement

Service Rate Information (In Excel Calculator)

APPENDIX 49. EMPLOYER OF RECORD FILE BOX

Portable Locking File Box is provided along with hanging file folders labeled as follows:

#	Label on File	Form	Provided By
1.	Applicants	Information Gathered on Applicants who are **not** hired	Employer of Record
2.	Back-Up Staffing Incident Reports	Back-Up Staffing Incident Reports	Community Navigator
3.	Criminal Background Check Request Results	Results of Criminal Background Checks are filed separately and not included in Employee Personnel Files	Financial Support Agency
4.	DHHS Restrictive Intervention Details Report	DHHS Restrictive Intervention Details Report, blank copies. Completed Reports are placed inside file folder	Community Navigator
5.	DHHS Incident and Death Report	DHHS Incident and Death Report blank copies. Completed Reports are placed inside file folder	Community Navigator
6.	Individual Clinical Documentation	Completed documentation forms and other clinical information related to individual service provision	Employer of Record
7.	Financial Support Agency Correspondence	Information sent to Employer of Record by Financial Support Agency	Provided by Financial Support Agency
8.	Financial Support Agreement and Purchase Request Forms	Agreement and Forms provided by Financial Support Agency	Provided by Financial Support Agency
9.	Employer of Record Monthly Budget Reports	Monthly Employer of Record Report	Provided by Financial Support Agency
10.	Completed Time and Billing Sheet	Copies of Time and Billing Sheet	Employer of Record
11.	Workers' Compensation Insurance Policy	Copies of Policies	Financial Support Agency

#	Label on File	Form	Provided By
12.	Confidentiality Statement	Confidentiality Statement in Employer Resources and forms	Community Navigator
13.	Criminal Background Check Request Forms	Criminal Background Request/Release Form	Financial Support Agency
14.	Documentation Forms	Documentation Forms	Community Navigator
15.	Employee Support Agreement	Employer Resources and Forms	Community Navigator
16.	Employment Application	Employer Resources and Forms	Community Navigator
17.	Performance Evaluations	Employer Resources and Forms	Community Navigator
18.	Hepatitis B Notification	Employer Resources and Forms	Community Navigator
19.	Job Description	Developed by Employer of Record	Community Navigator
20.	Reference Release Checks	Employer Resources and Forms	Community Navigator
21.	Supervision Log	Employer Resources and Forms	Community Navigator
22.	Time and Billing Sheet	Blank Time Sheets and Billing Sheet (may submit electronically per Financial Support process)	Financial Support Agency
23.	Training Documentation	Obtained by Employer of Record	Employer of Record

APPENDIX 50. EMERGENCY PLANS REVIEW LOG

Date Developed		
Date Back-Up Staff Plan	Date Environmental Plan	Date of Medical Plan

Review of Back-Up Staff Plan **Review of Environmental Plan Plan** **Review of Emergency Medical**

Review of Back Up Staffing

Date Reviewed	Review Details	Employer Signature
	☐Review Completed Revised ☐Yes ☐No	
	☐Review Completed Revised ☐Yes ☐No	
	☐Review Completed Revised ☐Yes ☐No	
	☐Review Completed Revised ☐Yes ☐No	

Review of Fire-Disaster Plans

Date Reviewed	Review Details	Employer Signature
	☐Review Completed Revised ☐Yes ☐No	
	☐Review Completed Revised ☐Yes ☐No	
	☐Review Completed Revised ☐Yes ☐No	
	☐Review Completed Revised ☐Yes ☐No	

Review of Emergency Medical Plans

Date Reviewed	Review Details	Employer Signature
	☐Review Completed Revised ☐Yes ☐No	
	☐Review Completed Revised ☐Yes ☐No	
	☐Review Completed Revised ☐Yes ☐No	
	☐Review Completed Revised ☐Yes ☐No	

Note: Employer of Record and/or Representative is required to review Emergency Plans a minimum of quarterly and to update/revise them as needed. Please keep all completed forms

APPENDIX 51. HEALTH AND SAFETY CHECKLIST

Name of Direct Service Employee _____

Location of Service Address _____

City, State, Zip Code _____

Telephone Number at Service Location _____

Assurance	Met	Not Met	Comments
1. The home is free from any hazards that present a risk to the Participant's health and safety. Appropriate safety preventive devices are in place to include at a minimum of a smoke detector on each level of the home.			
2. Medications, hazardous cleaning supplies, or firearms in the home are kept in a secure (locked) location.			
3. Pets the Participant comes in contact with have up-to-date vaccinations. If the pet presents a risk to the safety of the Participant, the pet must be kept in a secure location, separate from the portions of the home accessed by the Participant.			
4. There is an evacuation plan specific to the Participant in the home, and it is tested at least monthly.			
5. If the Participant requires adaptive equipment for services and supports provided in the employee's home, that equipment must be available. Medicaid does not fund duplicate equipment for the purpose of availability in the employee's home.			
6. A criminal background check is performed for any adult who lives in the home and present during the time the Participant is receiving services. The results of the background check do not present any safety risk for the Participant.			
7. A healthcare registry check is performed for any adult who lives in the home and present during the time the Participant is receiving services. The results of the healthcare registry check do not present any safety risk for the Participant.			

