Appendix A |

IFDS Representative Screening Questionnaire

1. Member name: ______________________________
2. Member's legally responsible person (LRP), if applicable:

   ____
3. Member record number: ______________________________
4. Name of proposed Representative: ______________________________
5. Home address (including city, state, and ZIP code) of proposed Representative:

   ____
6. Mailing address (including city, state, and ZIP code) of proposed Representative (if not home address):

   ____
7. Day telephone number of Representative: ______________________________
8. Evening telephone number of Representative: ______________________________
9. Emergency contact name for Representative: ______________________________
10. Emergency contact telephone number for Representative: ______________________________
11. What is your relationship with the member?
    (Include how long you have known the member and how frequently you have contact.)

    ____
12. What is your relationship with the member's LRP?
    (Include how long you have known the individual and how frequently you have contact.)

    ____
13. Are you currently paid to care for the member? ☐ Yes ☐ No
14. If yes, identify the source of payment and the purpose of the funds:

    ____
15. Have you ever been paid to care for the member? ☐ Yes ☐ No
16. If yes, identify when, the source of payment and the purpose of the funds:

    ____

17. Do you understand that while you are the member's Representative, you cannot be paid to provide any service, except for guardianship services, to the member?

☐ Yes ☐ No

18. Do you understand that while you are the member's Representative, you cannot be paid to provide any paid supports to the member?

☐ Yes ☐ No

19. Are you willing to meet face-to-face with the member and Employer of Record or Managing Employer at least monthly?

☐ Yes ☐ No

20. Are you at least 18 years old? ☐ Yes ☐ No

21. How well do you know the member?

___

___

22. Describe in your own words your knowledge and understanding of the member's needs and preferences.

___

___

___

23. Are you willing to respect the member's preferences to ensure that they can live a meaningful live as independently as possible?

☐ Yes ☐ No

24. Do you have any history of physical, mental, or financial abuse of another individual or their funds?

☐ Yes ☐ No

25. Have you been excluded from participating as a provider of Medicare or Medicaid services?

☐ Yes ☐ No

26. Have you ever been convicted of Medicare or Medicaid fraud?

☐ Yes ☐ No

27. Have you ever settled an allegation of Medicare or Medicaid fraud?

☐ Yes ☐ No

28. Are you willing and able to cooperate with Vaya Health for care management, utilization management, and monitoring functions?

☐ Yes ☐ No

29. Are you willing and able to receive in-person training by a Community Navigator to become competent as a Representative for the member?

    ☐ Yes ☐ No

30. Have you completed Individual and Family Directed Services Training (or has a referral to training been made)?

    ☐ Yes ☐ No

31. If yes, when?

32. Are you willing to volunteer to serve as the member's Representative?

    ☐ Yes ☐ No

33. If you become the member's Representative, are you willing and able to act in the member's best interest, even if that means returning the member to provider-directed services or withdrawing as the Representative?

    ☐ Yes ☐ No

34. Are you willing and able to comply with any and all program requirements, as amended from time to time, which include, but are not limited to:

    ☐ Yes ☐ No a. NC Innovations Waiver?

    ☐ Yes ☐ No b. NC Medicaid Clinical Coverage Policy 8-P?

    ☐ Yes ☐ No c. Vaya Health Individual and Family Directed Services Employer Handbook?

Representative's signature: ______________________________

Representative's printed name: ______________________________

Date of Representative's signature: ______________________________

IFDS Representative Screening Questionnaire received by:

Care manager's signature: ______________________________

Care manager's printed name: ______________________________

Date of care manager's signature: ______________________________

NOTE: The care manager will submit this completed IFDS Representative Screening Questionnaire to the Vaya Utilization Management Team, along with the Plan of Care requesting participant-directed services for the member's current/upcoming plan year, will add it to the member's administrative health record with Vaya, and will provide a copy to the Employer of Record, Managing Employer, and/or Agency with Choice, as applicable.