DEVELOPMENTAL DISABILITIES
OF CLARK COUNTY
WHERE PEOPLE GROW

Agency Guidance and Handbook

HPC and other Non-Day Services

Courtesy of:

Sarah Hess, Provider Liaison

Ph: 937-346-0740

Email: shess@clarkdd.org

DEVELOPMENTAL DISABILITIES
OF CLARK COUNTY
WHERE PEOPLE GROW

Common Issues for HPC/Non-ADS Providers

1. **Are services matching the PCP?**
    a. Johnny's plan says he wants to explore his community, try new things, and meet new people, but aside from attending a day program, he only leaves home once a week for grocery shopping and the occasional cup of coffee from a drive-thru window. This doesn't match the plan and doesn't support achieving his outcome.
    b. Refusals-if a person is refusing outcomes or activities or the frequency of them that is in the plan, these need documented and what is being done to address this-prompts/encouragement/reminders, notifying the team, talking to the person about why (do they even want that outcome, is it too often to meet their current capability, etc.) and make the team aware of needed changes to the plan if applicable or needed changes to the approach. An example of changing our approach is to ask "what's the first step in getting ready to mop," don't tell them "you need to get the bucket."
2. **Are services being done in the community? Is there community engagement?**
    a. Johnny's current activity is not community engagement. He does not have the opportunity to ENGAGE with anyone else in the community which could lend itself to establishing relationships and connections. There are a number of ways to create these opportunities based on Johnny's interests, for example through volunteering, participating in community classes and activities offered by parks, master gardeners etc. There are social clubs for walkers and hikers, board game enthusiasts among many other things in our community and others.
3. **Is there evidence of opportunities for individual choice?**
    a. Every day the schedule is the same, Johnny comes home from his day program, eats a snack and watches TV until dinner time. He takes his medications, bathes and watches westerns and old tv shows until bed time. This doesn't reflect choices of the individuals or offer choices on the schedule. While he chooses his TV shows, he doesn't get to choose other activities for his day. Examples of ways to show opportunities for choice:
        i. Talk with Johnny about his interests and plan activities and events for next month or next quarter-that. LOTS of local events are publicized on local TV. If Johnny has a roommate or two, include them. Have a weekly "meeting" to talk about ideas or instigate a dinner conversation about fun things to do.
        ii. Suzie wants to increase her exercise and loves skating, once or twice a month we go to a skating rink and Johnny goes, too because it sounded fun and he likes it, too.
4. **Trainings**

a. Whether you are an agency employee or an independent provider, you are required to have trainings every year. These can vary between service types.
b. Make sure all individual specific training was done PRIOR to working with the person(s)
c. Make sure you have record of all of these trainings
d. Supervisors are required to have additional trainings, see Provider Cert rule 5123:2-2-01

5. **BCI, Rapback**
   a. Make sure you're running BCI for all staff and not allowing them to work past the 60 calendar days if the BCI has not come back yet.
   b. Make sure ALL staff are enrolled in Rapback within 14 days of receiving the criminal records check(s) or within 14 days of hire, whichever is later
      i. See DODD's info page with tips for providers: https://dodd.ohio.gov/wps/portal/gov/dodd/providers/initial-renewal-certification/enrolling-in-rapback
      ii. Enroll in Rapback: https://rapback.ohioattorneygeneral.gov/Default.aspx
   c. Ensure 5-year background checks are done for all employees who have been employed with you for 5 years and are not in Rapback/ARCs.
6. **Check out the Handbook** (Agency or Independent), the rules for your services, and the Compliance Tool and Required Documents sheet from DODD's website that reviewers use when reviewing Agencies. This can be found on the Compliance page (under Support for Providers) then go to Compliance Tools on the left-hand side of the page. Search for "Agency compliance tool" and "agency required documents" to help you. See screen shot guidance.
7. **If you are an agency,** Reviewers want to see evidence of an internal compliance review system both in policy and in practice.
8. **Finances-**Those who have access to the funds should not be the ones reconciling the funds each month. If you are an independent provider, the SSA for that person is often the choice for reconciling the account.
   a. Ensure that each person who works with personal funds is trained on personal funds and that the training meets the rule requirements. 5123:2-2-07 Personal funds of the individual
9. **MUI/UI-** Make sure you have record of each incident, record of reporting in a timely manner required by rule, and record of to whom notifications were made.
   a. Have a Monthly UI log tracking system with all required information (see rule, and see templates offered by DDCC and DODD)
   b. Have specific and measurable plan of correction to address the risks of reoccurrence.
   c. Make sure someone is reviewing the log monthly and identifying trends and patterns (sign and date per each review)
   d. Send copies quarterly to DDCC by email to MUIreport@clarkdd.org or Fax: 937-328-5245

e. Complete annual MUI report. Contact MUIreport@clarkdd.org with any questions on UI/MUI reporting and tracking.

10. Documentation

a. Make sure you're documenting the services you are designated to provide in the plan
b. Make sure you include all required elements on your documentation sheet. These can vary by service and can be found in each service rule (most often in section E of the rule).
c. For example, the HPC rule 5123-9-30 section E says:
(E) Documentation of services
Service documentation for homemaker/personal care shall include each of the following to validate payment for Medicaid services:
(1) Type of service.
(2) Date of service.
(3) Place of service.
(4) Name of individual receiving service.
(5) Medicaid identification number of individual receiving service.
(6) Name of provider.
(7) Provider identifier/contract number.
(8) Written or electronic signature of the person delivering the service or initials of the person delivering the service if a signature and corresponding initials are on file with the provider.
(9) Group size in which the service was provided.
(10) Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided.
(11) Number of units of the delivered service or continuous amount of uninterrupted time during which the service was provided.
(12) Times the delivered service started and stopped.

11. **Transportation-**Don't forget to document # of miles and destination points.

FOR FURTHER ASSISTANCE CONTACT:

Sarah Hess, Provider Liaison

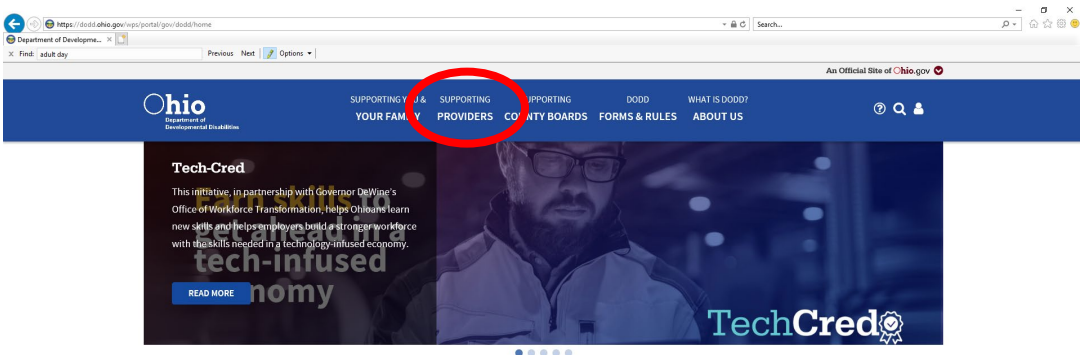
Ph: 937-346-0740

Email: shess@clarkdd.org

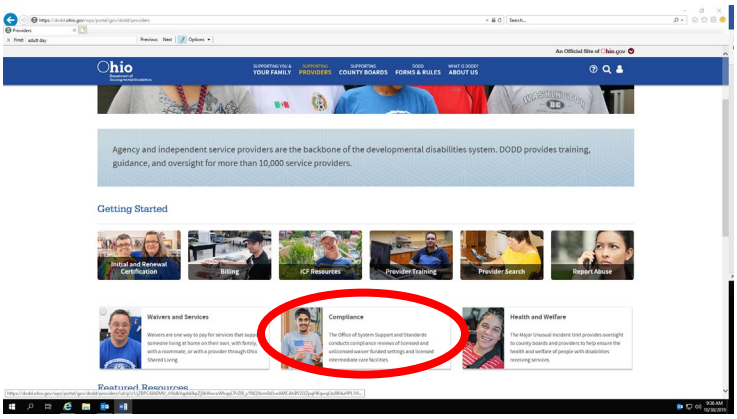
How to Find Compliance Tools

Agency Providers

1. Go to dodd.ohio.gov
2. Click “Supporting Providers”

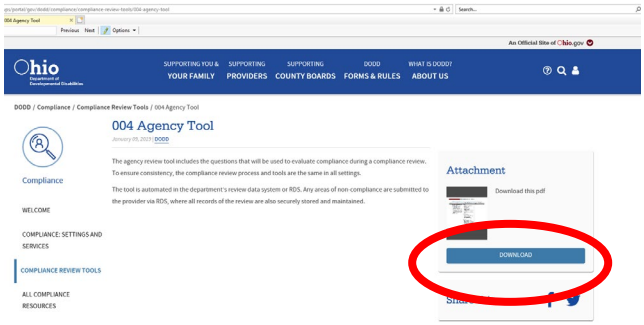


3. Click Compliance (May need to scroll down some)



4. Click Reviewer Resources (left-hand side)

5. Scroll to find “004 Agency Tool” and “Download”



6. Back to the Compliance Review Tools page, scroll down and select “015F Agency Required Documents List”and repeat the steps above to download

*Today's Community Experience*_____
Check the box that applies to today's community based Experience.

Did not seem to like the experience. Refused to engage/have fun and wanted to leave right away.	Minimal participation and enjoyment. Engaged briefly and at least tried to be involved.	Engaged and seemed to like the experience, at least for a minimal limited time and seemed somewhat interested in today's experience.	Clearly enjoyed today's experience or at least was very interested in observing or "feeling it out". Seems like they may want to return.	Actively participated and clearly enjoyed the experience. Showed emerging skills to engage. Clear body language showing interest in today's experience.	Actively and totally engaged in today's experience. Clearly this was a great match. Need to return soon to build on the great things that happened.
Struck Out ☐	**Walked** ☐	Base Hit ☐	Double ☐	**Triple** ☐	**Home Run** ☐

Completed by_____
Date_____

INTEGRATION DOCUMENTATION

Name:	Month & Year:	Type of Service:
Medicaid #:	Provider:	Provider #:

Outcome:	Action Steps & Frequency/Duration

Date	Location	What did you do and who did you meet?	Integration value	Initials

Barriers or Recommendations**:**	Next Steps:

Staff Signature &Initials	Date & Supervisor Initial

Additional Notes:

INTEGRATION DOCUMENTATION

Name_____
Date_____

Where did you go?
Who did you go with?
What did you do?
Who did you meet?
What did you talk about?
Did you like what you did?
Did your staff help you? What did they do?
Do you want to do it again?
What would you like to do next?
When do you want to do it?

Additional Notes:

DEVELOPMENTAL DISABILITIES OF CLARK COUNTY

PERSON-CENTERED PLAN
Learning Skill: Learning Log FOR

DATE	What did the person ? What, when, where, how long, etc.?	Who was there? (Names of staff, friends, others, etc.)	What did you learn about what worked well? What did the person like about the activity? What needs to stay the same?	What did you learn about what didn't work well? What did the person not like about the activity? What needs to be different?

