SERVICE DELIVERY MONITORING AND SUPERVISORY VISIT DOCUMENTATION FORM

This form shall be used by Direct Care Worker (DCW) agencies to monitor and evaluate the quality of the provision of direct care services through supervisory/monitoring visits in accordance with AMPM 1240-A Policy. The act of supervision is an assessment of the DCW's competency to provide services in accordance with the member's individualized service needs and preferences. The scope of the assessment includes observing, gathering feedback from the member/Health Care Decision Maker (HCDM) and identifying resources for the DCW when opportunities for improvement or support are identified. These visits are also intended to serve as opportunities to build relationships between members, their families, the DCWs and the DCW agency.

_____	_____
MEMBER NAME (LAST, FIRST, M.I.)	*MEMBER AHCCCS ID*
_____	_____
DIRECT CARE WORKER NAME	*DIRECT CARE WORKER DATE OF BIRTH (DOB)*

☐ DCW is a live-in caregiver

Live-in Caregiver Relationship
- ☐ Spouse
- ☐ Adult Children/Stepchildren
- ☐ Son-in-Law/Daughter-in-law
- ☐ Grandchildren
- ☐ Siblings/Step Siblings
- ☐ Stepparent
- ☐ Grandparent
- ☐ Mother-in-law/Father-in-law
- ☐ Brother-in-law/Sister-in-law
- ☐ Parents/Adoptive Parents/Legal Guardians
- ☐ Other

Effective Dates: XX/XX/XX
Approval Dates: XX/XX/XX

Supervisory Visit Date _____

Service(s)

☐ Attendant Care
☐ Personal Care
☐ Homemaker

SUMMARY OF VISIT TIMELINE REQUIREMENTS

- The service start date is defined as the date the DCW started providing service(s) to the member.
- For members being served by a new DCW (initial visits), supervision is required within five days (virtual is permitted, including both audio and visual), 30 days, 60 days (if issues have been identified by the member, DCW agency or Contractor), and 90 days. The DCW must be present during the 90th day visit.
- For members continuing to be served by the same DCW (continuing visits), supervision is required every 90 days. The DCW must be present at a minimum twice per year. The annual yearly timeframe begins with the first 90th day visit.

☐ Initial Visit

TIMEFRAME	DCW PRESENT	Virtual
☐ 5th day	☐	☐
☐ 30th day	☐	N/A
☐ 60th day	☐	N/A
☐ 90th day	☐*(Required)*	N/A

Effective Dates: XX/XX/XX
Approval Dates: XX/XX/XX

☐ Continuing (90 day) Visit
☐ DCW Present *(Required twice per year)*

Reminders:

- The form is not intended to be a checklist, but rather a form to document conversations, observations, and follow ups.
- All DCW agencies are permitted to create and utilize their own supervisory visit documentation forms as long as the minimum data elements are captured.
- If warranted, DCW agencies may conduct additional service delivery monitoring or supervisory visits to evaluate the quality of the service provision.
- The completed forms must be kept in the member's file.
- For additional information, refer to the AHCCCS Medical Policy Manual (AMPM) Policy 1240-A Direct Care Services.

Instructional note: Attest to the following regarding preparation for the visit by checking and initializing the statements**.**

I (Supervisor) attest:

☐I have reviewed data in the Electronic Visit Verification (EVV) system regarding any missed and late service visits and the agency's response to those situations (documented as resolution codes) to inform discussions pertaining to actual events or risks to the non- provision of services. Initials ___

☐I have reviewed the member's Person Centered Service Plan (PCSP) and any documentation outlining tasks to be performed by the DCW to familiarize myself with the individualized assessed needs and preferences related to the provision of services to support observations of the care delivery and competency of the DCW.

Initials _____

INSTRUCTIONAL NOTE: Check the appropriate box and enter a comment for each item to document evidence in support of the observation.

