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|  | **Administrative:** |  |
|  | Verification of Contact Information (address, phone, email for site locations) [Employment (1915c and ECF), Reportable Events, Re-credentialing, and EVV] if applicable. | *Ensure all contact (address, phone, email for site locations) is accurate on the Recredentialing Application. Please ensure a contact for each of the following areas: has been established:*  *Employment (1915c and ECF)*  *Reportable Events*  *Recredentialing*  *EVV] if applicable.*  *.* |
|  | Verification of Approved Services and Counties | *Ensure approved services and counties are accurate on the Recredentialing Application. .* |
|  | Verification of Services and Counties (actually providing services) | *Verify the counties and services the provider is actually providing.* |
|  | National Provider Identifier (if applicable) |  |
|  | Medicaid ID Number | *Required by all providers* |
|  | Tax Identification Number (TIN) | *Required by all providers* |
|  | Organizational (Org.) Chart | *Submit a current organizational chart with the Recredentialing Application.* |
|  | Job Descriptions with responsibilities for key personnel to match positions on the Org. Chart | *Submit job descriptions with responsibilities for key personnel and ensure that the positions match the Organizational chart.* |
|  | **Licensure:** |  |
|  | State and/or County of TN Business License as applicable | *Submit county or state business license, as applicable. \*Business license must match the provider’s business name on the recredentialing application and Secretary of State*  *FOR ENABLING TECH PROVIDERS:*  *Submit copy of provider’s* ***“Certificate of Existence / Authorization”*** *which shows that the provider is registered to provide services in state of TN if provider is out of state; link:* [*Certificate of Existence Instructions - Business Services Online (tn.gov)*](https://tnbear.tn.gov/Ecommerce/CertOfExistenceInstr.aspx) |
|  | [Applicable Service License(s)](https://www.dropbox.com/s/14tlh72mixw33lp/2%20-%20Licensing%20Requirements.docx?dl=0) | *Verify current* ***DIDD service license (or site license, if required)*** *for each contracted service and for each contracted DIDD Region.* |
|  | Applicable Professional Licenses and/or Certifications per applicable employee. | *Verify current professional license or certification for each licensed or certified employee. Submit a copy of each, as required.* |
|  | Professional Support Service License | *Submit copy of the PSSL license from the Department of Health if applicable clinical provider.* |
|  | Insurance: |  |
|  | General Liability Insurance | *Submit copy of declaration page for Comprehensive Commercial General Liability (including personal injury & property damage, premises/operations, independent Provider, contractual liability and completed operations/products coverage) with bodily injury/property damage combined single limit not less than seven hundred fifty thousand dollars ($750,000.00) per occurrence and one million, five hundred thousand dollars ($1,500,000.00) aggregate* |
|  | Professional Liability Insurance, if applicable | *Submit copy of declaration page for Professional Malpractice Liability coverage, as may be required by DIDD, with a limit of not less than seven  hundred fifty thousand dollars ($750,000.00) and one million, five hundred thousand dollars ($1,500,000.00) aggregate.* |
|  | Automobile Coverage, if applicable | *Submit copy of declaration page for Automobile Liability coverages(including owned, leased, hired, and non-owned vehicles coverage) with a bodily injury/property damage combined single limits not less than one million, five hundred thousand dollars ($1,500,000.00).* |
|  | Worker’s Compensation Insurance | *Submit copy of declaration page for Worker’s Compensation & Employers Liability (including all States' coverage) with a limit not less than seven hundred fifty thousand dollars ($750,000.00) per occurrence for employers' liability.* |
|  | REM Process Review: |  |
|  | Review Critical Incidents/Reportable Events process (Information about abuse/neglect and how to report to APS/CPS and DIDD) | *Submit copy of REM Policy* |
|  | Assess REM training compliance. | *Please have training materials and sign-in sheets for Reportable Events* |
|  | Provider and policies and procedures promote the treatment of people with respect and dignity. | *Submit copy of Respect to Persons Supported Policy.* |
|  | Background Check/Registry Review: |  |
|  | Number of new hires:  Number of new hires qualifications (link qualifications) validated: |  |
|  | Number of tenured employees:  Number of tenured employees’ qualifications validated: |  |
|  | Number of employees:  Number of employees with LEIE checks validated: |  |
|  | Number of employees:  Number of employees with Criminal Background Checks validated: |  |
|  | Number of employees:  Number of employees with SAMS Checks validated: |  |
|  | Number of employees:  Number of employees with TN Abuse Registry Checks validated: |  |
|  | Number of employees:  Number of employees with National and Tennessee Sexual Offender Registry Checks validated: |  |
|  | Number of employees:  Number of employees with Felony Offender Registry Checks validated: |  |
|  | Policy/ process in place for conducting criminal background/registry checks. | *Submit copy of Criminal Background Check Policy* |
|  | Financial Review : |  |
|  | Independent Audit (if applicable) | *Please submit copy of most recent Independent Audit (if applicable)* |
|  | Personal Funds Policy | *Review of Personal Funds Policy.* |
|  | Policy Review: |  |
|  | Advocacy | *Submit copy of Advocacy Policy.* |
|  | Crisis Intervention Policy | *Submit copy of Crisis Intervention policy.* |
|  | Provider and member complaint and appeal processes | *Submit copy of Complaint Resolution and Appeals Process Policies.* |
|  | Emergency/Urgent Care | *Submit copy of Emergency/Urgent Care Policy.* |
|  | Fire, Sanitation and Emergency Precautions | *Submit copy of Fire, Sanitation and Emergency Precautions Policy.* |
|  | Health Care Needs | *Submit copy of Health Care Needs Policy.* |
|  | Quality assessment, assurance, and improvement | *Submit copy of Quality assessment, assurance, and improvement Policy.* |
|  | Person Supported Records Management | *Submit copy of Person Supported Records Management Policy.* |
|  | Employee Records Management | *Submit copy of Employee Records Management Policy.* |
|  | Good Nutrition | *Submit copy of Good Nutrition Policy.* |
|  | EVV | *Submit copy of EVV Policy. Please submit training materials and sign-in sheets for EVV.* |
|  | Succession Planning | *Submit copy of Succession Planning Policy.* |
|  | Employee/Volunteer/Sub-Contract Screenings | *Submit copy of HIPAA Policy. Please submit training materials and sign-in sheets for HIPPA.* |
|  | Transportation for Persons Supported | *Submit copy of Transportation for Persons Supported Policy.* |
|  | Back-Up Staff | *Submit copy of Back-up Staff Policy.* |
|  | Hiring Practices | *Submit copy of Hiring Practices Policy.* |
|  | Title VI | *Submit copy of Title VI Policy.* |
|  | Person Centeredness | *Submit copy of Organization’s Person-Centered Approach policy. Please submit training materials and sign-in sheets for Person-Centered Support Plan. Please submit training materials and sign-in sheets for Orientation to the Population That You Support.* |
|  | Use of Positive Approaches | *Submit copy of Use of Positive Approaches Policy.* |
|  | Training Review: |  |
|  | Well-Trained Staff Policy | *Submit copy of Well-Trained Staff Policy.   Please submit training materials and sign-in sheets for Documentation of Service Delivery.* |
|  | Other |  |
|  | HCBS Settings Rule | *Please submit training materials and sign-in sheets for HCBS Settings Rule, if applicable.*  *Please complete the TN* ***Residential*** *Provider Self-Assessment and the TN* ***Non-Residential*** *Provider Self-Assessment, as applicable.* |
|  | Deficit Reduction Act (DRA) | *Please submit policy, training materials and sign-in sheets for Fraud, Waste, and Abuse.*  *.* |