DEVELOPMENTAL DISABILITIES OF CLARK COUNTY

PERSON-CENTERED PLAN
Learning Skill: 4+1 FOR

WHAT DID YOU TRY?	**WHAT DID YOU LEARN?**	**WHAT ARE YOU PLEASED ABOUT?**	**WHAT ARE YOU CONCERNED ABOUT?**
What did you do?	**What did you learn from your efforts?**	**What did you like about what your tried?**	**What challenges did you encounter?**
When did you do it?		**What went \well?**	**What didn't you like about what you tried?**
Who else was there		**What worked well for you?**	**What didn't work for you?**
Given your learning, what will you do next?			

DEVELOPMENTAL DISABILITIES OF CLARK COUNTY

PERSON-CENTERED PLAN
Learning Skill: Next Steps FOR

What would you like to do?	Who will do it and who will help?	By When?

DEVELOPMENTAL DISABILITIES OF CLARK COUNTY

PERSON-CENTERED PLAN
Matching Interests FOR

SUPPORTS NEEDED	SKILLS REQUIRED	PERSONALITY CHARACTERISTICS
		WANT
		DON'T WANT
		NICE TO HAVE – SHARED INTERESTS

New Adventures – Ideas for Exploration

Name_____

Scale:
1-Yes! I'd Love to do That! 2-That could be fun, I will try it 3-No Way!

Faith:
Visit churches/find a church to join 1 2 3
Join a Bible Study Class 1 2 3
Be a greeter at church 1 2 3

Food and Feeling Good:
Join an exercise class 1 2 3
Join a gym 1 2 3
Work with a personal trainer 1 2 3
Join a health/wellness class or group 1 2 3
Go for walks/hikes 1 2 3
Take a cooking/baking class 1 2 3
Join/Start Community Garden 1 2 3

Give Back:
Volunteer at a sporting event 1 2 3
Volunteer at a library 1 2 3
Volunteer cleaning up the park 1 2 3
Volunteer at an animal shelter 1 2 3
Volunteer at a soup kitchen or food pantry 1 2 3
Volunteer somewhere, but not sure where 1 2 3
Join an advocacy or civic group 1 2 3

Fun and Creative:
Take a class in art/painting 1 2 3
Take a class in crafts (sewing, drawing, crochet, scrapbook, etc...) 1 2 3
Make crafts for sale 1 2 3
Join a book club: 1 2 3
Join a dance class 1 2 3

Friends and Family
Meet some of my neighbors 1 2 3
Have cookouts and invite friends, neighbors 1 2 3

I need some help thinking of new ideas. I am not sure what is out there to do: Yes No

I am (or want to be) a _____

Who are the other _____ in the community?

1. _____
2. _____
3. _____
4. _____
5. _____

How could I meet other _____?

1. _____
2. _____
3. _____
4. _____
5. _____

Where in the community do other _____ spend their time?

1. _____
2. _____
3. _____
4. _____
5. _____

What activities does a _____ do regularly?

1. _____
2. _____
3. _____
4. _____
5. _____

What do I need to be a _____?

1. _____
2. _____
3. _____
4. _____
5. _____

Who can help me be a _____?

1. _____
2. _____
3. _____
4. _____
5. _____

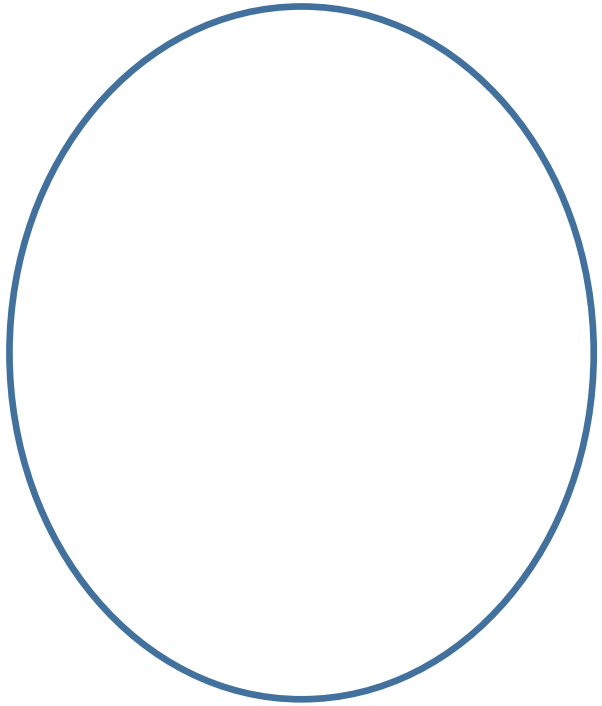
DEVELOPMENTAL DISABILITIES OF CLARK COUNTY

PERSON-CENTERED PLAN
One page Description FOR

WHAT PEOPLE LIKE AND ADMIRE ABOUT ME

MY PHOTO

WHAT IS IMPORTANT TO ME



HOW TO BEST SUPPORT ME

FOR A GOOD MATCH I NEED THESE CHARACTERISTICS

DEVELOPMENTAL DISABILITIES
OF CLARK COUNTY

PERSON-CENTERED PLAN
Communication Chart FOR

WHEN THIS HAPPENS	I DO THIS	IT USUALLY MEANS	AND I WANT YOU TO

DEVELOPMENTAL DISABILITIES OF CLARK COUNTY

PERSON-CENTERED PLAN
Good Day / Bad Day FOR

TIME OF DAY	TYPICAL	BETTER	WORSE
Morning at Home			
Commute			
Morning at Work			
Lunch			
Afternoon at Work			
Commute			
Evening			
Overnight			

DEVELOPMENTAL DISABILITIES OF CLARK COUNTY

PERSON-CENTERED PLAN
Morning Routine FOR

TIME	ACTIVITY
6 AM	
6:15 AM	
6:30 AM	
6:45 AM	
7 AM	
7:15 AM	
7:30 AM	
8 AM	
8:15 AM	
8:30 AM	
8:45 AM	
9 AM	
9:15 AM	
9:30 AM	
9:45 AM	
10 AM	
10:15 AM	
10:30 AM	
10:45 AM	
11 AM	
11:15 AM	
11:30 AM	
11:45 AM	
12 NOON	

_____'s Comfort and Celebration Rituals

Contributors:

Comfort Rituals	Celebration Rituals

Positive Rituals Survey

For:

Contributors:

What rituals help to create a positive experience and good day? Select rituals from the list below, and add others that may also be important. Complete a more detailed description for appropriate routines/rituals.

List of Rituals/Routines	Description
Morning (getting up) Rituals	
Nighttime (going to bed) Rituals	
Arriving at work, school, or training Rituals	
Arriving at home Rituals	
Sunday Rituals	
Regular Weekly Rituals	
Birthday Rituals	
Holiday Rituals	
Other Celebration Rituals	
Comfort Rituals	
Other Rituals	

2 Minute Drill

For:
Contributors:

In 2 minutes tell me:

- What should I know (important to/important for), and
- What should I do to make it a meaningful, safe, and enjoyable day for the person?"

Important To

Actions:

Important For

Actions;

Reframing Reputations

For:

Contributors:

What is the reputation? _____

1. Are there ever circumstances where this can be positive? If yes, what is it called?
   _____

2. Does the "behavior" demonstrate or reflect something that is *important to* the person?
   _____

3. If the "behavior" truly is negative, what is the support strategy?
   _____

Then ask…

Given what we have learned:

1. Are there things that are present in the person's life that need to change?
   E.G .How the person lives; what the person is asked to do; who the person lives with?

2. Are there things that we need to do differently?
   I.E. How the person is supported?

Risk Analysis Tool

Where is the risk identified? Locations

Name of risk?

Description of Risk, (what does it look like)

What is the individual trying to communicate?

How to address risk? Adaptions - Locking items vs adding staff, what's more intrusive?

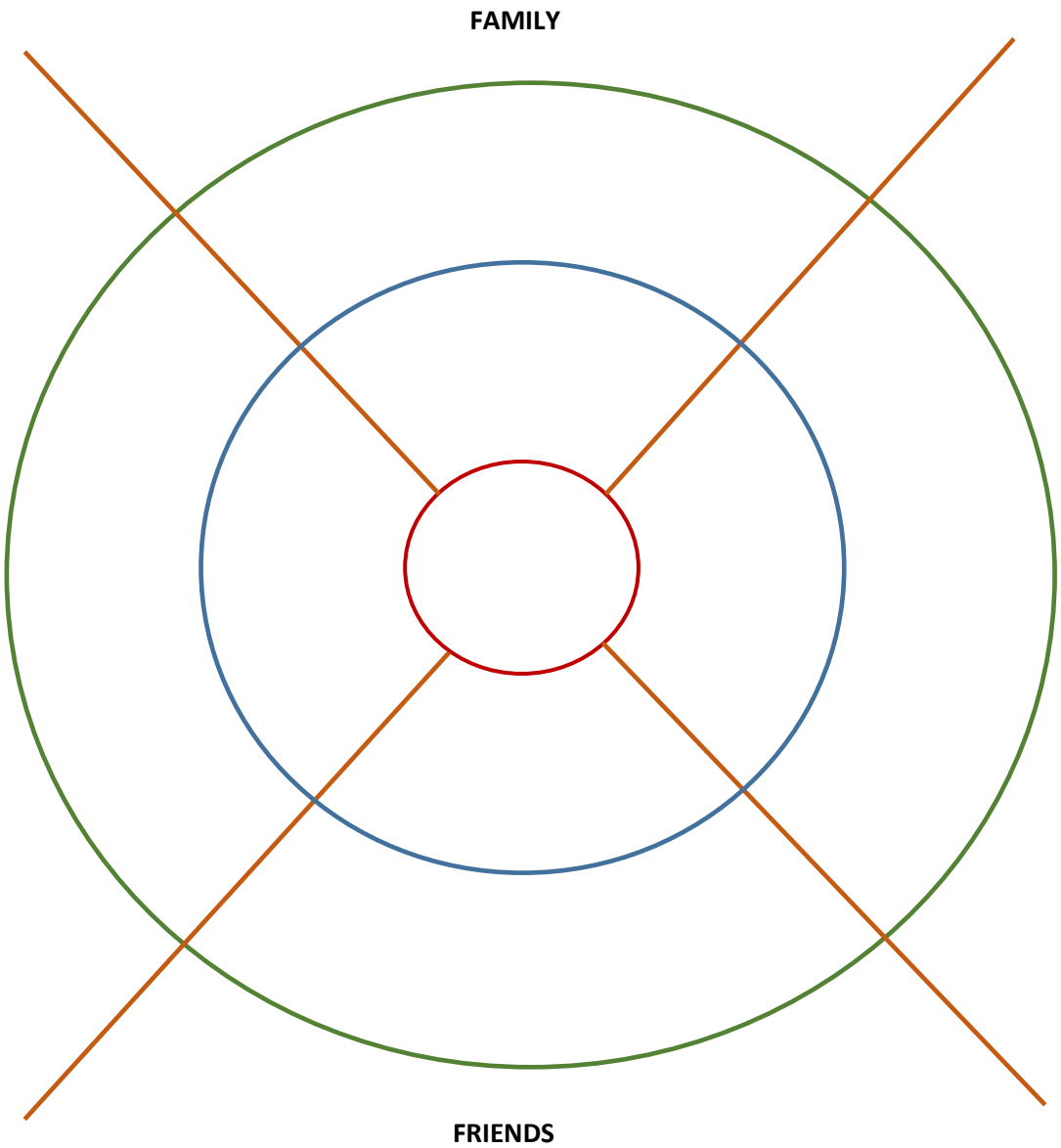
Like & Admire – Talk To and Listen To

For:
Contributors:

What do you like about _____	What do you admire about _____	When's the last time you had fun together?