- The Employer of Record verifies this information is accurate and has been discussed with the Direct Service Employee providing Community Living and Supports or Respite in his/her own home. This checklist is valid for this location only.
- Services provided are documented in the Individual Support Plan with the Direct Service Employee's home listed as the service location.
- Services provided at this location are based on the documented needs of the Participant, not for the convenience of the employee.
- The Individual Support Plan states how the Participant's needs are better met in the direct service employee's home.
- Community Living and Supports/Respite are not billed when the direct service employee is providing direct care to another child or person. If the direct service employee is providing direct care to another child or person, the Participant's health and safety must be assured.
- The Participant may not clean or perform other household tasks in the direct service employee's home, including preparing meals for the direct service employee's family.
- Medication administration regulations are followed for any medications that the Participant is assisted in taking.
- If the Participant has a goal to learn to evacuate the Participant's private home, that goal must be trained in the Participant's home.
- The Participant and/or Participant's guardian/family may not be charged for any damage to the Direct Service's Employee's property or any additional charge for the service provided. The issue of liability insurance to cover accidents to/by the Participant is addressed by the Provider Agency.
- The NC Innovations Waiver does not pay for room and board costs.
- The Care Manager has access to the service location during hours that services are provided to the Participant for both announced and unannounced monitoring visits.
- The Provider Agency will make and document at least one monthly site visit during hours of service provision to make sure that the services provided are consistent with the Individual Support Plan, and that the environment continues to be healthy and safe for the Participant.
- The Provider Agency agrees to immediately notify the Participant's Care Manager if there is any situation that involves the health and safety of the Participant in the Direct Service Employee's home, including providing the Care Manager with a copy of any Incident Report.

Signature of Employer or Record	Date
Signature of Participant/Legally Responsible Person	Date

Signature of Direct Service Employee	Date
Signature of Community Navigator Agency Representative	Date

Original Maintained in Agency or Participant's

APPENDIX 52. SAMPLE LEVEL I INCIDENT REPORT FORM

Level One incident should be reported to the EOR or Representative and documented within 24 hours. All incident reports are confidential quality assurance documents, protected by NC General Statues.

DO NOT file this form in the individual's service record.

Section One: Consumer Information

Name: _____ Date of Birth: _____

Staff Name Completing the report: _____

Other people Involved: _____

___No one ___Friend ___Family ___Friend of Family ___Staff ___ Stranger ___Unknown ___Other

Section Two: Type of Incident

Check all that apply.

- ☐ Restrictive Interventions
- ☐ Participant Injury
- ☐ Abuse/Neglect/Exploitation
- ☐ Medication Error
- ☐ Suicidal Behavior
- ☐ Sexual Behavior (Shown by the individual)
- ☐ Participant Act (Aggressive or destructive)
- ☐ Participant Absence
- ☐ Suspension (from services)
- ☐ Fire
- ☐ Other: Please Specify_____

Section Three: Incident Information

Date of the Incident:_____ Time of Incident: _____ ☐ AM ☐ PM

Location of the Incident: _____

Describe cause of the incident: _____

_____

_____

_____

List steps taken to resolve incident:

_____

_____

Signature: _____ Date: _____

Section Four: Supervisor Section

The report was submitted within 24 hours: ___YES ___NO (Provide Explanation Below)

Explain how the health and safety needs of the individual were addressed: _____

_____

_____

Describe strategies that can be utilized to prevention this incident from occurring in the future:

_____

_____

Additional comments:

_____

_____

Supervisor: _____ Date: _____

APPENDIX 53. BACK-UP STAFFING INCIDENT REPORTING FORM

Participant Name: Participant DOB:

County of Service Provision: _____

Date of Incident: Time of Incident:

Location where services were scheduled to occur: _____

Name of person(s) who discovered issue: _____

Name of Provider Agency: _____ Contact Number: _____

Provider Agency Address: _____

Name of Provider to provide staffing: _____ Contact Number: _____

_____*Back-up staffing not available (as applicable)*

Indicate name of service(s): _____

Indicate the number of hour's participant was without staff: _____

Indicate specific reason back-up staffing was not available: _____

What options were provided to the participant /legally responsible person? _____

Who was notified of the incident (list names)?_____

How was the participant's health and safety ensured? _____

How was time covered? _____

What follow-up was provided to participant /legally responsible person? _____

What corrective measures will your agency implement to prevent this from occurring in the future?

_____

_____

_____

_____*Back-up staffing offered but declined by participant/legally responsible person (as applicable)*

Indicate name of service(s): _____

Indicate the number of hours participant was without staff: _____

Indicate reason participant /legally responsible person declined back-up staffing: _____

Who was notified of the incident? _____

_____ _____

Signature/Credentials of person completing form: Date:

Supervisor Action: _____Action Pending _____ Action Complete

_____

_____

Signature/Credentials: _____ Date: _____

Quality Management Action: _____Action Pending _____ Action Complete

_____

_____

Signature/Credentials _____ Date: _____

Email or Fax to Quality Management Coordinator
Email:
Fax: 252-215-6880
Phone Number:

APPENDIX 54. DHHS INCIDENT AND DEATH REPORT

North Carolina Department of Health & Human Services – Division of Mental Health/Developmental Disabilities/Substance Abuse Services

CONFIDENTIAL **DHHS Incident and Death Report** *CONFIDENTIAL*

Provider Agency Name	Consumer's Name	LME Client Record Number.

