|  |
| --- |
| **Enter monitoring visit or review date(s) below:** |
| **Enter the State Fiscal Year below being monitored:** |
| **Enter the Monitor’s Name, Job Title and organization below:** |
| **Indicate the type of provider that is being monitored by checking the appropriate box below:**  Community Service Provider *(organization that contracts directly with AAA to receive the funding from the AAA and to directly provide a service)*  Sub-contractor of a Community Service Provider *(The Community Service Provider contracts with the AAA to receive the funding from the AAA, but does not directly provide a service. The Community Service Provider contracts with an organization that will directly provide a service. This organization that the Community Service Provider contracts with is referred to as the sub-contractor).*  **For Subcontractor Monitoring Only:**  If this tool is being completed by staff employed by a Community Service Provider and is being used to monitor a sub-contractor as defined above, the Community Service Provider staff attests that the sub-contractor requirements of the 308.2: Monitoring Plan of the AAA Policy and Procedure Manual were followed.  YES  NO  N/A |
| **Enter the name of the organization being monitored below:** |
| **Indicate the type of monitoring by checking the appropriate box(es) below:**  Programmatic Review  Unit Verification |
| **Enter the Name(s) and Job Title(s) of the organization staff that were interviewed during this monitoring visit or acted as informant(s) during this review below:** |

|  |  |  |  |
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| **SERVICE DEFINITION** | **YES** | **NO** | **N/A** |
| The program provides dependable, scheduled, short term relief for the caregiver. (A caregiver is  defined as an unpaid person who assists the care recipient). |  |  |  |
| The program provides supervision and socialization including activities and as applicable, nutrition, as  required per the Group Respite Policies and Procedures for program participants. |  |  |  |
| Program staff (paid and volunteer) do not provide any hands-on/personal care which includes  assistance with basic personal care hygiene, grooming, toileting (incontinence care), feeding, and  ambulation to program participants. |  |  |  |
| The program provides information resources for caregivers, recipients and the community. |  |  |  |
| **GROUP RESPITE PARTICIPANTS** | **YES** | **NO** | **N/A** |
| Participants attending the program have a caregiver. |  |  |  |
| Participants attending the program are in need of assistance (no hands-on/personal care while in  attendance at the group respite program) and/or supervision with self-care. |  |  |  |
| Group respite program attendees are referred to as Participants. |  |  |  |
| **OPERATIONAL DAYS AND HOURS** | **YES** | **NO** | **N/A** |
| The program operates on a scheduled basis. |  |  |  |
| The program operates at least 1 day per week for at least 3 continuous hours. |  |  |  |
| The program does not operate more than 6 hours per operational day. |  |  |  |
| The program does not operate more than 4 days a week. |  |  |  |
| **ADVISORY BOARD** | **YES** | **NO** | **N/A** |
| The program has an Advisory Board that meets on a regularly scheduled basis. |  |  |  |
| **LIABILITY INSURANCE** | **YES** | **NO** | **N/A** |
| The program has liability insurance to cover employees, volunteers and advisory board members. |  |  |  |
| **PARTICIPANT RIGHTS** | **YES** | **NO** | **N/A** |
| The program operates in compliance with the Americans with Disabilities Act. |  |  |  |
| The program operates in compliance with the Civil Rights Act of 1964. |  |  |  |
| The program has all staff (paid and volunteer) and volunteers\* read and sign the Participant Rights  Statement. |  |  |  |
| The program keeps a copy of the signed Participant Rights Statements on file. |  |  |  |
| The program provides a copy of the Participant Rights Statement to the participant/caregiver. |  |  |  |
| **CONFIDENTIALITY** | **YES** | **NO** | **N/A** |
| The program has signed copies of the agreement for staff to maintain confidentiality. |  |  |  |