DEVELOPMENTAL DISABILITIES OF CLARK COUNTY

PERSON-CENTERED PLAN
People Map FOR



Community Integration Add-On: Things to Know

- It only applies to Day Services (not HPC)
- It may be used when the service is provided in the community during integrated activities
- Groups of 4 or fewer individuals per staff person (this can be a group of 8 with 2 staff, but a group of 9 with two staff could only bill for 4 individuals).
- Staff providing the service have demonstrated enhanced competency by successfully completing a DODD approved program of instruction in Community Integration.
- This Add-On adds $0.52 per unit during the time the individual is out in a group of 4 or fewer per staff
- This Add-On would not be used for every hour, every day. Only those hours for which the above criteria are met.

Home and community-based services waiver-adult day support under the individual options, level one, and self-empowered funding waivers 5123:2-9-17

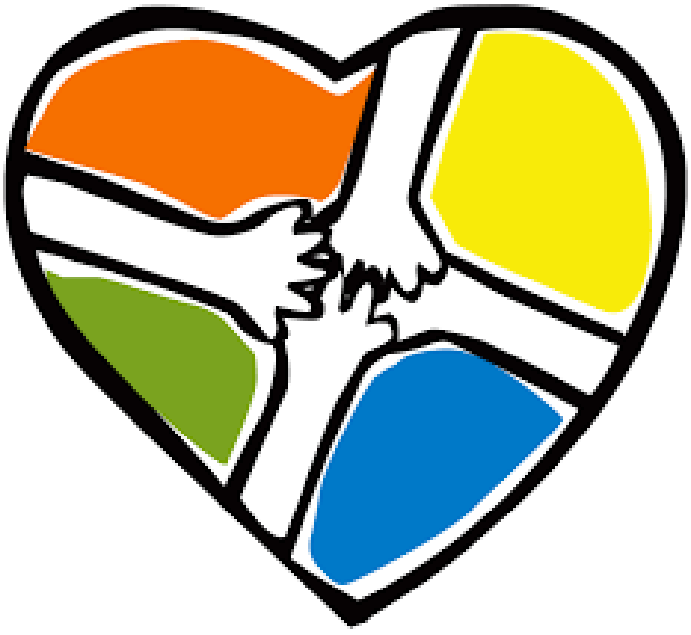
See page 9 & 11 of the Rule

See pages 2 & 5 of the Appendix

For further assistance contact Sarah Hess, Provider Liaison at shess@clarkdd.org or 937-346-0740.

DEVELOPMENTAL DISABILITIES
OF CLARK COUNTY

Agency Provider Orientation Handbook



Glossary & Abbreviations

1. **PCP** also known as the Person Centered Plan, previously the IP or Individual Plan
2. **SSA-**Service and Support Administrator, formerly known as Path Coordinators
3. **DODD**-Ohio Department of Developmental Disabilities
4. **UI** or **UIR**-Unusual Incident/ Unusual Incident Report
5. **MUI**-Major Unusual Incident
6. **IA**-Investigative Agent
7. **DDCC**-Developmental Disabilities of Clark County

How to access rules governing services

Visit Dodd.ohio.gov
→Click on "DODD Forms & Rules"

→Click on "Rules in Effect" for current rules (Left side of the screen)

→To stay up to date or participate in public comment/hearings on proposed rule changes, click on the "Rules under development" option.

👉 It is very important that you stay familiar with the rules governing the services you provide to ensure compliance

Change in Agency CEO

A change in agency CEO must be reported to DODD within 14 days. In PSM, click on Update CEO to enter new CEO information.

The new CEO of an existing agency will need to map their PSM User ID to the agency's DODD contract number.

On company letterhead, include the name of the new CEO, the CEO's newly created PSM User ID, and the DODD contract number for the agency, signed by the agency owner or CEO. Email the document as an attachment to provider.certification@dodd.ohio.gov.

As a Provider, you are required by the Ohio Department of Developmental Disabilities to maintain your own certification and meet the rule requirements based on the services you provide. Included on the following pages are some of the key responsibilities you have as an Agency Provider.

Your Person Centered Planning Responsibilities

- All staff working with an individual will need to be trained on the PCP (Person Centered Plan). You (or designee) will sign an agreement to the services before you can start providing services so make sure you agree with the services you are designated to provide. A start date for your agency will be confirmed by the SSA. You or a designee will also need to participate in team planning meetings and sign an agreement of the services prior to the PCP start date each year/with revisions as requested.
- The PCP is the authorizing document, meaning that it tells you what you are being paid to provide. The services your agency provides an individual, and the frequency of these services, must line up with the individual's PCP, and therefore reflect what is important to and for them.
- You must keep a copy of the current PCP with your records. You or designated employee should receive an emailed copy of the PCP at least 15 days prior to the plan start date, as well as with any revisions. All PCPs will be sent by email and you are required to open them and review. These emails are encrypted for confidentiality reasons, so you will need to follow the steps in the email to set up an account to open the PCP attachments. If you have not received a copy of the PCP prior to the individual's start of their plan year, you will need to contact the individual's SSA to follow-up.
- When you receive the PCP, to remain in compliance you must promptly update your service documentation to reflect any changes to the services you are responsible for and documenting on.
- You are an important PCP team member and you have valuable input to share in the planning process. If something in the PCP is not accurate, you need to let the SSA know.

Documentation

DOCUMENTATION REQUIREMENTS

For any service you provide, you must have documentation of that service.
Each service has its own documentation requirements, which can be found within the rule for each service.
The Rules can be found at http://dodd.ohio.gov/RulesLaws/Pages/RulesInEffect.aspx
Your form can appear any way you want it to, but MUST contain all the required elements.
Forms examples can be found on:

- DODD (http://dodd.ohio.gov/Providers/Billing/Pages/Documentation.aspx)
- DD of Clark County (https://clarkdd.org/resources/)

THINGS TO REMEMBER

-Documentation should be maintained in an accessible location.
-Invoices submitted for payment or billing records are NOT considered service documentation.
-Ensure your documentation meets the requirements for the service(s) you are providing.
-You must maintain your documentation records for 6 years from the date you received payment.

COMMONLY USED SERVICE DOCUMENTATION REQUIREMENTS

Homemaker Personal Care	HPC Transportation	Shared Living
Type of Service, Date of Service, Place of Service, Name of Individual Receiving Service, Medicaid Number of Individual, Name of Provider, Provider Identifier / Contract Number, Written or electronic signature of the person delivering the service; initials if the provider has corresponding signature and initials on file, Group size in which the service was provided, Description and details of the service delivered that directly relate to the services specified in the approved service plan , Number of units of the delivered service or continuous amount of uninterrupted time the service was provided, Times the delivered service started and stopped	Type of Service, Date of Service, Name of Individual Receiving Service, Medicaid Number of Individual Receiving Service, Name of Provider, Provider Identifier / Contract Number, Origination and destination points of transportation provided, Total number of miles of transportation provided, Group size in which transportation is provided, Written or electronic signature of the person delivering service, or initials if provider has corresponding signature and initials on file, Description and details of the services delivered that directly relate to services specified in the approved service plan	Type of Service, Date of Service, Place of Service, Name of Individual Receiving Service, Medicaid Number of Individual, Name of Provider, Provider Identifier / Contract Number, Written or electronic signature of the person delivering the service; initials if the provider has corresponding signature and initials on file, Group size in which the service was provided, Description and details of the service delivered that directly relate to the services specified in the approved service plan

Incident Reporting/Tracking Requirements

- **KNOW THE RULE!** OAC 5123-17-02. Changes were made effective January 1, 2019. Go to DODD MyLearning and take the latest, FREE MUI/UI training.
- **REPORTING:** To report an incident, contact our MUI department (see contact information on the following page. You will need to complete an Incident Report Form (UIR). You can complete the online form on our website Click "Providers" and select Major and unusual incidents from the drop down. Click the "Online Submittal Form" button on the right side of the screen. A fillable form can be found by clicking the button directly below this. Also, a physical form is also included in this packet which you can scan and email or fax.

    - Your annually required training on Major Unusual Incidents (MUI) and Incident Reporting will give you details of when and what you are required to report. The next page of this handbook also summarizes your reporting requirements and reporting timelines.

- **TRACKING of Major Unusual and Unusual Incidents**: You need to maintain an Unusual Incident log for each month. Even if there are no incidents to report, you will need to have a log completed to show you are mindful of the tracking. The log has to have verification documented that it was reviewed monthly and what was done with the findings. Either a trend/pattern was discovered and a prevention put into place or no trends/patterns noted. This needs to be signed and dated when it was reviewed. You can also find the UIR log on our website in the Provider link under "Information and resources"→ Major unusual and unusual incidents page, click "Monthly UI Report Log".

- You are required to provide your incident tracking for MUIs to our Investigative Agent (IA) Department annually. You will need to complete the analysis report and send it to Heather Bowen at hbowen@clarkdd.org or MUIreport@clarkdd.org. You will email one report each year for January 1st through December 31st. Find the form in this packet or obtain from Marci Dowling.

- You are required, quarterly, to send your monthly unusual incidents log to Heather Bowen at hbowen@clarkdd.org or MUIreport@clarkdd.org as well. Check with her for assigned months.

While you must send them to Heather quarterly, you are **still required to track them monthly. When you send your reports, you will send the last 3 months of logs (since you last sent the report). If you have questions about this, please contact Marci or Sarah Hess.