This form is used to report Level II and Level III incidents, including deaths and restrictive interventions, involving any person receiving publicly funded mental health, developmental disabilities and/or substance abuse (MH/DD/SA) services. Facilities licensed under G.S. 122C (except hospitals) and unlicensed providers of community-based MH/DD/SA services must submit the form, as required by North Carolina Administrative Code 10A NCAC 27G .0600, 26C .0300, and 27E .0104(e)(18). Failure to complete this form may result in administrative actions against the provider's license and/or authorization to receive public funding. This form may also be used for internal documentation of Level I incidents, if required by provider policy or LME contract. **Effective March 8, 2006, this form replaces the *DHHS Incident and Death Report (Form QM02, Revised 11/18/04).***

Instructions: *Complete and submit this form to the local and/or state agencies responsible for oversight within 72 hours of learning of the incident (See page 3 for details). Report deaths of consumers that occur within 7 days of restraint or seclusion immediately. If requested information is unavailable, provide an explanation on the form and report the additional information as soon as possible.*

Page 1-2 Instructions: *The staff person who is most knowledgeable about the incident should complete pages 1-2 of this form as soon as possible after learning of the incident and submit to the unit supervisor for review and approval.*

Date of Incident: _____ **Time of Incident:** _____ ☐ a.m. ☐ p.m. ☐ Unknown

CONSUMER INFORMATION

Consumer's Date of Birth: _____ **Consumer's Gender:** ☐ Male ☐ Female

All Diagnoses: _____ **Consumer's Ethnicity** (*Check all that apply*):

☐ Hispanic/Latino ☐ Native American ☐ Asian/Pacific Islander
☐ White/Anglo ☐ Black/African American ☐ Other (*specify*): _____

Does consumer receive CAP/MR-DD Waiver services? ☐ Yes ☐ No ☐ Unknown

DESCRIPTION OF INCIDENT

LOCATION OF INCIDENT

☐ Provider premises
☐ Consumer's legal residence
☐ Community
☐ Other (*specify*) _____
(such as hospital, state institution, etc.)
☐ Unknown

OTHER PEOPLE INVOLVED

(Provide the name of the person and his/her relationship to the consumer that is the subject of the report. Do not provide the name or other identifying information for other consumers in this section. Instead indicate the number of other consumers who were involved.)

	Other Consumer	Staff	Other
1.	☐	☐	☐
2.	☐	☐	☐
3.	☐	☐	☐
4.	☐	☐	☐
5.	☐	☐	☐

Name / title of first staff person to learn of incident _____

Was the consumer under the care of the reporting provider at the time of the incident? ☐ Yes ☐ No

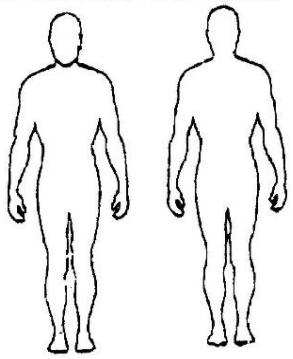
Was the consumer treated by a licensed health care professional for the incident? ☐ Yes ☐ No Date: _____

Was the consumer hospitalized for the incident? ☐ Yes ☐ No Date: _____

Describe the incident, including Who, What, When, Where, and How. *(Describe any preceding circumstances, resulting harm to people, property damage, and any other relevant information. Attach additional pages if needed. Do not provide another consumer's name or identifying information here.)*

INJURY

On the figures below, circle the location of any bruises, cuts, scratches, injuries, or other marks that occurred as a result of the incident.



FRONT BACK

NOTE: Incident reports are confidential quality assurance documents, protected by GS 122C-30, 122C-31, 122C-191 and 122C-192. Do not file incident reports in the consumer's service record. Confidentiality of consumer information is protected under Federal regulations, 42 CFR Part 2 and HIPAA, 45 CFR Parts 160 and 164.

North Carolina Department of Health & Human Services – Division of Mental Health/Developmental Disabilities/Substance Abuse Services

CONFIDENTIAL **DHHS Incident and Death Report** *CONFIDENTIAL*

Provider Agency Name _____ Consumer's Name _____ LME Client Record Number. _____

TYPE OF INCIDENT

CONSUMER DEATH

Death due to: ☐ SUICIDE ☐ ACCIDENT ☐ HOMICIDE / VIOLENCE ☐ Terminal illness / natural cause ☐ Unknown cause

Did death occur within 7 days of the restrictive intervention? ☐ Yes ☐ No *If yes, immediately submit this form to your supervisor.*

DETAILS OF DEATH REPORTABLE TO NC DEPARTMENT OF HEALTH & HUMAN SERVICES

Complete this section only for deaths from suicide, accident, or homicide/violence or occurring within 7 days of restrictive intervention.

Address where consumer died: _____

Physical illnesses / conditions diagnosed prior to death: _____

Dates of last two (2) medical exams: _____ _____ ☐ Unknown ☐ None

Date of most recent admission to a hospital for physical illness: _____ ☐ Unknown ☐ None

Date of most recent admission to an inpatient MH/DD/SAS facility: _____ ☐ Unknown ☐ None

Height: _____ ft _____ in ☐ Unknown Weight: _____ lbs ☐ Unknown Adjudicated incompetent? ☐ Yes ☐ No

RESTRICTIVE INTERVENTION

(Number in order of use)

_____ Physical Restraint

_____ Isolation

_____ Seclusion

Is the use of restrictive intervention part of the consumer's Individual Service Plan? ☐ Yes ☐ No

Was the restrictive intervention administered appropriately? ☐ Yes ☐ No

Did the use of restrictive intervention(s) result in discomfort, complaint, or require treatment by a licensed health professional? ☐ Yes ☐ No

Attach a Restrictive Intervention Details Report (Form QM03) or a provider agency form with comparable information.

OTHER INCIDENT

INJURY

Report injuries requiring treatment by a licensed health professional

(Check only one)

Injury due to:

☐ Aggressive behavior

☐ Self-injury/mutilation

☐ Trip or fall

☐ Auto accident

☐ Other (specify) _____

ABUSE ALLEGATION

(Check all that apply)

☐ Alleged abuse of a consumer

☐ Alleged neglect of a consumer

☐ Alleged exploitation of a consumer

Report any alleged or suspected case of abuse, neglect or exploitation of a consumer, as required by law, to the county Dept. of Social Services and the DFS Healthcare Personnel Registry, as well as the host LME.

MEDICATION ERROR

Report errors that threaten health or safety

(Check only one)

☐ Wrong dosage administered

☐ Wrong medication administered

☐ Wrong time *(administered more than one hour from prescribed time)*

☐ Missed dosage *(including refusals)*

CONSUMER BEHAVIOR

(Check only one)

☐ Suicide attempt

Report the following whenever a report to legal authorities is made:

☐ Inappropriate or illegal sexual behavior

☐ Illegal acts by a consumer

☐ Other consumer behavior

OTHER INCIDENT

(Check only one)

☐ Suspension of a consumer from services [*Enter number of days* _____]

☐ Expulsion of a consumer from services

☐ Fire that threatens or impairs a consumer's health or safety

☐ Unplanned consumer absence more than 3 hours over time allowed in the Person Centered Plan or service plan *(where absence is restricted by the plan)* or absence reported to legal authorities

Name/title of staff person documenting incident *(Please print)*: _____ Phone (____) _____

Signature _____ Date _____ Time _____ ☐ a.m. ☐ p.m.

NOTE: Incident reports are confidential quality assurance documents, protected by GS 122C-30, 122C-31, 122C-191 and 122C-192. Do not file incident reports in the consumer's service record. Confidentiality of consumer information is protected under Federal regulations, 42 CFR Part 2 and HIPAA, 45 CFR Parts 160 and 164.

North Carolina Department of Health & Human Services – Division of Mental Health/Developmental Disabilities/Substance Abuse Services

CONFIDENTIAL **DHHS Incident and Death Report** *CONFIDENTIAL*

Provider Agency Name _____ Consumer's Name _____ LME Client Record Number. _____

Page 3 Instructions: The supervisor of the service should review pages 1-2 of this form, complete page 3 and submit to required agencies in the required timeframes. Use Criteria on page 5 to determine the level of incident. Refer to the Incident Response Manual for further details.

PROVIDER INFORMATION

Facility / Unit _____ Facility /Unit Director: _____

Service address: _____ City: _____ County _____

Facility /Unit Phone Number: ( ) _____ Provider Tax ID or Social Security No.: _____

Service being provided at time of incident: ☐ Residential ☐ Non-residential *(specify)* _____ ☐ N/A

122C-Licensed service? ☐ No ☐ Yes *(License No.)* _____ *If yes, note reporting instructions for Level III below.*

LEVEL OF INCIDENT

☐ **Level II (Moderate)**

Send this form to the host LME (LME responsible for geographic area where service is provided) within 72 hours. If required by contract, also report to the consumer's home LME if different.

☐ **Level III (High)**

Immediately report verbally to the host LME. Convene an incident review committee within 24 hours if services were being actively provided at time of incident. (See manual for details.) Send this form within 72 hours to:

- *host LME (see bottom of page)*
- *consumer's home LME*
- *NC Division of MH/DD/SAS, Quality Management Team, 3004 MSC, Raleigh, NC 27699-3004. Voice: (919) 733-0696, Fax: (919) 715-3604*

NOTE: *Report deaths that occur within 7 days of seclusion or restraint immediately.*

NOTE: *If the service is licensed under G.S.122C, also use the same deadlines to report death from suicide, accident, or homicide/violence and deaths occurring within 7 days of restraint or seclusion, to the NC Division of Facility Services, Complaint Intake Unit, 2711 MSC, Raleigh, NC 27699-2711 Voice: 1-800-624-3004 Fax: 1-919-715-7724*

PROVIDER RESPONSE

Describe the cause of the incident *(attach additional pages if needed)*:

Describe how this type of incident may be prevented in the future and any corrective measures that have been or will be put in place as a result of the incident *(attach additional pages if needed)*:

REPORTING INFORMATION

Indicate authorities or persons notified of the incident *(as applicable)*:

Agency / Person	Contact Name	Phone	Notification Date
☐ Host LME _____		( )	
☐ Home LME _____		( )	
☐ Law enforcement		( )	
☐ County DSS _____		( )	
☐ Health Care Personnel Registry		( )	
☐ Service Plan Team		( )	
☐ Parent / Guardian		( )	
☐ NC DMH/DD/SAS		( )	
☐ NC DFS Complaint Unit		( )	
☐ Other _____		( )	

Name/title of supervisor authorizing report *(Please print)*: _____ Phone ( ) _____

Signature _____ Date _____ Time _____ ☐ a.m. ☐ p.m.

NOTE: Incident reports are confidential quality assurance documents, protected by GS 122C-30, 122C-31, 122C-191 and 122C-192. Do not file incident reports in the consumer's service record. Confidentiality of consumer information is protected under Federal regulations, 42 CFR Part 2 and HIPAA, 45 CFR Parts 160 and 164.

North Carolina Department of Health & Human Services – Division of Mental Health/Developmental Disabilities/Substance Abuse Services

CONFIDENTIAL **DHHS Incident and Death Report** *CONFIDENTIAL*

Provider Agency Name	Consumer's Name	LME Client Record Number.

Page 4 Instructions: This page is available for the provider agency or any agencies receiving the report to use for internal tracking and follow-up purposes. Leave this page blank when sending an incident report to the LME and/or other agencies..

INCIDENT TRACKING *(for internal use only)*

INTERNAL USE ONLY

Incident Report Receipt Date: _____

Current Consumer Status:

LME's (or Other Oversight Agency's) Response:

Name/title of follow-up staff person *(Please print)*:

_____ Phone (____) _____

Signature _____ Date _____ Time _____ ☐ a.m. ☐ p.m.

INTERNAL USE ONLY

Notes:

NOTE: Incident reports are confidential quality assurance documents, protected by GS 122C-30, 122C-31, 122C-191 and 122C-192. Do not file incident reports in the consumer's service record. Confidentiality of consumer information is protected under Federal regulations, 42 CFR Part 2 and HIPAA, 45 CFR Parts 160 and 164.

DHHS Criteria for Determining Level of Response to Incidents

Incidents are events that are inconsistent with the routine operation of a service or care of a consumer that are likely to lead to adverse effects. Providers must report incidents, as defined below, that occur while a consumer is under their care. Individuals receiving residential and ACT Team services are considered under the provider's care 24 hours a day. Individuals receiving day services and periodic services are considered under the provider's care while a staff person is actively engaged in providing a service. See Manual for details.

	EVENT	LEVEL I	LEVEL II	LEVEL III[1]	EXCEPTIONS
CONSUMER DEATH	Consumer Death	----------	Due to: - Terminal illness or other natural cause - Unknown cause	Due to: - Suicide - Violence / homicide - Accident Or occurring: - Within 7 days of seclusion or restraint	• Providers of non-residential services should report as soon as they learn of death. • Review of Level III incidents within 24 hours needed only if actively engaged in providing service at time of death.
RESTRICTIVE INTERVENTION	Seclusion Isolated time-out Restraint	Any planned use administered appropriately and without discomfort, complaint, or injury[2]	1. Any emergency, unplanned use OR 2. Any planned use that exceeds authorized limits, is administered by an unauthorized person, results in discomfort or complaint, or requires treatment by a licensed health professional	Any restrictive intervention that results in permanent physical or psychological impairment within 7 days	Providers will submit aggregate numbers of Level I restrictive interventions to the host LME quarterly.[2]
CONSUMER INJURY	Due to: - Aggressive behavior - Self-injury/mutilation - Trip or fall - Auto accident - Other / unknown cause	Any injury that requires only first aid, as defined by OSHA guidelines[2] *(regardless of who provides the treatment)*	Any injury that requires treatment by a licensed health professional *(such as MD, RN, or LPN)* beyond first aid, as defined by OSHA guidelines[2]	Any injury that results in permanent physical or psychological impairment and any allegation of rape or sexual assault by someone other than a staff member or caregiver	Providers of non-residential services should report Level II incidents only if actively engaged in providing service at time of incident
ABUSE	Abuse of consumer Neglect of consumer Exploitation of consumer	----------	Any allegation of abuse, neglect or exploitation of consumer by staff or other adult, including inappropriate touching or sexual behavior	Any allegation of abuse, neglect or exploitation of consumer that results in permanent physical or psychological impairment, arrest, or involves an allegation of rape or sexual assault by a staff member or caregiver	• Providers of non-residential services should report as soon as they learn of allegation. • Review of Level III incidents within 24 hours needed only if actively engaged in providing service at time of alleged incident.
MED ERROR	Wrong dose Wrong medication Wrong time (over 1 hour from prescribed time) Missed dose or medication refusal	Any error that does not threaten the consumer's health or safety *(as determined by the physician or pharmacist notified of the error)*	Any error that threatens the consumer's health or safety *(as determined by the physician or pharmacist notified of the error)*	Any error that results in permanent physical or psychological impairment	• Providers of periodic services should report errors for consumers who self-administer medications as soon as learning of the incident. • Review of Level III incidents within 24 hours needed only if actively providing service at time of incident. • All providers will submit aggregate numbers of Level I medication errors to the host LME quarterly.[2]
		NOTE: Report all drug administration errors and adverse drug reactions to a physician or pharmacist immediately, as required by 10A NCAC 27G .0209(h).			