OBSERVATION OF DCW	YES	NO	COMMENT
1. Does the member appear to be in a safe and clean environment?	☐	☐	
2. Is the member able to freely navigate their environment (with or without assistance) without barriers or risks?	☐	☐	
3. Is the member's condition consistent with previous visitations?	☐	☐	
4. Is the member clean and wearing clean clothes?	☐	☐	
5. Was support provided that is consistent with the assessed need outlined in the PCSP? (e.g., tasks outlined in the member's HCBS Needs Tool)	☐	☐	
6. Does the DCW demonstrate competency in providing the assessed services in accordance with the member's individualized service needs and preferences as outlined in the PCSP? (e.g., level of assistance needed with each tasks including supporting the member to perform as much of the tasks as they are willing and able)	☐	☐	
7. Is the DCW observed to be providing person directed care? (e.g., asking when and how they would like assistance; referring to them by name; providing personal care in private)	☐	☐	

OBSERVATION OF DCW	YES	NO	COMMENT
8. Is the DCW observed to have a positive relationship with the member (e.g., respectful communication related and unrelated to care; positive body language)	☐	☐	
9. Is the DCW observed to be communicating with the member in their preferred language and style?	☐	☐	
10. Are there any visible obstacles or barriers that could impact service delivery?	☐	☐	

Instructional Note: All questions shall be directed to the member who shall be given the opportunity to participate in the visit supporting their self-determination (regardless of age) to the maximum extent possible engaging their health care decision maker as appropriate. If the member is limited in or unable to engage in this process, that should be reflected in the comment section. Additionally, consideration should be given to having these conversations in private with the member.

DISCUSSION WITH MEMBER	YES	NO	COMMENT
Please describe what the DCW typically does when they come to your home?			
11. Does the DCW listen to you and provide assistance in support of your preferences?	☐	☐	
12. Does the DCW support you to do some things for yourself and only help when you need it?	☐	☐	
13. Do you know who to contact when your DCW doesn't show up or can't provide services that day?	☐	☐	

Effective Dates: XX/XX/XX
Approval Dates: XX/XX/XX

DISCUSSION WITH MEMBER	YES	NO	COMMENT
14. Do you think you are receiving care that meets your needs in the way you want them to be met?	☐	☐	
15. What else would you like to tell me about the services being provided by your DCW?			

Instructional note: This part of the discussion is reserved for live-in caregivers that are getting paid to provide care.

LIVE IN CAREGIVER CHECK-IN	COMMENT
16. What are the most challenging aspects of your caregiving role? What is impacting your ability and availability to provide paid care?	
17. Are you able to take care of yourself and recharge? Are you taking measures to maintain your own health care needs?	
18. Are you able to access the resources you need to effectively care for your loved one? Is there anything specific you wish you had more support with?	

Instructional note: For any follow up items (#20-25) marked "yes", please include the action that will be undertaken to address it and the timeline for completion.

Effective Dates: XX/XX/XX
Approval Dates: XX/XX/XX

FOLLOW UP	YES	NO	ACTION ITEM	TIMELINE
19. Is there an opportunity to improve the DCW's competency to provide the assessed services in a person-directed manner and in accordance with the member's individualized service needs and preferences as outlined in the PCSP?	☐	☐		
20. Is there an opportunity to provide additional support to the DCW who is a live-in caregiver?	☐	☐		
21. If the member has a fixed EVV device, did you observe that it **was not** fixed within the home? Note: As appropriate, the discussion about another device option should be considered as an alternative to the allowable use of a paper timesheet.	☐	☐		
22. Is it time to review the member's contingency plan? **Note:** It must be reviewed at least annually.	☐	☐		
23. Have you determined that the services were not provided as authorized that have not previously been reported? Note: The reasons for the non-provision of services shall be documented in the member's case file and reported to the health plan or Tribal ALTCS.	☐	☐		
24. Have you determined the member has exhibited the need for additional medical or psychosocial support, or a change (decline or improvement) in condition? Note: This information shall be documented in the member's case file and reported to the health plan or Tribal ALTCS.	☐	☐		

I (Supervisor) attest:

☐I have or will review the findings of the visit with the DCW and relevant action items that pertain to follow up specific to training and support needs of the DCW.

Monitor, Supervisor Name	*Title*
Signature:	*Date*
Member/Health Care Decision Maker (HCDM)	*Date*
Signature	