

**DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES**  
**PD PARENT/STEP-PARENT AS A PA 1 PROVIDER**  
**UNDER SPECIFIC CIRCUMSTANCES**

**Consumer:** \_\_\_\_\_ **Consumer PID:** \_\_\_\_\_

**Parent/Step-Parent offering PA 1 service:** \_\_\_\_\_

**Nurse Coordinator:** \_\_\_\_\_

**SECTION I "SPECIFIC CIRCUMSTANCE"**

Must meet one of more of the following (please check all that apply):

- Yes  No Person lives in rural area. Please specify where: \_\_\_\_\_
- Yes  No Person does not have any other dependable or qualified resources available to safely operate health related technology (G peg tube feeding, home dialysis, etc.)
- Yes  No Person is functionally quadriplegic and is dependent on others to perform health and safety related supports and other routine activities of daily living
- Yes  No Person needs supports critical to their health and safety during non-traditional work hours, such as during the night

**SECTION II "CONTROLS"**

Must meet all of the following:

- Yes  No Parent/Step-Parent meets criteria as a personal assistant as outlined in the service description and therefore qualifies to furnish this service
- Yes  No The service is specified in the person's PCSP
- Yes  No Service is paid at a rate that does not exceed that which would otherwise be paid to an employee  
Current MAR rate for PA 1: \$\_\_\_\_\_
- Yes  No FMS provider receives time sheets and other required documentation on hours worked by parent/ step-parent  
Name of FMS: \_\_\_\_\_

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**SECTION III “OTHER MONITORING REQUIREMENTS”**

I (person’s name) \_\_\_\_\_ understand that the following needs to apply:

1. Monthly reviews by the FMS of hours billed for parent/step-parent.
2. Nurse Coordinators will contact the Parent/Step-Parent by phone or email on at least a quarterly basis to identify the proper usage of and compliance with the program to ensure the Health and Safety of the person and if the specific circumstance(s) still applies.

**SECTION IV “QUARTERLY REVIEW AND SIGNATURES”**

Initial Review Date: \_\_\_\_\_ Person’s Signature: \_\_\_\_\_

Nurse Coordinator (RN) Signature: \_\_\_\_\_

<u>Quarterly review date</u>	<u>Contact type</u> P=phone, E=e-mail, F=face to face	<u>Specific circumstance</u> <u>still applies</u> Y=yes, N=no	RN initials

Yes  No Annual SAS review performed by nurse coordinator

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**Technical Guidance for Form Completion**

When using this tool, the Administrative Nurse Coordinator will provide equal treatment to all participants across the waiver.

The Physical Disabilities waiver State Implementation Plan explains that:

- Monthly reviews by the FMS of hours billed for parents, step-parents care (will be conducted). These reviews will be overseen by the administrative nurse coordinators to ensure the appropriate usage and compliance with the billing process;
- The administrative nurse coordinators will contact the person (waiver participant) by phone or e-mail on at least a quarterly basis to identify the proper usage of and compliance with the program and to also ensure the persons health and safety as well as the status of the person and if the specific circumstance still applies; and
- The administrative nurse coordinator will conduct annual Self-Administered-Services Method (SAS) reviews and will review all of the required documentation that goes along with this method.

The above described mechanisms are in place to verify that the hours provided by parents/step-parents are accounted for. These practices must be implemented in order to ensure that the time billed is appropriate and that the service is actually received (this process includes reviewing hours billed on the PCSP and verifying there is no duplication of service).