[1] Providers should notify the host and home LMEs by phone upon learning of any Level III incident, even if not actively providing service at the time of the incident.
[2] See Manual for details.
NOTE: Incident reports are quality assurance documents. Do not file incident reports in the consumer's service record. Confidentiality of consumer information is protected. Use the form according to confidentiality requirements in NC General Statutes and Administrative Code and the Code of Federal Regulations.

DHHS Criteria for Determining Level of Response to Incidents

	EVENT	LEVEL I	LEVEL II	LEVEL III[1]	EXCEPTIONS
CONSUMER BEHAVIOR	Suicidal behavior	Any suicidal threat or verbalization that indicates new, different or increased behavior	Any suicide attempt	Any suicide attempt that results in permanent physical or psychological impairment	Do not report previous suicide attempts by persons seeking services through the LME Access unit or for whom inpatient commitment is being sought.
	Sexual behavior	Inappropriate sexual behavior that does not involve a report to law enforcement or complaint to an oversight agency	Any sexual behavior that involves a report to law enforcement, a complaint to an oversight agency, or a potentially serious threat to the health or safety of self or others	Any sexual behavior that results in death, permanent physical or psychological impairment, arrest of the consumer, or public scrutiny *(as determined by the host LME)*	----------
	Consumer act	Any aggressive or destructive act that does not involve a report to law enforcement or complaint to an oversight agency	Any aggressive or destructive act that involves a report to law enforcement, a complaint to an oversight agency, or a potentially serious threat to the health or safety of self or others	Any aggressive or destructive act reported to law enforcement or an oversight agency that results in death, permanent physical or psychological impairment, or public scrutiny *(as determined by the host LME)*	----------
	Consumer absence	Any absence of 0 to 3 hours over the time specified in the service plan, if police contact is not required	Any absence greater than 3 hours over the time specified in the individual's service plan or any absence that requires police contact	----------	Report absences of competent adult consumers receiving non-residential services <u>only</u> if police contact is required.
OTHER	Suspension from services Expulsion from services	Any provider withdrawal of services for less than one day for consumer misconduct	Any provider withdrawal of services for one day or more for consumer misconduct	----------	----------
	Fire	Any fire with no threat to the health or safety of consumers or others	Any fires that threatens the health or safety of consumers or others	Any fire that results in permanent physical or psychological impairment or public scrutiny *(as determined by the host LME)*	----------
	Search and seizure	Any	----------	----------	All providers will submit aggregate numbers of searches and seizures to the host LME quarterly.[2]
	Confidentiality breach	Any	----------	----------	----------

<u>Direct questions to</u>: *ContactDMHQuality@ncmail.net Phone: (919) 733-0696*

[1] Providers should notify the host and home LMEs by phone upon learning of any Level III incident, even if not actively providing service at the time of the incident.
[2] See Manual for details.

<u>NOTE</u>: Incident reports are quality assurance documents. Do not file incident reports in the consumer's service record. Confidentiality of consumer information is protected. Use the form according to confidentiality requirements in NC General Statutes and Administrative Code and the Code of Federal Regulations.

APPENDIX 55. INNOVATIONS INCIDENT REPORTING FOR FAILURE TO PROVIDE BACK-UP STAFFING

For Semi-Monthly Period Covering: _____

Name of Provider Agency:_____ MCO: _____

Date:	Individual Name and DOB:	Service:	# of Hrs	Reason:	Comment, if "Other":

Name/Credentials of Person Completing This Form: _____ Contact Number: _____

APPENDIX 56. SAMPLE RIGHTS ACKNOWLEDGEMENT

I understand it is the policy of the State of North Carolina to assure basic human rights to each person receiving services. These rights include the right to dignity, privacy, humane care, and freedom from mental and physical abuse, neglect, and exploitation.

I acknowledge that I have reviewed and/or am aware of the Rights afforded to me or my child, as outlined in NC General Statute 122C, Article 3, which include the right to treatment, including access to medical care and habilitation, regardless of age or degree of mental illness, developmental disabilities, or substance abuse and the right to an individualized written treatment plan (or ISP). A list of Client Rights can also be found in the Trillium Health Resources Enrollee & Family Handbook.

_____

Name of Person Receiving Services through Innovations Waiver

Signing below Indicates Individual is Aware of Rights Referenced Above

EOR's and/or LRP's Name	Representative's Name, if applicable
EOR's and/or LRP's Signature	Representative's Signature, if applicable
Date	Date

Signature of Individual Served (if able) Date

*** DISCLAIMER: Please note that this sample form meets requirements and review guidelines as of 3/23/17. It is still the responsibility of the EOR to stay up to date with any changes in requirements and adjust forms/documentation as needed.***

APPENDIX 57. FIRE-DISASTER PLAN

Review exits and emergency evacuation routes in the home with all employees so they know which route to use in case of a fire in various locations in person's home. Inform employees of assembly areas outside the home and expectation that they will go to that location after leaving the home due to a fire.