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| **WRITTEN PROGRAM POLICIES** |  | | |
| The program maintains the following program policies (check all below that are in place):  Mission statement  Target population  Eligibility and discharge criteria indicating the participants that the program can appropriately serve and any limitations including age or ability criteria for participants, the number of participants and criteria for referral from the program to a more appropriate level of care  Medication use by participants while at program  Wandering Participants  Safety and emergency procedures including missing, injured participants and participants  that may become ill while in attendance at the program  Prevention of communicable illnesses  Criminal Background Checks procedure for potentially paid staff whose criminal background check reveals a criminal history will affect the individual’s employment with the program  Volunteers’ Criminal History Attestation procedure for a volunteer whose signed attestation attests to a criminal history and how a signed attestation indicating a criminal history will affect the  individual’s volunteering with the program  Other, Specify here: | | | |
| ***Annual Review of Program Policies*** | **YES** | **NO** | **N/A** |
| The Program Manager reviews the above policies annually to ensure their continued relevance and that they are current. |  |  |  |
| **FACILITY** | **YES** | **NO** | **N/A** |
| The facility has sufficient space to accommodate program participants, activities and services. |  |  |  |
| The program makes accommodation within the facility for participants who do not wish to participate in group activities. |  |  |  |
| The space complies with all applicable local, county, state, and federal building regulations, zoning, fire and health codes or ordinances. |  |  |  |
| The facility is accessible to individuals with physical disabilities. |  |  |  |
| A clearly identified safe outside area is provided for the arrival and departure of participants. |  |  |  |
| Arrangements are made for inclement weather. When feasible, this may include a sheltered entrance, the availability of large umbrellas, someone to shovel ice or other barriers to safety, etc. |  |  |  |
| **PROGRAM SETTING** | **YES** | **NO** | **N/A** |
| The portion of the building utilized for the group respite program (Program Setting) provides a minimum of 40 square feet of indoor space per participant, and has written policies stating the maximum number accommodated. |  |  |  |
| Furnishings include a sufficient number of sturdy, comfortable chairs or sofas for informal interaction by all participants and a sufficient number of straight chairs and tables for all participants to engage in table activities in the Program Setting. |  |  |  |
| The Program Setting has 2 available restrooms, at least one of which is accessible to individuals with physical disabilities, or a minimum of one accessible toilet is available for each 12 adults (including staff, volunteers and participants) in the program area. |  |  |  |
| The areas in the Program Setting are adequately lit for the safety of the participants. |  |  |  |
| The program has access to a space where caregivers, staff (paid and volunteer) or participants may have private conversations. |  |  |  |
| The Program Setting is smoke-free. |  |  |  |
| The Program Setting is clean with no visible dirt or dust on the floor or furniture. |  |  |  |
| The flooring is conducive to safety. No throw rugs. |  |  |  |
| 1. A telephone system dedicated to the program is available during the program’s operational hours. |  |  |  |
| The Program Setting has adequate heat and air conditioning for year-round use. |  |  |  |