Incident Reporting Guidelines

Required Notifications: must be made the same day ☐ Guardian, advocate, or person identified ☐ SSA for individual ☐ Licensed or certified residential provider ☐ Staff or family in the home	**MUI Reporting**: During business hours, and after hours: Call: (937) 328-5245 Submit Online Form: https://clarkdd.org/ui-mui/ Email: MUIreport@clarkdd.org Fax: (937) 328-4575

MUI = Major Unusual Incident (CategoryA)	**MUI = Major Unusual Incident (Category B&C)**	**UI = Unusual Incident**
Report to DDCC within **4 hours** and Report **immediately** to Law Enforcement or Children Services in cases of suspected child abuse (up to age 22): ○ Accidental or suspicious death ○ Exploitation ○ Neglect ○ Prohibited Sexual Relations ○ Misappropriation ○ Physical Abuse ○ Sexual Abuse ○ Verbal Abuse ○ Failure to Report ○ Rights Code Violation	Report to DDCC the within **4 hours:** ○ Attempted Suicide ○ Death other than accidental or suspicious death ○ Missing Individual ○ Law Enforcement ○ Medical Emergency ○ Peer to peer act ○ Unapproved Behavior Support ○ Significant Injury ○ Unanticipated Hospitalization	Report to DDCC by **3p.m. the next working day:** Include but not limited to: ○ Minor medical emergencies: dental, falls, etc. that do not require doctor visits ○ Emergency room or urgent care treatment center visits (not requiring hospitalization ○ Overnight relocation of an individual due to fire, natural disaster, or mechanical failure ○ A minor incident involving two individuals served ○ Rights code violations or unapproved behavior supports without a likely risk to health and welfare ○ Program Implementation incidents-failure to follow a person centered support plan when such failure causes minimal risk or no risk Ex: no supervision for a short period, car accidents without harm, self-reported incidents with minimal risk

CEO Ongoing Training Responsibilities

- Within 30 days of initial certification or of hire as CEO, complete web-based orientation for CEOs of agency providers.
- Within 60 days of initial certification or of hire as CEO, complete training in
  - Service documentation
  - Billing for services
  - Internal compliance programs
  - The rights of individuals
  - Review of health and welfare alerts and UI/MUI
- In second year
  - Agency providers role and responsibilities
  - The rights of individuals
  - MUI/UI, Health and Welfare alerts issued since the previous year's training

Staff Requirements and Training

- Initial Hire:
  - At least 18
  - Has valid Social Security Number and one of the following:
    - State of Ohio ID
    - Valid driver's license; or
    - Other government issued ID
  - High school diploma or GED
  - Is able to read, write and understand English
  - Has valid "American Red Cross" or equivalent CPR/FA certification with in-person skills assessment completed.
  - Successfully completes, prior to providing direct services, eight hour of training to include:
  - Training specific to each individual on what is important to and important for them and each individual's support needs prior to providing direct services

**There are some exemptions, see rule 5123:2-2-01 (E)

Common Services and training requirements

	Career Planning	Ind. Emp. Support	NMT	Money Mgmt.	Informal Respite	HPC Transport	HPC	Shared Living
8 hours of annual training	X	X		X			X	
CPR & First Aid	X	X	X		X	X	X	X
Provider's role/ responsibility w/ regard to Person Centered Planning, Community Integration, Self-Determination & Self-Advocacy	X	X	X	X	X	X	X	X
Individual Rights	X	X	X	X	X	X	X	X
MUI Rule w/ a review of Health & Welfare alerts	X	X	X	X	X	X	X	X
Services that comprise Career Planning	X							
Services that comprise Ind. Emp. Support		X						
Topics that enhance skills and competencies related to the provision of money management				X				
Requirements relative to provider's role in providing behavioral support							X	
Activities required to meet individual's needs					X			

ADULT DAY SUPPORT STAFF TRAINING

Check out the Rule 5123:2-9-17 Section C (4) for full training requirements. Don't forget the Community Integration training to be eligible for the Community Integration Add-On 5123:2-9-17 Section F(8)

Recertification

- You are responsible for knowing your certification expiration date and for the renewal of your certification every 3 years.
- To avoid having a lapse in your certification and/or billing, DODD is asking that you submit your application and supporting documentation **90 days prior to your expiration date**.
- To complete your recertification, go to dodd.ohio.gov and click "Login". Click "Applications" and click the drop down arrow to choose "PSM-Portal" to complete your reapplication. If you need assistance with this process or use of a computer, please contact shess@clarkdd.org or 937-346-0740.
- You will need the following documents
    - **Current report from the Bureau of Criminal Identification and Investigation (BCII) for CEO/co-owners:** *Find more organizations that offer Web Check on the Ohio Attorney Generals' website.*
    - **Completion of Annual Required Training for CEO:** Evidence of completion of annual training on MUI, Client Rights, AND provider's role and responsibilities with regard to services including person-centered planning, community integration, self-determination, and self-advocacy.
    - **Additional Documents may be required based on the services you are certified to provide.** See the rule for each service.

For more information about your responsibilities regarding your certification and the specific services you provide, please refer to the DODD Rules. These can be found at www.dodd.ohio.gov. Click on "DODD Forms & Rules" at the top of the screen, then on "Rules in Effect" on the left side on the next page. The rules are listed in numerical order or you may press Ctrl+F for the "Find" function and type in a keyword. Ex: "certification"

Billing for Services Provided

BILLING REQUIREMENTS

You can only bill for services that you have provided that are identified in an approved service plan AND have been documented.

You are responsible for the accuracy of your billing.

You can choose to use a DODD approved billing agent, the form is available here: (https://dodd.ohio.gov/wps/portal/gov/dodd/providers/billing/billing+agent)

You can submit the billing as often as you would like. Billing claims are pulled into the system for processing at noon on Wednesdays and it takes 3 weeks for the claim to process.

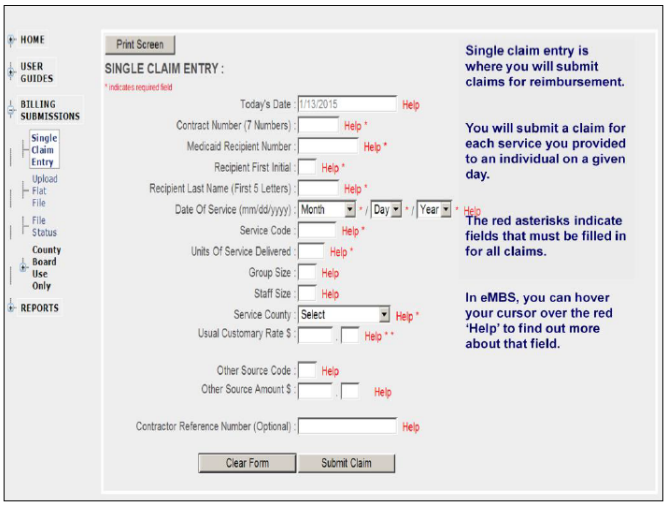
If your claim is denied, or there was an error; you can adjust your billing and resubmit it for processing. You have 350 days from the date of service to submit your claims.

Information can be found on:

- DODD (https://dodd.ohio.gov/wps/portal/gov/dodd/providers/billing)

SUBMITTING CLAIMS

When you want to bill, sign in to your DODD Account and access the application "eMBS"
Select "Billing Submissions" from the menu on the left side of the page, then "Single Claim Entry"
Fill out the following for each claim you are making, billing codes and usual customary rate information can be found in the Appendix for the rule of each service.



Record Keeping

DOCUMENTATION

- Keep all of your documentation current and up to date
- You should document all services you provide as soon as you are able
- BEST PRACTICE- Have an active file with your current documentation as well as the individual's service plan that corresponds with the document and maintain any prior span documentation along with the service plan, clearly labelled
- Keep your documentation easily accessible

UI / MUI

- Keep copies of all Incident Reports that are completed
- Maintain a monthly UI Log, even if you have 0 incidents
- Complete, submit and retain for your records the Annual MUI Analysis

TRAINING

- Maintain records of ALL trainings completed by leadership and direct support employees
- It is your responsibility to ensure you are in compliance with all training requirements and have the documentation / certificates to prove you have completed all requirements

TIMELINE FOR DOCUMENTATION & RECORDS

COMPLETE UP TO DAILY-

- Service documentation
- Incident reports (if they occur)

COMPLETE MONTHLY-

- Completed and signed service documentation
- UI Log and log review(even if there are 0 incidents)

ANNUALLY

- MUI Analysis (send to hbowen@clarkdd.org or MUIreport@clarkdd.org)

AS NEEDED

- Training, Maintain compliance with IRS, BWC and all other governing entities and applicable laws.

Compliance

You are required to have an internal system to ensure compliance with requirements in several areas. See rule 5123:2-2-01 Section D(10)

Check out DODD's Compliance page
https://dodd.ohio.gov/wps/portal/gov/dodd/compliance

Compliance Reviews

INFORMATION

At least once in your certification span, you will undergo a compliance review.

WHAT IS REQUIRED FOR A REVIEW?

You can find the Compliance Review Tool here:
https://dodd.ohio.gov/wps/portal/gov/dodd/about-us/compliance_resources/compliance-review-tools/004-agency-tool

You can find the list of required documents for a Compliance Review here:
https://dodd.ohio.gov/wps/portal/gov/dodd/about-us/compliance_resources/compliance-review-tools/015f-agency-required-documents-list

TIMELINE FOR A REVIEW

- 90 days prior to the review- you will receive notification that a review will occur
- 60 – 45 days prior – reviewer will contact you to set the review date
- Onsite Review- review occurs

AFTER THE REVIEW

Once the review is complete:

- If you have received no citations- you will receive a letter signifying that you have completed your review with no citations
- If you have received any citations- you will receive a compliance summary and a request for a Plan of Correction (POC)
    - Within 14 days of receiving the request, you must submit your POC or you can appeal the citation(s)
        - If the POC is approved- you will receive a POC approval letter and a completed compliance survey
        - If the POC is disapproved- you will receive correspondence from the reviewer asking for additional information and you will have to resubmit a POC
    - Within 90 days of POC approval- the reviewer will verify that the POC has been implemented

Medication Administration

- If you administer medication to an individual who lives with their family, and the family is willing to delegate, the responsible family member will need to complete a family delegation form with the SSA stating that they will provide training to you on how they would like you to administer the medication. If you have questions about this, contact the individual's SSA.
- DODD approved medication administration training is required if you administer medication to an individual not residing with family.
- If you have questions about medication administration, please reference rule **Chapter 5123:2-6** or email shess@clarkdd.org
- If you are certified in Medication Administration and providing Medication Administration assistance to any individual you serve, you will be subject to a Medication Administration review:

Medication Administration Review

5123:2-6-07 (D)(3) The quality assessment registered nurse shall complete quality assessment reviews so that a review of each provider location in the county where certified developmental disabilities personnel perform health-related activities, administer oral prescribed medication, administer topical prescribed medication, administer topical over-the-counter musculoskeletal medication, administer oxygen, or administer metered dose inhaled medication is conducted at least once every three years. The quality assessment registered nurse may conduct more frequent reviews if the quality assessment registered nurse, county board, provider, or department determines there are issues to warrant such.

Medical Appointments and tracking

If you are designated in the Person Centered Plan as being responsible for medical appointments and follow-up, you are required to document the completion of this service as with any other service you are designated in the plan to provide. It is best practice to have a tracking system for these appointments and follow-up appointments, particularly when there is an unusual or major unusual incident that requires medical attention, it is important to have documentation from the medical professional and any follow-up appointments. Please see the template for professional appointments included in this packet. This can be used for eye appointments, dentists, therapy, general practitioners, or any other professional appointments.

Personal Funds Management

If you are designated in the Person Centered Plan as being responsible for assisting a person with managing their personal funds, please refer to the personal funds of the individual rule **5123:2-2-07**. Please see example funds forms included in this packet for each type of funds. Please ensure all required information (as outlined in the rule) is included in your form. It's important to note that per the rule, someone "other than the person who provides direct assistance to the individual with managing personal funds or the one who maintains the written or electronic system of accounting for the provider shall conduct the reconciliations required." There are also specific requirements for depositing checks, time frames for turning over funds when you cease to provide services, among other things. Please refer to the rule and use the included forms to assist you in tracking. It is your responsibility to ensure that all required elements are included in your documentation per the rule. Rules and requirements are updated regularly by DODD. The best place to check requirements is on the "Rules in Effect" page at dodd.ohio.gov "DODD Forms & Rules" to get the latest and most accurate guidelines. The provided forms are samples to aid you in documentation creation and tracking.

