APPENDIX E

Agency with Choice IFDS Assessment

Member name: _____

Care Manager/Care Coordinator completing assessment: _____

Person assessed: _____

Position of person assessed (check one): ☐ Managing Employer ☐ Representative

Assessment date: _____

	Yes	No
Are you age 18 or older?	☐	☐
Have you ever been convicted of Medicare or Medicaid fraud or excluded from participating in the Medicare or Medicaid programs?	☐	☐
Do you plan to continue to use Community Navigator services?	☐	☐
Do you have a Representative identified? If so, whom? Name: _____	☐	☐
Are you willing to name a Representative or use Community Navigator services, if you are assessed to need one or both?	☐	☐

What services do you plan to self-direct?	

	Individual meets readiness criteria	Individual needs self-direction assistance
Has copies of all manuals and forms related to the Individual and Family Directed Services (IFDS) option selected, knows how to obtain additional forms and updates, and knows how to access the NC Medicaid NC Innovations Waiver website and Vaya Partners website	☐	☐
Understands the differences between IFDS and provider-managed services	☐	☐
Knows the difference between Employer of Record (EOR) and Agency with Choice (AWC) models of the IFDS option (if both models offered)	☐	☐
Understands a Representative may be appointed at any time, the Representative's role, and the process for appointing a Representative	☐	☐
Understands how the Individual and IFDS Budgets work, including what is included in each part of the budget and how to request additional funding in the IFDS Budget	☐	☐
Understands what the AWC Agreement is and how to work with the AWC provider to complete it	☐	☐
Knows how to contact the Community Navigator and the AWC provider	☐	☐
Understands how and where to recruit employees	☐	☐
Is able to interview prospective employees	☐	☐
Is able to work with the AWC to develop Employee Support Agreements	☐	☐
Understands the AWC provides workers' compensation insurance for employees hired	☐	☐
Understands that the AWC provider must complete background checks and that the Managing Employer may not review those background checks	☐	☐
Understands only the AWC provider may offer a job to a potential employee	☐	☐
Understands the purpose of Community Navigator services	☐	☐
Understands the care plan must be followed (service frequency and duration) and that changes to it must be requested through the Care Manager/Care Coordinator, including how to request additional Community Navigator services	☐	☐
Knows how to review the AWC Quarterly Revenues and Expenditures Reports and how to work with the AWC provider if there are problems with the report	☐	☐
Understands the requirements for documentation of services	☐	☐
Understands the Employer may choose to terminate the IFDS option or transfer to a different model at any time and that specific processes must be followed	☐	☐
Has completed initial orientation by the Community Navigator	☐	☐
Has completed initial self-direction training by the Community Navigator	☐	☐
Has read and understands the Vaya Partners IFDS Employer Handbook	☐	☐

	Assistance needed?		
	Yes	No	With AWC
Understands and is able to comply with applicable labor laws that apply to the model selected	☐	☐	☐
Understands staff qualifications for each service definition and the individual specific staff qualifications	☐	☐	☐
Understands how and where to recruit employees, including how to place a newspaper ad	☐	☐	☐
Knows how to develop employee guidelines	☐	☐	☐
Has resources for employee training; has a plan or training protocols for any training the Employer is providing	☐	☐	☐
Understands how to address problems with employees, including documenting those actions and recommending dismissal of employees with poor job performance	☐	☐	☐
Has a plan for back-up staffing and has selected a crisis services provider for Community Living and Supports, as applicable	☐	☐	☐
Understands confidentiality requirements for both individual and employee documentation and has established methods for meeting those requirements	☐	☐	☐
Understands the difference between billable and non-billable time under Medicaid	☐	☐	☐
Has developed emergency protocols, a plan for testing them, and a plan for documenting those tests	☐	☐	☐

Notes:

Assessment of Support:

The Managing Employer or Representative, if applicable (check one)	
☐	Is requesting the Community Navigator assist with ongoing training and support if self-direction of services is authorized
☐	Is not requesting the Community Navigator assist with ongoing training and support if self-direction of services is authorized
☐	Has indicated intention not to request Community Navigator services beyond the T2041-U1 U6 initial training hours currently included in the care plan

Signatures:

Signature of Care Manager/Care Coordinator _____ Date signed _____

Signature of person assessed _____ Date signed _____

cc: Employer of Record/Representative
Care Manager/Care Coordinator (receives original)
Vaya Partners Utilization Management Department
(with care plan update requesting approval of self-directed service)
Member's Administrative Health Record (AHR)