

Day Facility Final Rule Assessment (Pilot Group)

PROVIDER INFORMATION

Provider Name _____ Phone Number _____
EIN/TIN _____ E-mail Address _____
NPI _____ Website _____
DHHS Provider Number _____
Address _____
City _____ State _____ Zip _____

Person(s) Completing Assessment

Name(s) _____ Title _____
Phone Number _____ E-mail Address _____

Setting Information

Name of Facility/Program _____
Physical Address _____
City _____ State _____ Zip _____
Phone Number _____ E-mail Address _____

Setting Type

- | | | |
|--|---|---|
| <input type="checkbox"/> DDSN Day Facility | <input type="checkbox"/> Residential – SLP I | <input type="checkbox"/> Residential – CTH II |
| <input type="checkbox"/> Adult Day Health Care | <input type="checkbox"/> Residential – SLP II | <input type="checkbox"/> Residential – CRCF |
| <input type="checkbox"/> DMH Community Program | <input type="checkbox"/> Residential – CTH I | |

Does this setting provide Medicaid Waiver Services? ☐ YES ☐ NO

Services Offered at this Setting (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Adult Attendant Care | <input type="checkbox"/> Care Coordination | <input type="checkbox"/> Environmental Modifications |
| <input type="checkbox"/> Adult Companion Services | <input type="checkbox"/> Career Preparation Services | <input type="checkbox"/> Health Education for Consumer Directed Care |
| <input type="checkbox"/> Adult Day Health Care | <input type="checkbox"/> Case Management | <input type="checkbox"/> Home Delivered Meals |
| <input type="checkbox"/> Adult Day Health Care Nursing | <input type="checkbox"/> Community Services | <input type="checkbox"/> Incontinence Supplies |
| <input type="checkbox"/> Adult Day Health Care Transportation | <input type="checkbox"/> Companion | <input type="checkbox"/> In-Home Respite Care |
| <input type="checkbox"/> Adult Dental | <input type="checkbox"/> Customized Goods & Services | <input type="checkbox"/> In-Home Support |

- | | | |
|--|--|--|
| <input type="checkbox"/> Adult Vision | <input type="checkbox"/> Day Activity Services | <input type="checkbox"/> Institutional Respite Care |
| <input type="checkbox"/> Attendant Care | <input type="checkbox"/> Early Intensive Behavioral Intervention | <input type="checkbox"/> Limited Durable Medical Equipment |
| <input type="checkbox"/> Audiology Services | <input type="checkbox"/> Employment Services | <input type="checkbox"/> Medicaid Waiver Nursing |
| <input type="checkbox"/> Behavior Support Services | <input type="checkbox"/> Enhanced Environmental Modifications | <input type="checkbox"/> Medical Day Care |
| <input type="checkbox"/> Medical Equipment, Assistive Technology and Appliances | <input type="checkbox"/> Personal Emergency Response System | <input type="checkbox"/> Respite in CRCF |
| <input type="checkbox"/> Nursing Home Transition Services | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Service Plan Development |
| <input type="checkbox"/> Nursing Services | <input type="checkbox"/> Prescription Drugs | <input type="checkbox"/> Speech and Hearing Services |
| <input type="checkbox"/> Nutritional Supplements | <input type="checkbox"/> Prevocational Services | <input type="checkbox"/> Support Center Services |
| <input type="checkbox"/> Nutritional Supplies | <input type="checkbox"/> Private Duty Nursing | <input type="checkbox"/> Waiver Case Management |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Private Vehicle Modifications | <input type="checkbox"/> Wraparound Para-Professional Services |
| <input type="checkbox"/> Peer Guidance for Consumer Directed Care | <input type="checkbox"/> Psychological Services | |
| <input type="checkbox"/> Peer Support Services | <input type="checkbox"/> Residential Habilitation | |
| <input type="checkbox"/> Personal Care I | <input type="checkbox"/> Respite Care | |
| <input type="checkbox"/> Personal Care II | | |
| <input type="checkbox"/> Specialized Medical Supplies, Medical Equipment, and Assistive Technology | | |