In Case of a Fire

After evacuating the home, dial 911 to alert Fire Department. Provide the following information:

- Street address / Location
- Nature of fire
- Fire location
- Name of person reporting fire
- Telephone number for return call

Procedures

- Evacuate home to pre-arranged assembly areas outside.
- Redirect occupants to stairs and exits away from the fire.
- Prohibit use of elevators (if outside home).
- Contact _____ as soon as possible to notify of situation.

To Prepare for Natural Disaster

- Build or restock emergency preparedness kit, to include a flashlight, batteries, non-perishable food items, water, and first aid supplies. Staff should know where these items are.
- Review evacuation plan and identify where the local emergency shelter is located if needed
- In case of a hurricane or tornado, bring in or anchor any loose, light weight objects outside that could become projectiles in high winds (if there is enough time to do this safely)
- Make sure cars have plenty of gas
- Charge cell phones
- Make sure there are enough medications (if applicable) to last in case of emergency or if stranded
- Turn refrigerator/freezer to coldest settings to stay cold longer in case of loss of power
- In the case of flooding, disconnect electrical appliances and, if advised, turn off gas and electricity at the main switch or valve.
- Turn on tv/radio or check city/county website for updates and emergency instructions
- Follow evacuation orders given by officials

During a hurricane or tornado:

- Stay inside and away from windows, skylights and glass doors.
- Find a safe area in the home (an interior room, a closet or bathroom on the lower level) such as _____. Get under a piece of sturdy

furniture, if possible, and use arms to protect head/neck.

- If flooding threatens a home, turn off electricity at the main breaker.

During a flood:

- Please note if certain travel routes should be avoided, based on historical incidences of flooding.
- No one should ever drive through standing water as this can lead to life- threatening situations.
- In imminent danger, get to the highest ground or area of the home possible.
- Follow processes below while in the home to manage any flooding concerns. Instructions should include any areas of the home to avoid and any safeguards that should be taken.

*** DISCLAIMER: Please note that this sample form meets requirements and review guidelines as of 3/23/17. It is still the responsibility of the EOR to stay up to date with any changes in requirements and adjust forms/documentation as needed.***

APPENDIX 58. EMERGENCY MEDICAL PREPAREDNESS PLAN

If a medical emergency occurs, dial 9-1-1 and request an ambulance. Provide the following information:

- Your location of victim(s)
- Nature of injury or illness
- Hazards involved
- Nearest entrance (emergency access point)

Contact the following individuals after call has been made to 911:

_____

_____

_____

_____

Locations of First Aid Kits _____

Procedures

- Only trained staff should provide first aid assistance.
- Do not move the person unless the location is unsafe.
- Control access to the scene.
- Take "universal precautions" to prevent contact with body fluids and exposure to blood borne pathogens.
- Meet the ambulance at the nearest entrance or emergency access point.

Preferred Medical Facilities/Providers (including Primary Care Physician, specialists, local urgent care, hospital):

_____

_____

_____

_____

_____

Please provide specific instructions for potential medical issues/emergencies that may arise due to a current health condition (such as Diabetes, Asthma, allergic reactions, seizures, etc.) or refer to another document for information. Please write in the name of document or include instructions below:

*** DISCLAIMER: Please note that this sample form meets requirements and review guidelines as of 3/23/17. It is still the responsibility of the EOR to stay up to date with any changes in requirements and adjust forms/documentation as needed.***

APPENDIX 59. SAMPLE RESTRICTIVE INTERVENTION POLICY

Restrictive Interventions include seclusion, physical restraint, isolation time-out and protective devices used for behavioral control. These interventions are to be used safely and only as a last resort. *Only staff who have been trained in prevention strategies and demonstrated competence to use these procedures may use them.*

Restrictive Interventions Statement:

Employees:

- ☐ May Not Use Restrictive Intervention (Check if employees are not allowed to use restrictive techniques)

OR

- ☐ May Use Restrictive Interventions (Check if employees are allowed to use restrictive techniques. For the safety of the person supported, before using restrictive techniques of any type, employee must attend standardized training such as NCI.)

  NC Interventions© (NCI) is a standardized training program to prevent the use of restraints and seclusion, created and supported by DMH/DD/SAS and used in various DMH/DD/SAS community agencies and state facilities.

  ONLY certified Instructor Trainers are authorized to train Instructors.
  ONLY certified Instructors are authorized to teach the curriculum.