Provider Checklist:
AFTER CERTIFICATION APPROVAL

I HAVE MY APPROVAL LETTER, WHAT'S MY FIRST STEP?

- ☐ If an individual is waiting for your approval to begin services, contact the SSA and provide a copy of your approval letter. This will be emailed to you from DODD upon your approval
- ☐ Notify the Provider Liaison, Sarah Hess, to be added to the Clark County provider database 937-346-0740 or complete the form on our website clarkdd.org/provider-information-form
- ☐ Review the rule(s) for the services you plan to provide.
- ☐ Within 30 days of initial certification or hire, the CEO will complete the web-based orientation for the CEO of agency providers. Within 60 days of initial certification or hire: CEO completes the following training: Billing and Service Documentation, Internal compliance programs, Rights of individuals, MUI/UI and Health and Welfare alerts.
- ☐ Create your documentation for each service you will provide. Be sure to include all required elements listed in the service rule
- ☐ Sign up for emails from DDCC about requests for providers, DODD updates/changes, and provider meetings. Visit clarkdd.org and click "Sign up for emails" and choose your lists. Also join our provider Facebook page at facebook.com/ddccproviders.

Once I'm providing services, what are my responsibilities

- ☐ REPORT UNUSUAL and MAJOR UNUSUAL INCIDENTS. Visit https://clarkdd.org/ui-mui/ for printable forms (see samples in this handbook) or to submit a report online.
- ☐ Keep monthly UI/MUI log. If no incidents occurred, mark "no incidents". Send these to Marci Dowling 4 times per year. See sample log and guidelines. Contact Marci for your assigned reporting months

Month completed_____ Month completed_____ Month completed_____ Month completed_____

- ☐ MUI Annual reporting. You must report even if you have no incidents occurring. See handbook for reporting details and form.

Annual: January 1 through December 31____

- ☐ **CHECK YOUR EMAIL** on a regular basis. Compliance review communication will **ONLY** be shared via email. DDCC also emails updates and important provider information to your provided email address for those who have signed up for our mailing list.
- ☐ Communicate with the service team. Keep the SSA, guardian, and other providers up to date on any changes. Stay involved and communicate!
- ☐ Ensure a representative familiar with the individual(s) attends service team meetings, this can be a DSP who knows them best.
- ☐ Stay up to date on trainings and certification requirements for staff and leadership. Keep a list of due dates to help keep you on track!
- ☐ Stay up to date on rule changes for providers and services. Sign up for DODD and DDCC updates to stay informed
- ☐ Keep all documentation for 6 years from the date you billed for the service.

Contact Information

If you have questions about any of the responsibilities and requirements included in this handbook, please contact:

Sarah Hess, Provider Liaison
Developmental Disabilities of Clark County
(937) 346-0740
Shess@clarkdd.org

For questions related to your user account with DODD, or applications on DODD's website, please contact:

DODD Support Center
1-800-617-6733
Opt.3-Provider Certification
Opt.4-Security (user account issues, password resets)

For questions related to incident reporting, please contact:
(937) 328-5245
muireport@clarkdd.org

To connect with other DD of Clark County employees:
(937) 328-2675

The following sample forms are meant to aid you in creating documentation and tracking services. You are responsible for knowing the documentation requirements governing your provided service type. Changes occur frequently in our field and you are encouraged to check the current rules found on the "Rules in Effect" page at dodd.ohio.gov under DODD Forms & Rules. Please contact Sarah Hess for assistance in accessing these rules if you need assistance.

Sample Homemaker/Personal Care Documentation Sheet

OAC 5123:2-9-30(E)

(Designed for an Independent Provider by DODD 1/1/2014)

Name of provider :	**Name of Individual receiving service:**
DODD Contract Number :	**Medicaid number of individual :**
Signature of Provider:	
My signature on this documentation sheet signifies that I have supported the individual as identified in the Individual Service Plan (ISP) and the time in/out and services provided are accurate.	

Type of Service							
Date of Service							
Place of Service							
Description of service as specified in the ISP (SCOPE)							
Group Size							
Time in (Begin Time)							
Time out (End Time)							
Number of units of service							

Notes:_____

_____

_____

Documentation of Waiver Services Provided

Month		Year	
Individual		Medicaid #	
Provider		Provider #	
Location		Service Type	
Signature		Initials	
ISP Span date			

Date of Service	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Provider Initials																															
Miles																															
Group Size Ratio																															
The provider will provide ISP services to the individual at the frequency and durations as outlined in the ISP.																															
Description of service (SCOPE) and frequency	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Benefit Note																														

Staff Signature: _____ Initials:_____ Date of Signature: _____

Ohio | Department of Developmental Disabilities

DODD – Possible or Determined MUI Report Form

Provider Name & Address

Individual's Name:	DOB:
Address:	City/County:

Date of Incident: Time of Incident: AM PM

Location of Incident (home in bathroom, at the mall, lunchroom at work):

Description of Incident (Who, What, Where, When):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Injury – Describe Type & Location:

_____
_____
_____

Immediate Action to Ensure Health & Welfare of Individuals:

_____
_____
_____

Name of PPI(s):	Relationship to Individual:
Witnesses to Incident:	Others Involved:

Type of Notification	Name/Title	Date/Time
Guardian / Advocate/Family		
SSA		
Licensed or Certified Provider		
Staff or Family living at the Individual's home		
LE (Name, Badge Number, Jurisdiction, Contact Info)		
Children's Services (if applicable)		
County Board		
Administrator (Required for ICF)		
Senior Management		
Other Providers of Service		

Additional Information/or Administrative Follow-Up:

A. Further Medical Follow-up:

_____
_____
_____

B. Administrative Action:

_____
_____
_____
_____

Printed Name: _____

Signature: _____ Title: _____ Date:_____

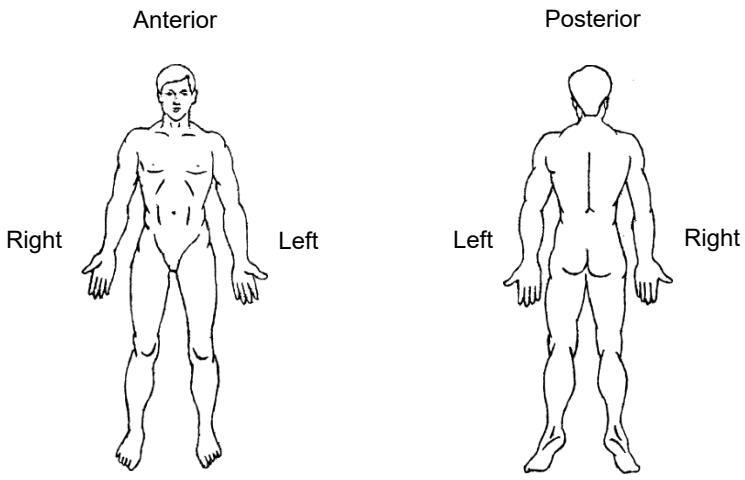
Body Part Injured:

Head or Face	Neck or Chest
Mouth / Teeth	Abdomen
Hands/Arms	Back/Buttocks
Feet/Legs	Genitals

Detailed description of area(s) injured:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Check All Areas Injured



Causes and Contributing Factors:

_____
_____
_____
_____
_____
_____

Preventive measures: (For Provider's internal use)

_____
_____
_____
_____
_____
_____
_____

Administrator Review: _____ Date: _____

Ohio | Department of Developmental Disabilities

Law Enforcement MUI Form

Individual's Name:_____ **Date Form Completed:** _____

Incident Date:_____ **MUI Number:**_____

Person Completing Form:_____ **Provider:**_____

Title:_____

Contact Information:_____

HISTORY / ANTECEDENTS:

Please list what led to the individual being charged, incarcerated, arrested or tased. Provide a timeline and whether this individual has a history of law enforcement involvement. Provide details of prevention measures from prior incidents.

_____
_____
_____
_____
_____
_____
_____

CRIMINAL CASE INFORMATION:

Law Enforcement Entity: _____
Outcome of Criminal Case: _____
Contact Information for Arresting Officer: _____
Incarceration Location: _____
General Population?_____**Probation?** _____ **Parole?** _____

SUPERVISION LEVEL:

Did the individual have a supervision requirement? If so, describe the supervision level. Was the supervision level met? Did the staff know about the supervision required? Was the staff trained on the implementation of the supervision requirements?

_____
_____
_____
_____

INJURIES / MEDICAL NEEDS:

Were there any injuries to the individual or anyone else involved in the Law Enforcement MUI? Did the individual receive timely medical attention? Are the individual's medical needs known – especially if the individual is incarcerated?

_____
_____
_____
_____
_____
_____
_____
_____

DESCRIPTION:

Describe in detail the incident.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

CAUSE AND CONTRIBUTING FACTORS:

Supervision not met	**Excessive noise**	**Medication changes**
Staff ratio was not appropriate	**1:1 attention unavailable**	**Illness**
Diet not followed	**Peer aggression**	**Possible Hallucination**
Asked to complete task	**Outing canceled**	**Loss of important relationship**
Change in routine	**Control issues - staff/family/peers**	**ISP/BSP followed**

Other:

PREVENTION MEASURES:

Physical/Social Environmental Change	**Medication Changes**
Agency Policy/System Change	**Follow up appointment scheduled**
Staff Training	**PT/OT/Speech referral made to address communication or mobility concerns**
Counseling	
Team Meeting to address ISP Changes	**Diet change ordered**
Appointment with Medical Care Provider	**Home Health Care**

Other:

INVESTIGATIVE AGENT REVIEW:
Comments & Questions:

_____
_____
_____
_____
_____

IA NAME: _____ **REVIEW COMPLETED DATE:**_____

Ohio | Department of Developmental Disabilities

Unanticipated Hospitalization MUI Form

Individual's Name: _____ **Date Form Completed:** _____

Date of Hospitalization: _____ **MUI Number:**_____

Name of Person Completing Form: _____

Title: _____ **Provider:** _____

Contact Information: _____

HISTORY / ANTECEDENTS:

Please list what led to the hospitalization and the medical history of the individual. Have there been recent similar illnesses? What was the health of the individual in the 72 hours leading up to the hospitalization?

_____
_____
_____
_____
_____
_____
_____

TYPE OF HOSPITALIZATION:

Medical Psychiatric

How many days was the individual in the hospital?

REASON FOR HOSPITALIZATION – Please mark all that apply:

Abdominal Pains	Cancer	Ingestion- PICA
Abnormal Blood Levels	Chest Pains	Kidney
Absent Pulse	Debucitus Ulcer	Medical Error
Allergic Reaction	Dehydration/Volume Depletion	Observation/Evaluation
Altered State	Edema	Placed item in Orifice
Baclofen Pump Issues Blood Pressure	Emesis (vomiting/diarrhea)	Pneumonia and Influenza
Blood Sugar Levels	Gallbladder	Seizures
Body Temperature Variations	Generalized Pain	Shunt
Bowel Obstruction	Heart Problems	Stroke
	Impaired Respiration	Syncope Uncontrollable
	Infection	Bleeding

Other:

SYMPTOMS AND RESPONSE:

What were the individual's symptoms – over what length of time – and what was the response?

_____
_____
_____
_____
_____
_____
_____

DIAGNOSIS AND DISCHARGE SUMMARY:

Please describe in detail the individual's diagnosis and discharge summary. Please attach discharge summary.

_____
_____
_____

FOLLOW-UP APPOINTMENTS / CHANGES TO MEDICATIONS / CONTINUING CARE

Please list the changes and the continuing needs of the individual along with the person responsible for these. Please attach discharge paperwork and follow-up appointment outcomes.

_____
_____
_____
_____
_____
_____

CAUSE AND CONTRIBUTING FACTORS:

Medication Change	Fall- Due to Mobility Issues
Choked on Food	Aspiration Due to Improper Diet Texture
Medication Error	Failure to Provide Timely Medical Care
Fall-Due to Environmental Factors	Staff Did Not Monitor Input/Output of Fluids

Other:_____

PREVENTION MEASURES:

Physical/Social Environmental Change	Medication Changes
Agency Policy/System Change	Follow up Appointment Scheduled
Staff Training	PT/OT/Speech Referral made to address communication or mobility concern
Counseling	Diet Change Ordered
Team Meeting to address ISP Changes	Home Health Care
Appointment with Medical Care Provider	

Other:_____

INVESTIGATIVE AGENT REVIEW:

Comments & Questions:

_____
_____
_____
_____
_____
_____
_____
_____

IA NAME: _____ Review Completed Date: _____

Ohio | Department of Developmental Disabilities

Unapproved Behavioral Support MUI Form

Individual's Name: _____ Date of UBS: _____ Name of Person Completing Form: _____ Title: _____ Contact Information: _____	Date Form Completed: _____ MUI Number: _____ Provider: _____

UBS/HISTORY ANTECEDENTS

Please list what led to UBS. Provide a time line and whether this individual has a history of this behavior. Provider details of prevention measures from prior incidents.
How many times was the intervention/support used? How long (total) was the individual restrained?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

BEHAVIOR STRATEGIES

Did the individual have behavioral support strategies outlined in their service plan? Did the staff know about the strategies? Was the staff trained on the implementation of the behavioral support strategies?

_____
_____
_____
_____
_____
_____

TYPE OF UBS (CHECK ALL THAT APPLY)

Physical Restraint:

- Baskethold
- Multiple Person Carry
- Multiple Person Escort
- One Person Carry
- One Person Escort
- One Person Restraint
- Physically Prompted Hands Down with Resistance
- Prone
- Restraint of Multiple Appendages
- Seated Restraint
- Side Restraint
- Standing Restraint
- Supine
- Time Out- list details of time-out, including length of time:_____
  _____
- Other: _____

Ohio | Department of Developmental Disabilities

Unapproved Behavioral Support MUI Form

(CHECK ALL THAT APPLY)

Chemical Restraint:

- Anti- Anxiety
- Anticonvulsant
- Antidepressant
- Antipsychotic
- Mood Stabilizer
- Other: _____

Mechanical:

- Full Body-papoose Board Wrap
- Full Body-seated Position
- Full Body-supine Position
- Gait Belt
- Helmet
- Locked Seat Belt/Vest – not during transportation
- Mitts
- Splints
- Transportation – locked seatbelt/vest/others
- Wheelchair controls disabled
- Wheelchair for individual - not used regularly
- Other: _____

INJURIES

Were there any injuries to the individual or anyone else involved in the UBS? Did the individual receive timely medical attention?

_____
_____
_____
_____
_____
_____

DESCRIPTION

Describe in detail the intervention/support and the reason used. How was it necessary for the health and welfare if individual or other individuals?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Unapproved Behavioral Support MUI Form

CAUSE AND CONTRIBUTING FACTORS (CHECK ALL THAT APPLY)

- Supervision Not Met
- Staff Ratio Not Appropriate
- Diet Not Followed
- Asked to Complete Task
- Change in Routine
- Excessive Noise
- 1:1 Attention Unavailable
- Peer Aggression
- Outing Cancelled
- Control Issues – Staff/Family/Peers
- Medication Changes
- Illness
- Possible Hallucination
- Loss of Important Relationship
- ISP/BSP Not Followed

Other: _____

PREVENTION MEASURES (CHECK ALL THAT APPLY)

- Physical/Social environmental changes
- Agency Policy/System Change
- Staff training
- Counseling
- Team meeting to address ISP changes
- Appointment with Medical care provider
- Medication changes
- Follow up appointment scheduled
- PT/OT/Speech referral made to address Communication or mobility concern
- Diet change ordered
- Home health care

Other: _____

INVESTIGATIVE AGENT REVIEW

Comments and Questions:

_____

_____

_____

_____

_____

_____

IA NAME: _____ **REVIEW COMPLETED DATE:** _____

Ohio | Department of Developmental Disabilities

ANNUAL REPORT – AGENCY PROVIDER

AGENCY PROVIDER NAME: _____

MUI ANNUAL REVIEW (January 1 through December 31) for the year _____

Agency providers are required to complete the Annual Review by January 31 and send to the County Board by February 28.

Total Number of MUI categories for the previous year: _____

Total Number of MUI categories for the same period 2 years ago: _____

Total Number of MUI categories for the same period 3 years ago: _____

Number of MUI categories by type:

MUI Categories	Previous year	2 years ago	3 years ago
Accidental/suspicious death			
Attempted suicide			
Death-Non-Accidental			
Exploitation			
Failure to Report			
Law Enforcement			
Medical Emergency			
Misappropriation			
Missing Individual			
Neglect			
Peer-to-Peer Act			
Physical Abuse			
Prohibited Sexual Relations			
Rights Code Violation			
Sexual Abuse			
Significant Injury			
Unapproved Behavioral Support			
Unanticipated Hospitalization			
Verbal Abuse			

Explain the reasons for any significant differences from year to year and any MUI categories with a high number of incidents (use additional pages as necessary):

_____

_____

_____

_____

_____

_____

_____

ANNUAL REPORT – AGENCY PROVIDER

Agency Trends and Patterns – current year

Identify and explain any agency-wide trends and any trends by residence, region, or program:

_____
_____
_____
_____
_____

Description of action plans and preventive measures to address these trends/patterns:

_____
_____
_____
_____

Agency Trends and Patterns - previous year

Previous year's agency–wide trends or trends by residence, region, or program:

_____
_____
_____
_____

Were the action plans and preventive measures effective?

_____
_____

Individual Trends and Patterns

Individuals with 5 or more MUI categories in 6 months or 10 or more MUI categories in 12 months in the current year:

Name: _____

MUI types: _____

Action plans and preventive measures taken to address this trend/pattern:

_____
_____
_____

Date the action plans and preventive measures were added to the individual's plan:_____
(Use additional pages to add additional individuals if needed.)

Date review wascompleted: _____

Name of person completing this review: _____

MUI REPORTING QUICK REFERENCE:

Report all MUIs within FOUR hours

Report regardless of where the incident occurred	
Accidental or suspicious death	Death of an individual resulting from an accident or suspicious circumstances
Attempted suicide	A physical attempt by the individual that results in emergency room treatment, in-patient observation, or hospital admission.
Death other than accidental or suspicious death	Death of an individual by natural cause without suspicious circumstances.
Exploitation	Unlawful or improper act of using an individual or their resources for monetary or personal benefit, profit, or gain.
Failure to report	A person who is required to report who has reason to believe that an individual suffered or faces substantial risk of wound, injury, disability, or condition as to reasonably indicate abuse, neglect, misappropriation or exploitation that results in a risk to the health and welfare of that individual and the person does not immediately report it.
Law enforcement	Any incident that results in the individual served being tased, arrested, charged, or incarcerated.
Misappropriation	Depriving, defrauding, or otherwise obtaining the real or personal property of an individual by any means prohibited by the Revised code.
Missing individual	An incident that is not considered neglect, when an individual's whereabouts are unknown and they are believed to be at or pose an imminent risk of harm to self or others.
Neglect	Failing to provide medical care, personal care or other support that results in or places a person at risk of a serious injury when there is a duty to do so
Peer-to-peer acts	Any incidents involving two individuals that involves • exploitation, • theft, • sexual act without consent of the other individual, • verbal act when there is opportunity and ability to carry out the threat, and • physical act or altercation resulting in medical treatment by a physician, physician's assistant, or nurse practitioner and that involves

MUI REPORTING QUICK REFERENCE:

	strangulation, a bloody nose, bloody lip, black eye, concussion, or biting that breaks the skin, or results in an individual being arrested, incarcerated, or subject to criminal charges
Physical abuse	Use of physical force that can reasonably expected to cause physical harm.
Prohibited sexual relations	A developmental disabilities employee engaging in consensual sexual conduct or sexual contact with an individual who is not the employee's spouse and for whom the employee was employed or under contract to provide care to or supervise the delivery of care at the time of the incident.
Sexual abuse; and	Unlawful sexual conduct or contact when it involves an individual
Verbal abuse	Use of words, gestures, or other communicative means to purposefully threaten, coerce, intimidate, or humiliate an individual

Report required only when the incident occurs in a program operated by a county board or when the individual is being served by a licensed or certified provider:

Medical emergency	An incident requiring emergency medical intervention to save an individual's life (Ex: Back blows, CPR, Epipen)
Rights code violation	Any violation of rights (see individual rights) that creates a likely risk of harm to the health or welfare of an individual.
Significant injury	Injury of known or unknown cause that is not abuse or neglect and results in a concussion, broken bone, dislocation, second or third degree burns or that requires immobilization, casting, or five or more sutures.
Unanticipated hospitalization	Any hospital admission or stay over twenty-four hours that is not pre-scheduled or planned.
Unapproved behavioral support	The use of prohibited measure (defined in 5123-2-06) or restrictive measure implemented without approval of the human rights committee or without informed consent of an individual or their guardian when the use of these results in a risk to the individual's health and welfare.

DEVELOPMENTAL DISABILITIES
OF CLARK COUNTY
WHERE PEOPLE GROW

Unusual Incident Log Reporting (Please report: contact Marci Dowling for reporting month assignment at 937-346-0735)

4 times a year the County Board will request a copy of your Unusual Incident Log from every provider. Even if you have had no Unusual Incidents, state rule requires that you report in with the County Board.

The Unusual Incident Log should contain (at least) the following information for each incident reported:

- Individual's Name
- Date of incident
- Time of incident
- Any injuries that may have occurred
- Location of Incident
- Incident reported completed by and Direct Witnesses
- Description of Incident
- Contributing Factors (if any)
- Immediate Action
- Prevention Plan

Major Unusual Incidents Reporting

- **Annual (January – December) is due February 28th.**

1 time a year the County Board will request every provider to report MUI Trends and Patterns. Even if you have had no Major Unusual Incidents, state rule requires that you report in with the County Board.

- Date of Review
- Name of Person completing review
- Time period of review
- Comparison of data for previous three years
- Explanation of data
- Data for review by major unusual incident category type
- Specific individuals involved in established trends and patterns (five major unusual incidents of any kind in six months or 10 major unusual incidents within a year, or other pattern identified by the individual's team
- Specific trends by residence, region, or program
- Previously identified trends and patterns

You can report in with the County Board by:
Email: MUIreport@clarkdd.org
Fax: 937-328-4575
Mail: Investigative Unit, 2527 Kenton Street, Springfield, Ohio 45505
Telephone: 937-328-5245; If no answer, please leave a message and a phone number and someone will call you back.

UNUSUAL INCIDENT REPORT LOG

Provider/Facility:						Month/Year:	County:			
Name	UI #	Date & Time	Injury	Home Name and Address	Location	Description of the Incident (Explain the risk of Harm)	Immediate Actions Taken to Ensure Health and Welfare	Causes and Contributing Factors	Prevention Plan	UI/MUI

Reviewed by:_____ Title:_____ Date:_____

Trends and Pattern Identified? YES ☐ NO ☐

Trends and Pattern Addressed? YES ☐ NO ☐ If yes, please complete section below.

Action taken to address identified Patterns and Trends:

O.A.C. 5123:2-17-02 (M)(8) Each agency provider and independent provider shall maintain a log of all unusual incidents. The log shall include, but is not limited to, the name of the individual, a brief description of the unusual incident, any injuries, time, date, location, and preventive measures.

DODD MUI 7/22/13

UNUSUAL INCIDENT REPORT LOG SAMPLE W/ INCIDENTS

Provider/Facility: Sunshine 123 Agency						Month/Year: January 2019	County: Clark			
Name	UI #	Date & Time	Injury	Home Name and Address	Location	Description of the Incident (Explain the risk of Harm)	Immediate Actions Taken to Ensure Health and Welfare	Causes and Contributing Factors	Prevention Plan	UI/MUI
John Doe	1	Jan 1 2019	Bruise-left knee	123 Maple Ln.	Kroger, E.Main, Springfield	JD slipped on ice in the parking lot and landed on his left knee.	DSP helped JD up, checked knee for injury, had a red spot but no abrasion. JD said he was okay. DSP held onto his arm for the rest of the walk in/out.	Untreated ice in the parking lot	DSP discussed getting boots with better traction or "yak tracks" for winter months.	UI
Larry Lin	2	Jan 6 2019	N/A	789 High St.	Home	LL vomited 3 times in the night.	Assisted LL with cleaning up vomit and providing him a trash can by his bed. Gave him water and, with his approval, placed a baby monitor in his room to monitor throughout the night to assist when needed.	LL has the flu	Took LL to the doctor first thing in the morning. He was given Tamiflu. Once feeling better, we talked about ways to prevent getting the flu-handwashing, covering your mouth, etc.	UI
Karen Jones	3	Jan 12 2019	N/A	456 Maple Ln.	Home	Refused to take her daily multivitamin	Staff LP asked KJ why she didn't want to take it-all other meds were taken without incident. KJ just shook her head. Staff asked KJ twice more over the next hour. KJ refused each time. No adverse effect	New multivitamin, but KJ could not say why she is refusing to take it.	Called KJ's doctor to notify of the refusal. Left a message on the nurse line requesting a call back.	UI
Karen Jones	4	Jan 13 2019	N/A	456 Maple Ln.	Home	Refused to take her daily multivitamin	Staff LP asked KJ why she did not want to take it. Again, she shook her head, but continued to refuse prompting over the next hour. No adverse effect.	New vitamin-unknown what she doesn't like about it.	Called KJ's doctor 3/3/19. Received a call from nurse to answer questions. Nurse said she'd speak to doctor.	UI
Karen Jones	5	Jan 14 2019	N/A	456 Maple Ln.	Home	Refused to take her daily multivitamin	Staff KG asked KJ why she didn't want to take it. KJ made a face indicating a bad taste. KG asked KJ if it tastes bad, KJ nodded once emphatically. No adverse effect.	KJ reported the new brand of vitamin tasted bad.	Called KJ's doctor and received approval to purchase new multivitamin that contained no iron. They will call in new order to pharmacy.	UI

Reviewed by: Ranger Smith Title: Program Manager Date: 4/1/19

Trends and Pattern Identified? YES [X] NO [ ]

Trends and Pattern Addressed? YES [X] NO [ ] If yes, please complete section below.

Action taken to address identified Patterns and Trends:

We saw a trend of KG refusing a new multivitamin, but through communication with a familiar staff person was able to discover that the medicine had a bad taste. We were able to request a different vitamin from her doctor and have seen no more refusals.

O.A.C. 5123:2-17-02 (M)(8) Each agency provider and independent provider shall maintain a log of all unusual incidents. The log shall include, but is not limited to, the name of the individual, a brief description of the unusual incident, any injuries, time, date, location, and preventive measures.

DODD MUI 7/22/13

AGENCY REQUIRED DOCUMENTS LIST

Below is a list of documents that will be reviewed during the compliance review, please have these items available at the beginning of the onsite review. Additional documents may be requested during the onsite review. Depending on the type of waiver and services provided some items will not apply to the review. Please contact the reviewer with any questions prior to the onsite review.

ISP for Individuals in Sample	**Completed**
1. Current and previous service plan, including addendums/revisions (Please note that the service plan should include information on restrictive measures or supports for behavioral concerns)	
2. Assessments used to develop the service plan	
3. Plan of Care signed by physician for Waiver Nursing	
MEDICATION ADMINISTRATION for Individuals in Sample	
4. Current Self-Medication Assessment	
5. Medication Administration Records (MAR) for the last 3 months	
6. Physician's orders	
DELEGATED NURSING (if applicable)	
7. Evidence of nurse supervision of delegation a. Log Notes b. Nursing Notes c. Any documentation used by delegating nurse to evidence supervision d. Any special conditions identified by the nurse e. On-going nursing assessments f. Statement of delegation g. Annual staff skills checklist h. Name and credentials of the Delegating Nurse	
WAIVER NURSING SERVICES (RN/LPN only)	
8. RN documentation a. Individual Record/Plan of Care b. Clinical and/or Nursing Notes c. Evidence of individual's home visits every 60 days d. Clinical notes or progress notes e. Documentation of face to face visits	
BEHAVIOR SUPPORT for Individuals in Sample (if applicable)	
9. If the plan includes restrictive measures: Evidence of an assessment within the past 12 months that describe the risk of harm or likelihood of legal sanction.	
10. Evidence that all staff responsible for implementation were trained on the restrictive measures	
11. If the plan includes restrictive measures: Evidence that informed consent was received prior to the plan being submitted to the HRC for approval.	

12.	List of Human Rights Committee members if own committee is utilized or verification that provider uses County Board HRC (as applicable)	
13.	Human Rights Committee member initial and/or annual training (as applicable)	
14.	Evidence of Human Rights Committee approval for restrictive measures	
15.	If a time out room is utilized, please provide the logs	
16.	Evidence that the provider notified DODD of restrictive measures prior to implementation – Restrictive Measure Notice (as applicable)	
17.	Agency's Behavior Support Policies and Procedures (as applicable)	
18.	Evidence that plans with restrictive measures are reviewed every 90 days by the team ***Please provide the last 3 status reports**	
DOCUMENTATION for Individuals in Sample		
19.	Waiver service delivery documentation for the last 3 months, including money management (ledgers, receipts, bills), behavior support, and healthcare, if required by the service plan. For employment services this includes the name of the individual's employer, number of hours worked and hourly wage	
20.	For providers of employment services evidence that a written progress report was submitted to the individual's team.	
21.	For providers of employment services evidence that employment outcome data was submitted to the web-based data collection system maintained by DODD.	
22.	For providers of employment services evidence that documentation includes the name of the individual's employer, # of hours worked and hourly wage.	
23.	For provider owned or controlled settings, the lease or residency agreement.	
MUI/UI		
24.	MUI and UI reports for the last 9 – 12 months, including follow up on incidents	
25.	UI Log(s) and evidence of monthly UI reviews for the last 3 months Please be prepared to pull incident reports as requested by the reviewer	
26.	Most recent Annual Analysis in MUI section	
27.	Evidence of a written procedure for internal review of major unusual incidents including senior management notifications	
PERSONNEL/BACKGROUND CHECKS for staff that work with individuals in the sample		
28.	Date of hire	
29.	<u>If the CEO has changed since last certification/recertification or review</u>: Evidence that the CEO or administrator is listed in PCW and approved by DODD	
30.	Initial BCII check	
31.	Evidence that employees have been enrolled into RapBack	
32.	Initial FBI check (required if employee lived outside of Ohio during the 5 years prior to employment)	
33.	Evidence that the employer conducted a BCII check, and FBI check if applicable every 5 years for direct service employees that could not be enrolled in RapBack	
34.	Evidence that the employee signed an attestation statement verifying that the employee has never been charged with, convicted of or pled guilty to a disqualifying offense <u>as well as</u> a statement verifying the employee will notify the employer in writing within 14 days if ever charged, convicted of or pleads guilty to a disqualifying offense	
35.	Evidence of initial and 5 year checks or enrollment in ARCS of the following: • abuser registry check	

	• nurse aide registry check • Inspector general exclusion list • sex offender and child victim offender database • US general services administration system for award management database • incarcerated and supervised offender's database	
36.	Evidence that the employee is 18 years of age or older	
37.	Verification of High School Diploma (such as transcripts or diploma) or GED or DODD rule waiver	
TRAINING/CERTIFICATION for staff that work with individuals in the sample		
38.	Evidence of appropriate certifications if the staff person administers medication, insulin injections, G tube, or J tube	
39.	Evidence of appropriate licenses/certifications	
40.	Current CPR certification- please note that online only certification will not be accepted. Online training must include evidence of hands on skills component.	
41.	Current First Aid certification- please note that online only certification will not be accepted. Online training must include evidence of hands on skills component.	
42.	Evidence that direct service staff, hired after 10/1/16 received initial training prior to providing services to individuals that included a. Overview of serving individuals with developmental disabilities including implementation of individual service plans; b. The role and responsibilities of direct services staff with regard to services including person-centered planning, community integration, self-determination, and self-advocacy; c. Universal precautions for infection control including hand washing and the disposal of bodily waste; d. The rights of individuals set forth in sections 5123.62 to 5123.64 of the Revised Code; and e. The requirements of rule 5123:2-17-02 of the Administrative Code including a review of health and welfare alerts issued by the department.	
43.	Evidence that the staff person, prior to providing direct services, received training on the ISP including a. What is important to the individual and what is important for the individual b. The individual's support needs including, as applicable, behavioral support strategy, management of the individual's funds, and medication administration/delegated nursing.	
44.	Evidence of annual MUI/UI training and training on the health and welfare alerts.	
45.	Evidence that supervisory staff for direct services positions completed training in service documentation, billing for services, management of individuals' funds	
46.	Evidence of annual written notification about the conduct for which an employee can be included on the abuser registry	
47.	Evidence of annual training on the rights of individuals with DD	
48.	Evidence of additional annual training as required by the waiver service the provider is delivering; please reference the rules for the services delivered. Including person-centered planning, community integration, self-determination and self-advocacy.	
49.	Evidence that all staff responsible for managing personal funds are trained on the rule and the policy.	

