MEDICAID WAIVER QUALITY REVIEW

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
AGING SERVICES/HOME AND COMMUNITY BASED DERVICES (HCBS)
SFN 1154 (1-2019)

Clear Fields

Complete on an annual basis during the first quarterly contact.

Client Name	Client Identification Number (ND Number) ND	Date
Respondent Name (if other than the client)	Relationship to Client	

Description/Identification of Survey Item	Yes	No	N/A	Other
a. Does the provider provide the amount of service as outlined on the ICP? *Ask the client to describe the time it takes the provider to complete the task and compare their description to the time allotted on the ICP.*				
If no, n/a or other, please explain:				
b. Does the provider come to your house as scheduled? *Ask the client if the provider comes when scheduled and leaves when scheduled? Does the provider just not show up or if they can't come do they call and cancel, etc.?*				
If no, n/a or other, please explain:				
c. Does the environment and client's appearance support the service provided in the amount outlined on the care plan? *Response is based onthe case management assessment and observation.*				
If no, n/a or other, please explain:				
d. Do the services and amount of service meet your need? *What is the client's opinion?*				
If no, n/a or other, please explain:				
e. Do you feel the services available meet the client's needs and assure that health, welfare and safety needs are met? *Response is based on the case management assessment and observation.*				
If no, n/a or other, please explain:				
f. Does the provider ever ask to use your property or take your property? *Ask the client if the provider asks to use their property, borrows money or if they have noticed any missing items or charges on cards that were unexpected, etc.*				
If yes, please explain:				
g. Does the provider treat you with respect? *Ask the client if the provider listens to their requests and completes tasks as requested by the client. Do they scold or yell at the client, etc.?*				
If no, n/a or other, please explain:				
h. Has the provider injured you? *Ask has a provider ever hurt you?*				
If yes, please explain:				
i. Has the provider restrained you? *Ask has a provider ever forced you to take medication or forced you to stay in a certain position or tied down your hands, etc.?*				
If yes, please explain:				

HCBS Case Manager's Signature	County