Employee Print Name: _____

Employee Signature: _____/_____

Website for NCI Trainers: https://www.ncdmh.net/nci-public/Default.aspx

Date Policy Created: _____

*** DISCLAIMER: Please note that this sample form meets requirements and review guidelines as of 3/23/17. It is still the responsibility of the EOR to stay up to date with any changes in requirements and adjust forms/documentation as needed.***

APPENDIX 60. EMPLOYER OF RECORD SELF-ASSESSMENT

Assessment Area	Satisfied	Not Satisfied	Comments
Employees follow schedule			
Able to hire employees who can provide services when I need them			
Employees are well known to me or are recommended by someone I trust			
Able to pay employees a fair salary			
Able to offer employees meaningful benefits			
Employees are qualified to do work (little training is needed)			
Employees follow my instructions and perform work to my satisfaction			
Workers are flexible when my needs or schedule change			
The Care Manager provides services that meet my needs			
The Provider Network staff are helpful when I need assistance			
The Utilization Management Care Manager is helpful when I need assistance			
The Individual & Family-Directed Supports Handbook is helpful in helping me implement Individual & Family-Directed Supports			
The Financial Support Agency is helpful when I need assistance			
My employees are paid on time			
The Community Navigator is helpful in helping me direct my services			
Other resources that are provided to me have helped me in directing my own services and supports			

APPENDIX 61. EMPLOYER OF RECORD SELF-ASSESSMENT

Assessment Area	Satisfied	Not Satisfied	Comments
Employees follow schedule			
Able to hire employees who can provide services when I need them			
Employees are well known to me or are recommended by someone I trust			
Able to pay employees a fair salary			
Able to offer employees meaningful benefits			
Employees are qualified to do work (little training is needed)			
Employees follow my instructions and perform work to my satisfaction			
Workers are flexible when my needs or schedule change			
The Care Manager provides services that meet my needs			
The Provider Network staff are helpful when I need assistance			
The Utilization Management Care Manager is helpful when I need assistance			
The Individual & Family-Directed Supports Handbook is helpful in helping me implement Individual & Family-Directed Supports			
The Financial Support Agency is helpful when I need assistance			
My employees are paid on time			
The Community Navigator is helpful in helping me direct my services			
Other resources that are provided to me have helped me in directing my own services and supports			

APPENDIX 62. REQUEST FOR OUT-OF-STATE TRAVEL

Date of Request: _____
Name of Individual:_____
Dates of Travel from:_____ to: _____
Destination: _____
Natural Supports Traveling with Individual (include relationship to individual):
_____

1. Individual's Daily Needs:
   _____
2. Staff Requirements (based on needs above):
   _____
3. Why are natural supports unable to meet individual's needs:
   _____
4. What services need to be delivered out-of-state (must be habilitative service):
   _____

On what schedule will these services be delivered:

Hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

- If licensed professionals are involved, Medicaid cannot waiver other state licensure laws
- Medicaid will not be responsible for room, board, or transportation cost
- Provider Agencies must assume all liability for their staff while out-of-state
- Treatment plans must not be changed to increase services while out-of-state
- Respite, based on the definition, would not be an appropriate service since natural supports are present during the travel

By signing below, the Employer of Record agrees with this request and to all above listed conditions:

_____ _____
Signature Date

_____ _____
Reviewer Signature Date

Send form to: Care Manager
Comments:_____
_____

TRILLIUM Use
☐ Approved
☐Denied

GENERAL RESOURCES

APPENDIX 63. FEDERAL & STATE EMPLOYER-RELATED RESOURCE FEDERAL GOVERNMENT RESOURCES

FEDERAL GOVERNMENT RESOURCES

General www.firstgov.com
Disability-related www.disability.gov
Benefits-related www.benefits.gov

EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

(for information about discrimination)
www.eeoc.gov
General Information: 1-800-669-4000
TTY: 1-800-669-6820

INTERNAL REVENUE SERVICE

(for forms related to employment and taxes)
www.irs.gov
General information: 1-800-829-1040
Business information: 1-800-829-4933
TDD: 1-800-829-4059

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

(for safety issues for employees)
www.osha.gov
General Information: 1-800-321-6742
TTY: 1-877-889-5627

U.S. CITIZENSHIP AND IMMIGRATION SERVICES

(for information regarding how to assure you are hiring a legal citizen)
www.uscis.gov
General Information: 1-800-375-5283
TTY: 1-800-767-1833

U.S. DEPARTMENT OF COMMERCE

www.commerce.gov

N.C. DEPARTMENT OF REVENUE

(for information about N.C. taxes)
www.dornc.com
General Information: 1-877-252-3052

U.S. DEPARTMENT OF LABOR

www.dol.gov
General Information 1-866-487-2365
TTY: 1-877-889-5627
800-877-8339

U.S. DEPARTMENT OF JUSTICE

www.usdoj.gov
General Information: 1-202-514-2000
TTY: 1-800-877-8339

U.S. SMALL BUSINESS ADMINISTRATION

www.sba.gov
General Information 1-800-827-5722

U.S. SOCIAL SECURITY ADMINISTRATION

www.ssa.gov
General Information: 1-800-772-1213
TTY: 1-800-325-0778

NORTH CAROLINA STATE GOVERNMENT RESOURCES

www.ncgov.com

N.C. DEPARTMENT OF COMMERCE

www.nccommerce.com
General Information: 1-919-733-4151

N.C. DEPARTMENT OF LABOR

www.nclabor.com
General Information: 1-800-625-2267

N.C. DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

www.ncdhhs.gov/mhddsas
General Information: 1-919-733-7011