

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 age 18 or older? 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.

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23. Are you willing to respect the member's preferences to ensure that they can live a meaningful life 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-managed 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/Care Coordinator signature: _____

Care Manager/Care Coordinator printed name: _____

Date signed: _____

NOTE: The Care Manager/Care Coordinator submits this completed IFDS Representative Screening Questionnaire to Vaya's Utilization Management Team, along with the care plan requesting self-directed services for the member's current/upcoming plan year, adds it to the member's administrative health record with Vaya, and provides a copy to the Employer of Record, Managing Employer, and/or Agency with Choice, as applicable.