Consumer-Direction Services Management Questionnaire

(Questions to consider if you want to become the employer of record on behalf of a member)

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| Member's Name *(Print)*: | | | Medicaid ID #: |
| 1. Do you and the member who is going to receive CD services generally agree on how personal care will be provided? | | | |
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| 2. How would you describe the concepts of personal care to the member who needs personal care? | | | |
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| 3. | How will you be able to determine the quality of work the personal assistant/aide performs? | | |
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| 4. | If an attendant did not fulfill his/her job duties adequately, what would you do? | | |
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| 5. | What are some examples of the attendant not performing his/her job duties? | | |
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| 6. Who would you contact if the member was injured or mistreated by the assistant/aide? | | | |
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| b. What type of action would you take if you were suspicious of mistreatment of the member? | | | |
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| c. What actions would you take once you have discovered that the member was injured or mistreated by the assistant/aide, even if the aide is a family member? | | | |
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|  | b. | Would you report an incident to Adult Protective Services, Child Protective Services, or another authority, even if the attendant were a family member?  □ Yes □ No | |
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| 7. | Would there be a reason that a family member would be hired to be the assistant/aide? If so, what would be the reason? What efforts would you make to find non-family members to be attendant before you hired a family member? | | | | | |
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| 8. | What is your experience providing services, hiring staff, or monitoring personal care services? | | | | | |
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| 9. If the member who is receiving CD services wants you to hire other individuals or fire an attendant, could you and would you? | | | | | | |
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|  | b. | Would you fire a family member? | | |  |  |
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| Check (√ ) the box of the relationship that this person has with the member (must be one of the following): | | | | | | |
| □ Legal Guardian | | | □ Spouse | □ Parent of a minor (under 18 yrs. old) | | □ Adult Child (18 yrs old +) |
|  | | |  |  | |  |
| Person completing this form *(Print name):*  Signature of person completing this form:  Services Facilitation Provider: | | | | |  | |
|  | Date: |