Provider Survey
Section One: General Information

Provider Name:

Street Address of this location:

City:

Zip:

PROMISe Provider ID number (9 digits):

Service/Site Location (last 4 digits of your PROMISe Provider ID - one survey per site location please):

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Name of Executive Director/President/CEO:

Name of Chairperson, Board of Directors:

This service location currently provides services to participants enrolled in the following waiver(s) (Please check all that apply):

	I provide services for this waiver	I do NOT provide services for this waiver
Aging Waiver	❑	❑
AIDS Waiver	❑	❑
Attendant Care Waiver	❑	❑
CommCare Waiver	❑	❑
Independence Waiver	❑	❑
OBRA Waiver	❑	❑
Adult Autism Waiver	❑	❑
Consolidated Waiver	❑	❑
Person/Family Directed Support Waiver	❑	❑

As of January 1, 2015, approximately how many participants do you serve in the AGING WAIVER (type 0 if you did not provide services)?

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As of January 1, 2015, approximately how many participants do you serve in the ATTENDANT CARE WAIVER (type 0 if you did not provide services)?

As of January 1, 2015, approximately how many participants do you serve in the AIDS WAIVER (type 0 if you did not provide services)?

As of January 1, 2015, approximately how many participants do you serve in the COMMCARE WAIVER (type 0 if you did not provide services)?

As of January 1, 2015, approximately how many participants do you serve in the INDEPENDENCE WAIVER (type 0 if you did not provide services)?

As of January 1, 2015, approximately how many participants do you serve in the OBRA WAIVER (type 0 if you did not provide services)?

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Indicate if you are providing services to any OLTL participants from this location for any of the following services:

1. Accessibility Adaptations
2. Adult Daily Living
3. Community Integration
4. Durable Medical Equipment and Supplies
5. Home Delivered Meals
6. Home Health
7. Non-medical Transportation
8. Nutritional Consultation
9. Occupational Therapy
10. Personal Assistance Services
11. Personal Emergency Response System
12. Physical Therapy
13. Prevocational Services
14. Residential Habilitation
15. Respite
16. Speech Therapy
17. Structured Day Habilitation
18. Supported Employment
19. Telecare
20. Therapeutic and Counseling
21. None of the above

Does this location provide Home and Community-Based waiver services in any of the following settings?

1. Nursing Facility
2. Institution for mental diseases
3. Public or private ICF/ID
4. Hospital
5. None of the Above

If yes, please provide the name of the institution / facility:

Does this location provide waiver services in a publicly or privately operated facility that provides inpatient institutional treatment?

1. Yes
2. No

If yes, please provide the name of the institution / facility:

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Does this location provide waiver services in a building on the grounds of, or immediately adjacent to, a public institution? (A public institution is an inpatient facility that is financed and operated by a county, state, municipality, or other unit of government. A privately owned nursing facility is not a public institution.)

1. Yes
2. No

If yes, please provide the name of the institution:

Does this location provide waiver services in any of the following settings?

1. Farmstead or disability-specific farm community
2. Gated/secured community for people with disabilities
3. Residential school
4. None of the Above

Do you own, rent/lease, or operate (i.e. licensed and unlicensed family living homes) a residential setting at this service location where waiver services are provided?

1. Yes
2. No

Section Two: Provider Owned, Rented/Leased or Operated Residential Settings

Do you provide opportunities for participants who reside in your home to participate in non-work activities such as the following:

	Daily	Weekly	Monthly	Quarterly	Annually	Do NOT provide
Shopping	☐	☐	☐	☐	☐	☐
Attending religious services	☐	☐	☐	☐	☐	☐
Sporting events	☐	☐	☐	☐	☐	☐
Restaurants/Dining out	☐	☐	☐	☐	☐	☐
Visiting parks	☐	☐	☐	☐	☐	☐
Visiting Friends/family	☐	☐	☐	☐	☐	☐
Other activities not listed	☐	☐	☐	☐	☐	☐

If there are other activities not listed above please give some examples:

Do participants have the opportunity to engage in the activities indicated above independent of the other program participants or must more than one participant attend?

Do participants have a lease or legally enforceable agreement?

1. Yes
2. No

Does your service location offer an option for a private bedroom?

1. Yes
2. No

How many participants at this location share a bedroom?

Do participants who share a bedroom have a choice of roommates?

1. Yes
2. No
3. N/A

Explain how participants who share a bedroom are provided a choice of roommates:

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Do participants have access to food at any time?

1. Yes
2. No

If no, please explain

Please answer the following:

	Yes	No
Do participants have the freedom to lock and/or unlock their bedroom doors at any time?	☐	☐
Does the participant have a key to their bedroom door?	☐	☐
Does the participant have a key to entrance/exit doors?	☐	☐
Do you have a policy on staff access to private rooms?	☐	☐
Does each participant have the freedom to decorate their bedrooms or homes differently?	☐	☐
Is the setting physically accessible for each resident?	☐	☐

If you answered No to any of the questions above please explain why:

Describe how each participant controls his or her own resources?

Section Three: Exploratory Questions

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Do you provide participants with privacy, especially during personal assistance such as bathing and dressing?
1. Yes
2. No

Please describe how you provide participants with privacy, especially during personal assistance.

Does the setting encourage visitors or other people from the greater community (aside from paid staff) to be present at the setting?
1. Yes
2. No

If yes, what are your visiting hours?

Do you encourage participants' interaction with the general public (example: individuals who do not receive waiver services or paid staff)?
1. Yes
2. No

If yes, provide specific examples of how that is done.

Do you ensure staff are interacting with participants in a manner in which the person would like to be addressed?
1. Yes
2. No

Please describe how you ensure staff are interacting with participants in a manner in which the person would like to be addressed?

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Does your setting optimize the participant's independence in making choices?

1. Yes
2. No

Please describe your process for optimizing the participants' independence in making choices:

Do you have a policy that ensures this location takes into account the participants preferences when delivering services?

1. Yes
2. No

Please describe how your policy ensures this setting takes into account the participants preferences when delivering services:

Do you educate your staff on the participant's needs, abilities and interests?

1. Yes
2. No

Please describe how you educate your staff on the participant's needs, abilities and interests:

Do participants have access to public transportation at this location?

1. Yes
2. No

Provider Survey

What systematic barriers exist to providing services in integrated settings?

Name of person completing survey:

Title of person completing the survey:

Email address of person completing this survey:

By checking below I certify that all the above information is correct to the best of my knowledge:

1. X

1. Provider Survey Tool