

Short Term Care

* = required field

Check all that apply:*

- ☐ Adult Foster Care
- ☐ Assisted Living Facility
- ☐ Hospital Based Adult Respite
- ☐ Rest Home
- ☐ Skilled Nursing Facility

I. General Policies and Procedures

- A. Attach a copy of your last Department of Public Health survey and Plan of Correction (if applicable).*

☐ N/A

Attachment Name: _____

- B. What is your referral procedure? Can you accept consumers on short notice?*

- C. Describe your medication policy with respect to ASAP referrals (i.e., should the consumer bring their own medications with them?). *

- D. Describe your policy to notify ASAP agency when there is a change in the consumer's status &/or needs (i.e. hospitalization).*

- E. Describe your policy to notify ASAP agency when service is altered from what was authorized (i. e. discharged prior to authorized date/ approval for MassHealth).*

II. Adult Foster Care

A. Describe your procedure for selecting homes where consumers will be placed.*

☐ N/A

B. Describe your procedure for supervising the care of consumers while they are in those homes.*

☐ N/A

III. Rate

A. What is your proposed rate for Short Term Care? Describe any additional charges. *

☐ N/A

B. Attach a copy of your current approved MMQ rates (if applicable).*

☐ N/A

Attachment Name: _____

Provider employee who completed this form*

Name: _____

Date: _____