**PERSONNEL AND STAFFING REQUIREMENTS**

|  |  |  |  |
| --- | --- | --- | --- |
| **ORGANIZATIONAL CHART** | **YES** | **NO** | **N/A** |
| The program has an organizational chart. |  |  |  |
| The organizational chart shows who is responsible for the management of the service. |  |  |  |
| The organizational chart identifies the paid Program Manager and any volunteers who are trained to function as the Program Manager in the absence of a paid Program Manager being on site. |  |  |  |
| **JOB DESCRIPTIONS** | **YES** | **NO** | **N/A** |
| There are job descriptions for all staff positions (paid and volunteer). |  |  |  |
| A job description is given to all program staff (paid and volunteer). |  |  |  |
| **STAFF TO PARTICIPANT RATIO** | **YES** | **NO** | **N/A** |
| The program has one staff member (paid or volunteer) functioning in the Program Manager role  who is on-site. |  |  |  |
| There are no more than six participants to each staff member on site (paid or volunteer). |  |  |  |
| 1. Stand-alone programs (those which operate in a space where no other staff is nearby when the program is being held) have at least one staff member (paid or volunteer) fulfilling the role of Program Manager and one other responsible person at the program at all times that the participants are present. |  |  |  |
| **PROGRAM MANAGER POSITION** | **YES** | **NO** | **N/A** |
| The program has a Program Manager who is responsible for the management of the service and ensures that activities and services are provided. |  |  |  |
| If the Program Manager is not on site, he/she has a substitute (paid or volunteer) fulfilling the role and duties of the Program Manager. |  |  |  |
| **The Program Manager is:** | **YES** | **NO** | **N/A** |
| 1. At least 21 years of age |  |  |  |
| 2. Has a minimum of a high school education and two years of post- secondary education from an accredited institution of education or has a high school education and two years of experience working with older adults and adults with disabilities and their families. |  |  |  |
| **Prior to employment, the program ensures that the individual fulfilling the Program Manager position has the following items completed and maintain them in her/his file:** | **YES** | **NO** | **N/A** |
| 1. 1. An application form containing referral source, background experience, and skills. |  |  |  |
| 2. A North Carolina statewide criminal background check covering the past five years. |  |  |  |
| 3. A statement signed by a physician, nurse practitioner or physician’s assistant indicating that the individual does not have a health condition that would pose a health risk to others and can perform the normally assigned job duties. |  |  |  |
| 4. A checklist indicating that the individual has been trained in: confidentiality policy, the Participant Rights Statement, and safety issues. |  |  |  |
| **Volunteers functioning and/or fulfilling the Program Manager position are subject to:** | **YES** | **NO** | **N/A** |
| 1. All personnel policies, except financial compensation, of the program are applied to the individual. |  |  |  |
| 2. The same training and orientation requirements as the paid Program Manager. |  |  |  |
| **Prior to employment, the program ensures that all other paid staff have the following items completed and maintain them in her/his file:** | **YES** | **NO** | **N/A** |
| 1. An application form containing referral source, background experience, and skills. |  |  |  |
| 2. A North Carolina statewide criminal background check covering the past five years |  |  |  |
| 3. A statement signed by a physician, nurse practitioner or physician’s assistant indicating that the individual does not have a health condition that would pose a health risk to others and can perform the normally assigned job duties. |  |  |  |
| 4. A checklist indicating the individual has been trained in: confidentiality policy, the Participant Rights Statement, and safety issues. |  |  |  |
| **Volunteers**  *\*Volunteers are defined as individuals who are present at the Group Respite program on a planned and continuous basis in order to support the program’s mission and activities. The exceptions to this definition are individuals who are periodically scheduled to come to the program and conduct a group activity such as a sing-a-long, bingo, or an arts and craft project, and/or individuals who come to the program for a one-time special event, such as a holiday program or a concert.* | | | |
| **Prior to volunteering, the program ensures that the volunteer has the following items completed and maintain them in her/his file:** | **YES** | **NO** | **N/A** |
| 1. An application containing referral source, background experience, interests and skills. |  |  |  |
| 2. Attested to his/her criminal history. |  |  |  |
| 3. Attested that he/she does not have a health condition that would pose a health risk to others. |  |  |  |

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| **Orientation and Training For All Paid Staff and Volunteers Functioning as Program Manager** | **YES** | **NO** | **N/A** |
| Program orientation and the necessary training and supervision is provided for the Program Manager to effectively carry out the required responsibilities as specified in previous section of tool. |  |  |  |
| Program seeks consultation or outside training when needed to meet the specific needs of participants or families. |  |  |  |
| The orientation includes at a minimum (check all that apply):  Program Mission and Purpose  Staff (paid and volunteer) roles  Program policies and procedures  Fire and safety techniques  Training in Universal Precautions  Confidentiality  Participant rights  Participant needs  Person-centered approaches  Activity planning  Dementia  Wandering  Communication with caregivers  Other, Specify: | | | |
| For All Volunteers Meeting the Volunteer Definition Above\* | **YES** | **NO** | **N/A** |
| Volunteers are trained and receive orientation covering at a minimum, the following topics: |  |  |  |
| 1. Program Mission and Purpose Staff (paid and volunteer) roles |  |  |  |
| 2. Fire and safety techniques |  |  |  |
| 3. Confidentiality |  |  |  |
| 4. Participant rights |  |  |  |

