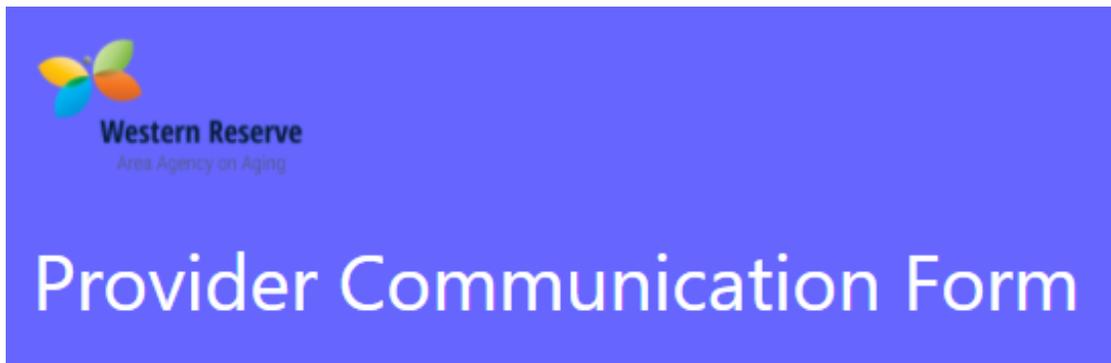


Provider Communication Form Instructions

The Western Reserve Area Agency on Aging will begin using a web-based provider communication form to allow all waiver providers to notify care management and waiver service coordination of missed services, and changes in service delivery.

The form can be located via this link: <https://forms.office.com/r/967nfdgjVc>



***Required Fields:** you will notice that some fields are **required* , meaning you will need to provide information in that field in order for the form to be able to be submitted:



Form Fields:

1. **Provider organization:** Enter/Select your provider agency by name: please be specific if a DBA name or franchise (Example: AAA HomeCare-Westlake, AAA-Meals-Akron)

1. Provider Organization *

Name of organization

Cleveland Based Waiver Service Provider

2. **Contact name**: Name of the contact person(s) at the provider agency who can be contacted if needed.

2. Contact Name *

Contact person for follow-up

Agency Representative name

3. **Provider Phone** #: Enter provider phone number

3. Provider Phone

*

Contact number for follow-up

Enter your answer

4. **Consumer Legal Last Name**: Enter last name of consumer receiving services.

4. Consumer Legal Last Name *

Enter your answer

5. **Consumer Legal First Name**: Enter first name of consumer receiving services.

5. Consumer Legal First Name *

6. **Consumer's Healthcare Plan/ Program**

Select the name of the program that the consumer is enrolled in, or MyCare Ohio HealthCare plan. If you do not know their current program select **unknown**.

***If the member is on the traditional Assisted living waiver you will select Assisted Living-Non-MyCare program**

***If the member is receiving Assisted living on the MyCare program select the Managed Care plan name first.**

6. Consumer's Program or Healthcare Plan *

- Buckeye
- CareSource
- United
- PASSPORT
- Assisted Living - Non-MyCare Program
- Ohio Home Care Waiver
- Unknown



***Once you select the program/healthcare plan, you will have additional choices to enter:**

7. Enter name of waiver service coordinator/care manager if known

7. Consumer's Case Manager/Waiver Service Coordinator *

Very helpful if known, but if not, enter "unknown"

Care manager/Waiver service coordinator name|

8. Enter member's Ohio Medicaid ID number 12 digits *

8. Medicaid Number *

Number is always 12 digits long

Enter your answer

9. Select the type of service impacted:

*Selecting the type of service will allow you to further define details of submission.

*Assisted living has its own set of reporting criteria; Assisted Living providers please scroll to # 20 on this list to see the reporting criteria:

9. Type Of Service Missed *

Personal Care

Home Delivered Meals

Homemaker

Waiver Nursing

Emergency Response

Transportation

Adult Day Service

Assisted Living

Other

10. Select the type of *change in service* being reported: (non-assisted living services)

10. Change In Service *

Select all that apply

Aide Was A No-Call/No-Show - Consumer notified agency – refused replacement

Aide Was A No-Call/No-Show - Consumer notified agency – replacement not available

Aide Was A No-Call/No-Show - Consumer did NOT notify Agency

Aide Called Off/Cancelled - Agency notified consumer – refused replacement

Aide Called Off/Cancelled - Agency notified consumer – replacement aide not available

Consumer Cancelled - Consumer cancelled prior to day of service

Consumer Cancelled - Consumer cancelled upon PCA arrival at home

Consumer Cancelled - Consumer requested hours reduced/cancelled

Consumer Unavailable/Not Home Upon PCA Arrival At Home

Consumer Institutionalized To Hospital/SNF

Other

Institutionalization

Please added details on hospital or SNF name if known

11. Enter the units of the service missed/impacted. *Different services have different *units*

Example: home delivered meals: 1 meal = 1 unit | Assisted living 1 day =1unit

Personal care service/homemaking: 15 minute = 1 unit

11. Units Of Service Missed *

15 minute increments (1 hour = 4 units)

Days

Meals

Transportation

12. Identify date(s) and units of service affected:

Example: 3/1/2022: -12 units (personal care)

Example: 3/1/2022: -7 units (home delivered meals)

Example: 3/1/22, 3/2/22, 3/3/22, -16 units each day (personal care)

12. Date(s) AND Corresponding No. Of Units Of Missed Service Or Change In Schedule *

Enter the date(s) AND number of units (based on selection in previous question) of service that were missed, e.g.
"2/1/22 - 6 units, 2/3/22 - 5 units, and 2/5/22 - 4 units" or "Week of Feb 28 except Wed and Thurs - 2 meals per day"

13. Indicate that the back-up plan for services was initiated at service change:
All program members are required to have a back-up plan for service delivery

13. Backup Plan Enacted? *

- Yes
- No
- Unknown
- N/A

14. Enter any pertinent details about utilization of back-up plan:

14. Please Provide Details Surrounding Backup Plan

Enter your answer

15. Enter the admission date if member institutionalized in hospital/SNF (if known):

15. Date Consumer Institutionalized To Hospital/SNF

If applicable

Please input date (M/d/yyyy)

16. Enter the discharge date from hospital/SNF (if known)

16. Date Consumer Discharged From Hospital/SNF

If applicable

Please input date (M/d/yyyy)

17. Date of service resumption. This will be the expected/anticipated date of consumer's service after hospital/SNF admission/discharge. Enter date to best of knowledge.

17. Date Consumer Will Resume Services Pending Authorization

If known

Please input date (M/d/yyyy)

18. Enter all additional details and information that the WRAAA staff might need to know on this impact on care.

18. Comments And/Or Concerns

Any additional Comments/concerns or information to share with care manager/waiver service coordinator

19. Click "Submit". If you have any required fields not fully completed, you will be prompted to fill the missing data. You will be able to save a copy upon completion for your records.

You can print a copy of your answer after you submit

Submit

20. **Assisted living Provider** entries: When selecting assisted living you will have services specifically related to reporting requirements for assisted living.

Select the applicable reporting requirement

10. Assisted Living: Provider Facilities Must Notify The Waiver Program Care Manager Within One Working Day When: *

- The Consumer has a change in condition.
- The Consumer is out of the Assisted Living Facility one day or more on a visit with friends/family.
- The Consumer requires Hospitalization OR Nursing Home placement.
- ER Visits.
- All Falls.
- The Consumer is requiring Skilled Nursing Care OR will be in excess of skilled nursing care.
- Allegations of Abuse, Neglect, and/or Exploitation.
- Theft allegations.
- The Consumer is not meeting financial obligations.

- Incidents of Physical Wandering by the Consumer.
- The Consumer requires implementation of a risk agreement.
- Accidents.
- Injuries.
- The Consumer is considering discharge processes.
- Medication Changes with health implications.
- Medication errors with health implications.
- The Facility is considering discharge processes.
- Environmental problems, i.e. Fire, Flooding, Bed Bugs, etc.
- The Consumer requests you call WRAAA.
- Unknown/Unexpected illnesses.
- Elopement.

- Elopement.
- Any incident reports completed by provider.
- If a 30 Day Notice for Discharge was issued.
- The Consumer requests you to call 911.
- Any leaves of absence from facility (for any reasons).
- Any negotiated agreements.
-

11. Enter room number of resident: Click Submit and you can save a copy of your reporting requirement.

11. Room Number *

If not known or applicable, enter "unknown" or "N/A"

Enter your answer

You can print a copy of your answer after you submit

Submit