THE CENTER FOR DISCOVERY

Group Day Hab Billing and Claiming Internal Audit Form

Name _____ Program_____ Location_____
Service Date_____ Billed_____ Half__ Full___

Case Record Includes:	Yes	No	Comments
1. Individual Service Plan (ISP) for the person which is effective on the date of service.			Effective Date:_____
2. An ISP which identifies The Center for Discovery as the Day Habilitation service provider.			
3. An ISP which includes elements of questions one and two above which is signed by at least one Center for Discovery MSC staff			
a) Specific services/valued outcomes are identified.			
b) Effective date of day hab services matches/precedes ISP effective date.			Effective Date:_____
c) Frequency is documented correctly (day).			
d) Duration is documented correctly (ongoing/indefinite).			
e) Signed by MSC Supervisor.			
4. A Group Day Habilitation Plan which identifies services to be provided for the person and which has been reviewed within the seven months prior to the date of service.			Review Date:_____
a) Plan includes name of person served and Medicaid number.			
b) Center for Discovery is identified as the service provider.			
c) Type of Hab service is identified.			
c) Valued outcomes correspond with ISP.			
d) Relevant safeguards are included or referenced in the plan.			
e) Includes printed name of; signature of; and title of the staff who wrote the plan.			
f) Includes date the plan was written/revised.			Effective Date:_____ Review Date: _____
5. Documentation that substantiates the duration standard for the unit of service billed (with meals and "to and from transportation" excluded).			Attendance Sheet

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Name _____ Program_____ Location_____
Service Date_____ Billed_____ Half__ Full___

Case Record Includes:	Yes	No	Comments
a) Clinic service time is excluded.			Attendance Sheet
b) Attendance hours are added correctly on the attached attendance sheet.			
6. For the date of service, documented evidence of the delivery of the required number of habilitation service(s) drawn from the Group Day Habilitation Plan. (two services for a full unit, one service for a half unit).			Individual Summary
a) Valued outcomes and services correspond with the day hab plan.			
b) Type of hab service is identified.			
c) Primary location of service is indicated.			
d) Staff verified service delivery for claim date by initials.			
e) Matching initials are in the "initial key box" with corresponding signature and title.			
f) All outcomes are being implemented.			
7. Evidence presented in question six above which is signed by the Day habilitation staff providing the service.			
8. Evidence presented in question six above includes a staff signature date which is contemporaneous (day of/next day) to the date of service.			
9. Documentation of the person's response to the Day Habilitation services provided by the end of the month following the date of service. (Monthly note)			Monthly Summary
a) Monthly note includes name of person served.			
b) Summarizes implementation of the services from the hab plan.			
c) States any issues about the plan or the person.			
d) Note summarizes all services indicated in the hab plan.			
e) Note addresses the person's response/progress.			
f) Note contains the signature /title of the staff who wrote the note.			
g) Date the note is written is contemporaneous.			

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Name _____ Program_____ Location_____ **Service Date_____ Billed_____ Half__ Full___**			
Case Record Includes:	**Yes**	**No**	**Comments**
10. Verification that the time related to any other Medicaid service is not counted toward billable service time for Day Habilitation (with the exception of certain MSC services.)			Attendance Sheet Individual Summary
a) Full Day = 2 services and 4 hours minimum.			
b) Half Day = 1 service and 2 hours minimum.			
TOTAL POINTS (one point per numbered question above)			