**SERVICE PROVISION**

|  |  |  |  |
| --- | --- | --- | --- |
| SAFETY OF PARTICIPANTS | **YES** | **NO** | **N/A** |
| The program has one staff member (paid or volunteer) currently certified in standard First Aid and CPR on duty at all times during the program’s operational hours. |  |  |  |
| WANDERING – PRECAUTIONARY MEASURES | **YES** | **NO** | **N/A** |
| Written policies and procedures to follow in the event of a missing participant are in place. |  |  |  |
| Secured exits (may use devices such as alarm systems, secure outside areas, or supervised exits) in accordance with the local fire marshal’s directives. |  |  |  |
| Staff (paid and volunteers) are knowledgeable about the Silver Alert process and how to file a Silver Alert report with local law enforcement. |  |  |  |
| NAME BADGES | **YES** | **NO** | **N/A** |
| Name badges for all participants and staff (paid and volunteer) |  |  |  |
| Identifying mark on participants’ name badges if they have dietary restrictions. |  |  |  |

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| **ACTIVITIES** | **YES** | **NO** | **N/A** |
| Group and individual activities: Planned, appropriate adult recreational activities each day of the program for participants, including socialization, exercise, and music as well as normal household activities such as food preparation and those associated with holidays or seasonal observances. |  |  |  |
| Participants are involved in planning activities to the greatest extent possible. |  |  |  |
| The program posts a daily schedule of activities each month. |  |  |  |
| **NUTRITION** | **YES** | **NO** | **N/A** |
| Daily nutritional refreshment is provided for participants each day that the program is held. |  |  |  |
| Liquid refreshment such as juice, tea, coffee or water is offered to participants. |  |  |  |
| Snacks and adequate hydration, although not always visible, is always available. |  |  |  |
| If the program lasts through a meal hour (12 noon – 1:00 pm, 5:30-6:30 pm) an appropriate meal is served. |  |  |  |
| If the program lasts longer than 4 hours, a healthy snack (such as: fruit or juice and a bread item (crackers or low fat cookies) and a meal is served. |  |  |  |
| **MEDICATIONS** | **YES** | **NO** | **N/A** |
| Medications are not administered to participants by group respite program staff (paid or volunteers) while participants are in attendance at the group respite program. |  |  |  |
| Participants self-administer medication while in attendance at the group respite program. |  |  |  |
| Medications, whether prescription or over the counter, are in their original bottle or container. |  |  |  |
| Program Managers only open a medication bottle or container if requested by a participant. |  |  |  |
| Program Managers only provide verbal cues to participants in the self-administration of medications. |  |  |  |
| Program Managers do not remove medications from bottles or containers or calibrate medications and hand to participants for participants to self-administer. |  |  |  |
| Participants do not have medications on his/her person while in attendance at the group respite program. |  |  |  |
| Medications are kept in a locked location and are retrieved only by the Program Manager. |  |  |  |
| The program has a written policy and procedure for how medications are checked in and checked out of the program. |  |  |  |
| **COMMUNITY RESOURCES** | **YES** | **NO** | **N/A** |
| The program has community services information available for participants and caregivers to learn about them and to use as needed. Examples are brochures/pamphlets/fliers regarding specific diagnoses, support groups, home care agencies, county departments of social services, local Social Security office. |  |  |  |

