

**ADMINISTRATIVE OVERVIEW**  
**SERVICE SPECIFIC ATTACHMENT**  
**Bill Payer/Representative Payee Services**

**I. Service Capacity**

- A. Attach copies of all policies and procedures related to the provision of Bill Payer/Rep Payee services.
  
- B. Describe your professional qualifications to provide Bill Payer/Rep Payee Services, including a brief history of your organization's engagement in providing this service. Attach relevant designations/certifications.
  
- C. Describe the process for matching consumers and Bill Payers/Rep Payees.
  
- D. Describe the documentation requirements for the service.
  
- E. How do you monitor the services provided to ensure the consumer's funds are safe and protected from misappropriation and/or financial exploitation?
  
- F. Describe your policy for ensuring consumer choice in the provision of this service.
  
- G. Is this service currently subject to audit by any other payer(s)? If so, provide details.
  
- H. What is your proposed rate for Bill Payer Services? Describe any additional charges.

**II. Staff Qualifications**

- A. What experience and qualifications are required for those providing direct service to consumers?
  
- B. Describe in detail the screening and interviewing process.

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**III. Training and In-Service Education**

- A. Describe the initial training and orientation of Bill Payers/Rep Payees. Attach a copy of the curriculum for training Bill Payers/Rep Payees.
  
- B. Describe the ongoing training requirements.

**IV. Supervision**

- A. Describe the procedures for supervision, including frequency, documentation, and credentials/qualifications of supervisors.
  
- B. Describe the procedures for reviewing bank and financial statements, including frequency and persons responsible.

Provider employee who completed this form

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## SERVICE SPECIFIC ON-SITE REVIEW

### Bill Payer/Representative Payee Services

Please note the documents and records which will be required for the Consumer files and/or Employee files to be reviewed at the time of On Site Evaluation

CONSUMER Record Review					
Provider					
Date					
Monitor					
Authorization/referral form					
ID Info – name; address; phone; DOB					
Emergency contact(s) and phone					
Functional status/limitations					
Name of current CM/RN					
Service start date & Termination date, if applicable					
Comments					
NOTE: Shaded data elements are only required in the Consumer File if provider is not on Provider Direct. Otherwise the PD Demonstrator will be asked to illustrate “on screen”.					
<b>Name and Position of Provider Direct Demonstrator</b>					

## SERVICE SPECIFIC ON-SITE REVIEW

### Bill Payer/Representative Payee Services

Please note the documents and records which will be required for the Consumer files and/or Employee files to be reviewed at the time of On Site Evaluation

EMPLOYEE Record Review					
Provider					
Date					
Monitor					
Service start date & Termination date, if applicable					
Number of reference checks					
CORI Check					
Job Description(s)					
Ongoing training dates: if applicable					
OIG monthly checks					
Annual Performance Appraisal: Date					
Comments					