50.	Money Management Waiver service: Evidence of annual training on topics that enhance competency relevant to providing money management	
51.	Evidence of agency internal compliance program	
52.	Evidence of training for vagus nerve stimulator, epinephrine auto-injector and/or administration of topical over-the-counter medication for the purpose of cleaning, protecting, or comforting the skin, hair, nails, teeth, or oral surface.	
53.	Evidence of Board Member Training for Major Unusual Incidents	
DAY SERVICES ONLY (Personnel Requirements) Adult Day Support; Vocational Habilitation; Career Planning; Individual & Group Employment Support		
54.	Within the first 90 days of employment evidence that direct services staff hired after 4/1/2017, who provide day and employment services completed an orientation program of at least eight hours that addresses, but is not limited to: a. Organizational background of the agency provider, including: b. Components of quality care for individuals served, including: c. Health and safety, including: d. Positive behavioral support, including: e. Services that comprise the day or employment services	
55.	During first year of employment: evidence of mentoring, on-the-job training specific to each individual and 8 hours training specific to the day service during the first year of employment	
56.	During second year of employment: evidence of 8 hours of training in MUI, Rights, role in behavior supports and best practices related to the specific service (ADS, Voc Hab, etc.)	
57.	Evidence that direct services providers and staff of adult day support, career planning, individual employment support, group employment support and vocational habilitation have the training and certifications as required in these rules.	
SELF SUPPORT BROKER		
58.	Evidence of successful completion of DODD Support Broker Training	
DRIVERS / ATTENDANTS / TRANSPORTATION – only applicable if providing transportation services – includes staff working with individuals in the sample		
59.	Evidence of initial Driver's Abstract (free online abstract available via BMV website is acceptable)	
60.	Evidence of driver's abstract every three years	
61.	Evidence of valid driver's license	
62.	Evidence of driver's Controlled Substance Test- (Non-Medical transportation only)	
63.	Evidence of driver's statement of physical qualifications – (Per Trip Non-Medical transportation only)	

64.	Evidence of current insurance policy for vehicles used for individuals identified in sample (includes private and/or agency policies)	
65.	Annual vehicle inspections – (Non-Medical transportation only)	
66.	Daily Pre-Trip Inspection Sheets - (Non-Medical transportation only)	
PHYSICAL ENVIRONMENT		
67.	All current required inspections a. Fire b. Water (if not on public system) c. Sewer (if not on public system)	
68.	Emergency/Fire plan approved by DODD, State Fire Marshall or Local Fire Authority	
69.	Written record of fire and tornado drills for the last 12 months-6 per year	

OHIO DEPARTMENT OF DEVELOPMENTAL DISABILITIES

PROFESSIONAL SERVICE AND FOLLOW-UP

To be completed prior to visit:

Name _____ **Date** _____ **Accompanied By** _____

Treating Professional (Doctor)/Title _____ **Phone #** _____

Reason(s) for the visit:

☐ Acute Illness ☐ Eye Exam ☐ Therapy (type) _____
☐ Follow Up ☐ Gyn. Exam ☐ Lab Work (specify) _____
☐ Initial Consultation ☐ Annual Physical ☐ Diagnostic (specify) _____
☐ Acute Injury ☐ Dental Exam/Cleaning ☐ Mental Health/Behavior
☐ Other _____

Symptoms (severity, frequency, duration) _____
_____

Questions _____

Pertinent Attached Information: ☐ Medication List ☐ Current Personal Summary
☐ Consults ☐ Labs ☐ Diagnostics ☐ Other _____

To be completed by TREATING PROFESSIONAL:

Diagnosis _____

Progress Note _____

Treatment Provided _____
_____
_____
_____

New/Changed Medication(s) – Name/Amount/Frequency/Duration_____
_____
_____
_____

FOLLOW UP INSTRUCTIONS/ORDERS _____
_____
_____

Restrictions for Activities/Work _____
Diagnostics _____
Labs _____
Diet _____ Therapy _____

Return Visit Needed? ☐ Yes ☐ No If so, when: _____

If no improvement in _____ days: ☐ Return to office ☐ Call doctor's office/doctor
If worsening: ☐ Return to office ☐ Call doctor's office/doctor

Signature of Treating Professional: _____Date:_____

HEALTH PROFESSIONAL APPOINTMENT LOG

NAME: Date of Birth:	Guardian ("G"): Phone # : Under what conditions does the guardian want to be notified:

DUE DATE	SCHEDULED DATE	REASON FOR THE VISIT OR PRESENTING PROBLEM	NAME OF TREATING PHYSICIAN/DENTIST/LAB X-RAY/PROFESSIONAL/THERAPIST	OUTCOME OF THE VISIT (see key below)				REFERRAL OR FOLLOW UP INFORMATION	"G" CALLED Yes or No

KEY: Outcome of the Visit "I" – Initial Visit "Res"-Condition Resolved "Ref"-Referral Made "Ret"-Return Visit

MONTHLY INDIVIDUAL FUNDS TRANSACTION RECORD

INDIVIDUAL'S NAME: _____ MONTH/YEAR: _____

Date	Description of Transaction	Ref. No	Debit (-)	Credit (+)	Balance	Individual's Signature	Staff Signature
			Beginning Balance				
			Ending Balance				

Reviewer's Signature _____ Date _____

Note: Reconciliation of the Transactions Record should be done no later than 60 days, from the date of the first entry

A receipt for each transaction must be attached

Updated 4/2017

Cash Reconciliation Form

Individual Name: _____ Month/Year _____

End Balance from previous month: _____

Plus total deposits (+) _____

Subtotal: _____

Less Debits: (-) _____

Adjusted ending balance: _____

Adjusted ending balance shown above should agree with the ending balance on the ledger **

Be sure the individual signed or marked acknowledging receipt of any personal spending funds, which the person is entitled to and able to spend without receipts per the individual service plan.

A person other than the one who provides direct assistance to an individual with managing personal funds or the one who maintains the written or electronic system of accounting for the provider must conduct the reconciliations of accounts. See rule **5123:2-2-07 Personal funds of the individual**

Person reconciling account (Print) _____

Signature of person reconciling account: _____ **Date:** _____

Individual Gift Card Ledger

Individual's Name: _____ Month/Year _____

Provider: _____ Individual Signature _____

ATTACH RECEIPTS FOR ALL GIFT CARD EXPENDITURES.

Balance brought forward $ _____

Date	Transaction Description	Deposit	Withdraw	Receipt #	Balance	Staff initials
	Amount Carried Forward					

Staff Signature: _____

Person Reconciling Signature: _____ Reconciled/Verified Date: _____

Please remember that someone other than the person handling the gift card will need to reconcile the ledger once every thirty days.

2/8/17

Gift Card/Certificate Reconciliation Form

Individual Name: _____ Month/Year _____

End Balance from previous month: _____

Plus total deposits (+) _____

Subtotal: _____

Less Debits: (-) _____

Adjusted ending balance: _____

Adjusted ending balance shown above should agree with the ending balance on the ledger **

Be sure the individual signed or marked acknowledging receipt of any personal spending funds, which the person is entitled to and able to spend without receipts per the individual service plan.

A person other than the one who provides direct assistance to an individual with managing personal funds or the one who maintains the written or electronic system of accounting for the provider must conduct the reconciliations of accounts. See rule **5123:2-2-07 Personal funds of the individual**

Person reconciling account (Print) _____

Signature of person reconciling account: _____ **Date:** _____

Checking Ledger

Individual Name: _____ Month/Year: _____

Page _____ of _____

Date	Num	Payee/Description	Catergory	Cleared	Debit (-)	Credit (+)	Balance
		Starting Balance					
						Total:	

Signature of person responsible: _____ Date _____

Signature of person reconciling: _____ Date _____

Savings Ledger

Individual Name: _____ Month/Year: _____

Page _____ of _____

Date	Num	Payee/Description	Catergory	Cleared	Debit (-)	Credit (+)	Balance
		Starting Balance					
						Total:	

Signature of person responsible: _____ Date _____

Signature of person reconciling: _____ Date _____

Reconciliation Form

Individual Name: _____ Month/Year _____

Outstanding Charges/Deposits

Check #	Debits (-)	Credits (+)
Total:		

End Balance on Bank statement: _____

Plus Deposits not shown: (+) _____

Subtotal: _____

Less Debits (-) not shown: (-) _____

Adjusted ending balance: _____

Adjusted ending balance shown above should agree with the balance shown in the check book. **

Be sure to deduct any charges, fees or withdrawals shown on the statement, but not in the checkbook that may apply to the account. Also, be sure to add deposits, interest accruals, shown on the statement, but not in the check book that apply to the account.

A person other than the one who provides direct assistance to an individual with managing personal funds or the one who maintains the written or electronic system of accounting for the provider must conduct the reconciliations of accounts. See rule **5123:2-2-07 Personal funds of the individual**

Person reconciling account (Print) _____

Signature of person reconciling account: **Date:** _____

Individual Food Stamp Ledger

Individual's Name: _____ Month/Year _____

Provider: _____ Individual Signature _____

ATTACH RECEIPTS FOR ALL FOOD STAMP EXPENDITURES.

Balance brought forward $ _____

Date	Transaction Description	Deposit	Withdraw	Receipt #	Balance	Staff initials
	Amount Carried Forward					

Staff Signature: _____

Person Reconciling Signature: _____ Reconciled/Verified Date: _____

Please remember that someone other than the person handling the food stamps will need to reconcile the ledger once every thirty days.

2/8/17

TIPS FOR FINANCIAL DOCUMENTATION
GUIDELINES TO REMEMBER WHEN HANDLING A PERSON'S FINANCES

All accounts, which include: checking, savings, credit and/or debit cards, food stamps and gift cards, MUST be accounted for through the use of a "ledger" or "log." Everything is to be documented on the ledger as it takes place. For example when cash is taken out for a person to go out to dinner, the amount taken out should be documented on the ledger when it is taken out. The return of any change and the amount spent should be a second documentation notation.

Tips/Guidelines for using the ledger:

1. Keep a separate page for each month
2. Include type of account (checking. savings, etc.)
3. Include person's name
4. Date each transaction and enter on ledger in order by date
5. Number all receipts and put corresponding number on receipt
6. Include all receipts – for purchases of any kind; bank withdrawal/deposits; spending money to person signed by the person and staff giving money to the person
7. Write or print **LEGIBLY**
8. No checks written to "CASH", staff or another person (individual in the program)
9. **EXPLAIN RIGHT ON THE LEDGER** any differences, discrepancies, or questionable transactions
10. Double check math on all transactions; if there is a discrepancy between the actual cash-on-hand and the amount there should be, document. Ask for help to resolve if necessary. **NEVER ADD CASH OR TAKE CASH OUT** of cash-on-hand to make it balance. **ASK FOR HELP TO RESOLVE**.
11. Actual account balance of cash-on-hand should **ALWAYS** match actual amount of cash-on-hand
12. Count cash-on-hand together at shift change, daily
13. ALL transactions, incoming and outgoing are to be documented and initialed, legibly by staff completing the transaction.
14. Incoming funds – document the source, date and amount.
15. Always include a beginning and end balance

The most important thing to keep in mind when handling a person's finances is that someone who is unfamiliar with the documentation should be able to come in and be able to understand how the person's money has been spent.