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|  | **GROUP RESPITE CLIENT NAME** | **SERVICE CODE** | **GROUP RESPITE CLIENT ELIGIBILITY** | | | **GROUP RESPITE CLIENT FILE** | | | | | | | | | | | **UNIT VERIFICATION** | | |
| **#** | **GROUP RESPITE CLIENT NAME** | **Enter the service code for HCCBG (309) or CARES (909)** | **Over Age 60?**  **Enter Birthdate listed on the DAAS-101** | **1. Needs supervision**  **2. Has a caregiver**  **3. Supervision with ADLs while at program is provided through verbal reassurance, cueing and physical cueing**  **4. Does not need any hands-on care while at program**  **5. Can communicate (though not necessarily verbally) personal needs** | **Participant either has:**  **1. a physical impairment \* or**  **2. cognitive impairment \*\*** | **DAAS-101** | | **Medical Examination Report is in participant file and meets requirements\*\*\*** | **Current photo in participant file that clearly identifies participant** | **Completed Provider Assurance Form for Consumer Contributions** | **Copy of Advance Directives for participants that have such directive** | **Signed Forms Permitting or Declining use of media** | **Social History/ Personal Interest(s) Inventory is in participant file and is updated annually\*\*\*\*** | **Indication that program provided Participant Rights Statement to participant/caregiver** | **Changes in participant needs are documented in the participant file** | **Signed participation form for each off site activity** | **# units reported** | **# units verified** | **# unverified units to be adjusted in ARMS** |
| **DAAS-101 and DAAS-5027 complete?**  **Date of most recent DAAS-101?** | **DAAS-101 updated at least every 12 months?** |
| 1 |  |  | Y  N  Birthdate: | Y  N  Documentation reviewed: | Y  N  Documentation reviewed: | Y  N  Date: | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N |  |  |  |
| 2 |  |  | Y  N  Birthdate: | Y  N  Documentation reviewed: | Y  N  Documentation reviewed: | Y  N  Date: | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N |  |  |  |
| 3 |  |  | Y  N  Birthdate: | Y  N  Documentation reviewed: | Y  N  Documentation reviewed: | Y  N  Date: | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N |  |  |  |
| 4 |  |  | Y  N  Birthdate: | Y  N  Documentation reviewed: | Y  N  Documentation reviewed: | Y  N  Date: | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N |  |  |  |
| 5 |  |  | Y  N  Birthdate: | Y  N  Documentation reviewed: | Y  N  Documentation reviewed: | Y  N  Date: | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N |  |  |  |
| 6 |  |  | Y  N  Birthdate: | Y  N  Documentation reviewed: | Y  N  Documentation reviewed: | Y  N  Date: | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N |  |  |  |
| 7 |  |  | Y  N  Birthdate: | Y  N  Documentation reviewed: | Y  N  Documentation reviewed: | Y  N  Date: | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N |  |  |  |
| 8 |  |  | Y  N  Birthdate: | Y  N  Documentation reviewed: | Y  N  Documentation reviewed: | Y  N  Date: | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N |  |  |  |
| 9 |  |  | Y  N  Birthdate: | Y  N  Documentation reviewed: | Y  N  Documentation reviewed: | Y  N  Date: | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N |  |  |  |
| 10 |  |  | Y  N  Birthdate: | Y  N  Documentation reviewed: | Y  N  Documentation reviewed: | Y  N  Date: | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N | Y  N |  |  |  |

**\* that is medically stable & does not require hands on personal care or assistance or intervention while in attendance at the program – documented on medical exam repot and/or DAAS-101 \*\* which can be managed through redirection, distraction and reassurance – documented on medical report, DAAS-101 or Social History/Personal Interest(s) Inventory**

**\*\*\* 1. is appropriate for the Group Respite program, 2. does not have a health condition that puts others at serious risk that cannot be reasonably accommodated, 3. whose need for supervision can be addressed by the program**

\*\*\*\* **(minimum information to include interests, functional needs and abilities). A Social History of the participant includes information on the participant’s background, interests, hobbies, abilities and physical/cognitive limitations in order to plan and implement appropriate and supportive programming is in his/her file at the program.**

**Group Respite Fiscal Verification:**

**CARES Non-Unit Funds and Capital Acquisition Requests (code 910)**

Agency:       Date:

Agency Staff Interviewed:

Signature of Reviewer(s):

CARES Funds Codes: (Check all that apply)

932  957  933  958

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

**Group Respite Fiscal Verification- CARES Non-Unit Funds-Code 910**

For expenses related to CARES codes 932, 957, 933, 958, select a month of reimbursement in ARMS and the same month of expenses reported in the tracking spreadsheet.

1. Reimbursement correlates with actual expenses.

*(E.g. payments documented in the provider’s*

*general ledger or receipts and other proof of*

*purchases, etc.)* Yes  No  N/A

Documentation reviewed/Comments

2. Selected month’s reimbursement matches the

reporting of expenses in the tracking worksheet

for the same month. Yes  No  N/A

Documentation reviewed/Comments

**Capital Acquisition Requests**

3. Did the provider make any building modifications

and/or special acquisitions in excess of $5,000 and

if so, was prior approval given? Yes  No  N/A

Documentation reviewed/comments: