WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

I/DD Provider Agency: _____

I/DD Contact Person: _____

Date Self-Review is Due: _____

Assigned Provider Educator: _____

_____

# of Employee Files in 100% Sample
Who Delivered I/DD Waiver Services
During Assigned Review Period: _____

KEPRO
I/DD Waiver Provider Self-Review Tool
100% Staff Review for Submission

Instructions for Completion - PROFESSIONAL STAFF:

1. Indicate names of ALL staff members who provided IDD services during only the Assigned Review Period in columns A and B.
2. Add additional lines if necessary and assign a Staff Identifier number; (P) followed by the next number in the consecutive sequence; i.e.. P36, P37, P38. Create additional pages as necessary.
3. In column C, indicate which service(s) that staff provided.
4. In column D, inidcate the date of hire, and, if applicable, the date of separation.
5. Indicate the dates as described in columns E - M. Any lapses should be highlighted in yellow.
6. For items N - T indicate Yes, No, or N/A if it does not apply.
7. For item U, enter any applicable provider comments.

Assigned Review Period:	1/1/16-12/31/16
Review Due Date:	

Staff Identifier	**A.** Staff Last Name	**B.** Staff First Name	**C.** I/DD Service(s) billed by staff during the review period (i.e. SC, BSP I or II, RN, LPN)	**D.** Date of Hire	Date of Separation	**E.** Current CPR Certification Date	Current CPR Expiration Date	Previous CPR Certification Date	Previous CPR Expiration Date	**F.** Current First Aid Certification Date	Current First Aid Expiration Date	Previous First Aid Certification Date	Previous First Aid Expiration Date
	PROFESSESIONAL STAFF												
P1													
P2													
P3													
P4													
P5													
P6													
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P35													

G. Current Infectious Disease Control Training Date	Current Infectious Disease Control Training Expiration Date	Previous Infectious Disease Control Training Date	Previous Infectious Disease Control Training Expiration Date	**H.** Current Recognition of Abuse / Neglect Training Date	Current Recognition of Abuse / Neglect Training Expiration Date	Previous Recognition of Abuse / Neglect Training Date	Previous Recognition of Abuse / Neglect Training Expiration Date	**I.** Current Member Rights Training Date	Current Member Rights Training Expiration Date	Previous Member Rights Training Date	Previous Member Rights Training Expiration Date	**J.** Current Confidentiality Training Date	Current Confidentiality Training Expiration Date	Previous Confidentiality Training Date	Previous Confidentiality Training Expiration Date	**K.** Current Conflict Free Service Coordination Training Date **(n/a if Provider Only Agency)**

Current Conflict Free Service Coordination Expiration Date **(n/a if Provider Only Agency)**	Previous Conflict Free Service Coordination Training Date **(n/a if Provider Only Agency)**	Previous Conflict Free Service Coordination Expiration Date **(n/a if Provider Only Agency)**	**L.** Current CIB eligibility determination Date	Previous CIB eligibility determination Date	**M.** Facilitated WV APBS Overview of Positive Behavior Support or WVUCED Positive Behavior Support Direct Care Overview Training Date	**N.** Monthly Documentation Indicating staff person is not on OIG lists of excluded persons? **Indicate Yes or No.**	**O.** There is documentation to verify the staff person is at least 18 years of age? **Indicate Yes or No.**	**P. SERVICE COORDINATION ONLY** There is evidence that the SC meets degree and experience requirements. **Indicate Yes or No.**	**Q. BEHAVIOR SUPPORT PROFESSIONAL I ONLY** There is evidence the BSP I meets degree and experience requirements. **Indicate Yes or No.**	**R. BEHAVIOR SUPPORT PROFESSIONAL II ONLY** There is evidence the BSP II meets degree and experience requirements. **Indicate Yes or No.**	**S. LICENSED REGISTERED NURSE ONLY** There is evidence the RN meets licensing requirements. **Indicate Yes or No.**	**T. LICENSED PRACTICAL NURSE ONLY** There is evidence the LPN meets licensing requirements. **Indicate Yes or No.**	

U. PROVIDER COMMENTS

KEPRO
I/DD Waiver Provider Self-Review Tool
100% Staff Review for Submission

Instructions for Completion - DIRECT CARE STAFF:

1. Indicate names of ALL staff members who provided IDD services during only the Assigned Review Period in columns A and B.
2. Add additional lines if necessary and assign a Staff Identifier number; (P) followed by the next number in the consecutive sequence; i.e.. P57, P58, P59. Create additional pages as necessary.
3. In column C, indicate which service(s) that staff provided.
4. In column D, inidcate the date of hire, and, if applicable, the date of separation.
5. In columns E - M, indicate the dates as described. Any lapses should be highlighted in yellow.
6. For items N-O, indicate Yes or No.
7. For item P, enter any applicable provider comments.

Assigned Review Period: 1/1/16-12/31/16
Review Due Date:

Staff Identifier	A. Staff Last Name	B. Staff First Name	C. I/DD Service(s) billed by staff during the review period (i.e. F-PCS, HB-PCS, In Home Respite, Out of Home Respite, SE, JD, Pre-Voc)	D. Date of Hire	Date of Separation	E. Current CPR Certification Date	Current CPR Expiration Date	Previous CPR Certification Date	Previous CPR Expiration Date	F. Current First Aid Certification Date	Current First Aid Expiration Date	Previous First Aid Certification Date	Previous First Aid Expiration Date	G. Current Infectious Disease Control Training Date	Current Infectious Disease Control Training Expiration Date	Previous Infectious Disease Control Training Date	Previous Infectious Disease Control Training Expiration Date	H. Current Recognition of Abuse/Neglect Training Date	Current Recognition of Abuse/Neglect Training Expiration Date	Previous Recognition of Abuse/Neglect Training Date
		DIRECT CARE STAFF																		
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Previous Recognition of Abuse/Neglect Training Expiration Date	**I.** Current Member Rights Training Date	Current Member Rights Training Expiration Date	Previous Member Rights Training Date	Previous Member Rights Training Expiration Date	**J.** Current Confidentiality Training Date	Current Confidentiality Training Expiration Date	Previous Confidentiality Training Date	Previous Confidentiality Training Expiration Date	**K.** Current Direct Care Ethics Training Date	Current Direct Care Ethics Expiration Date	Previous Direct Care Ethics Training Date	Previous Direct Care Ethics Expiration Date	**L.** Facilitated WV APBS Overview of Positive Behavior Support or WVUCED Positive Behavior Support Direct Care Overview Training Date	**M.** Current CIB eligibility determination Date	Previous eligibility CIB determination Date	**N.** Monthly Documentation Indicating staff person is not on OIG lists of excluded persons? **Indicate Yes or No.**	**O.** There is documentation to verify the staff person is at least 18 years of age? **Indicate Yes or No**.	

P. PROVIDER COMMENTS