



Community-Based Neurobehavioral Rehabilitation Services (CNRS) Provider Quality Self-Assessment 2023

INSTRUCTIONS

This form is required for organizations enrolled to provide Community-Based Neurobehavioral Rehabilitation Services (CNRS) services.

It is strongly recommended that organizations required to submit the annual CNRS Provider Quality Self-Assessment, review the full instructions, Frequently Asked Questions (FAQ), troubleshooting tips, and complete the training found [here](#).

The annual CNRS self-assessment process requires the completion this CNRS Provider Quality Self-Assessment form as a fillable PDF and the form must remain in that format upon submission. It includes an electronic signature attesting that the information submitted is true, accurate, complete, and verifiable. Organizations are responsible for ensuring signatory authority. The annual CNRS Provider Quality Self-Assessment training and corresponding Frequently Asked Questions (FAQ) addresses some common problems with completing and submitting the self-assessment and can be found [here](#).

Each organization is required to submit an acceptable self-assessment by December 31 each year. Incomplete or inaccurate self-assessments will not be accepted. Failure to submit a complete and accurate self-assessment by December 31, will result in a referral to Iowa Medicaid's Program Integrity Unit for appropriate action, which may include sanctions and disenrollment from Iowa Medicaid.

Below is a brief explanation of each section of the CNRS Provider Quality Self-Assessment form. For full instructions, troubleshooting tips, and training on the annual CNRS Provider Quality Self-Assessment, please follow the links above.

[I. Organizational Details](#). Identifies the organization submitting the forms.

[II. Service Locations](#). Identifies the locations where your organization provides CNRS.

[III. Self-Assessment Questionnaire](#). Provides an outline of all basic standards required by law, rule, industry standards, or best practice. You should read each standard, consider your organization's current situation, and select the most appropriate response.

Selecting Yes means your organization meets the standards and would be able to provide verifiable evidence of meeting the standard. You may meet the standard because you are required to by law or rule, organization policy or because your organization does so as best practice or because you are required to by another oversight entity outside of Iowa Medicaid.

Selecting No means your organization does not meet the standard but is required to by law, rule, or organization policy or the standard is otherwise necessary for the services your organization is enrolled to provide. If you select No, you must provide a response in the designated box describing your plan to

meet the standard(s). A plan is sometimes also known as a “remediation plan”, corrective action plan, or “CAP”. It describes what the organization will do correct the problem with specific timelines for achieving compliance.

Selecting NA means the standard is not required by law, rule, or organization policy and is not otherwise necessary for the services your organization is enrolled to provided.

At the end of each topic, there is an opportunity for your organization to highlight how you meet or exceeds the requirements.

[IV. Guarantee of Accuracy](#). Identifies your organization’s pertinent certifications, accreditations, and licensures. The Guarantee of Accuracy also requires your organization to attest that the information and responses are true, accurate, complete, and verifiable.

Questions should be directed to the HCBS Specialist assigned to the county where the parent organization is located. For a complete list of Quality Improvement Organization (QIO) HCBS Quality Oversight Unit contacts and a list of HCBS Specialists by region, please click [here](#).

LINKS AND RESOURCES

[Iowa Medicaid website](#)

[Informational Letters](#)

[Provider Services and Provider Enrollment](#)

[Department of Inspections, Appeals, and Licensing website](#)

[CNRS Provider Quality Self-Assessment webpage](#)

[Competency-Based Training and Technical Assistance for Long-Term Services and Supports](#)

[Iowa Administrative Code and Rules \(IAC\)](#)

[Iowa Code](#)

I. ORGANIZATION DETAILS

Please identify your parent organization by providing the following information using the text entry fields below.

Employer ID Number (EIN) (9 digits):					
Associated NPI (list all, please separate with a semi-colon):					
Organization Name (as registered to EIN):					
Mailing Address:			Physical Address:		
City:	State:	Zip:	City:	State:	Zip:
County:			County:		
Executive Director/Administrator:			Title:		
Email:			Telephone:		
Self-Assessment Contact:			Title:		
Email:			Telephone:		
Organization Website:					

II. SERVICE LOCATIONS

Complete the fields below to identify each location where your organization provides CNRS.
 If CNRS is provided at the location listed in section I., include it again in section II.

Check this box if organization has more than 9 service locations. If checked, leave section II. blank. An HCBS Specialist will contact you with an additional document to complete.

	Location 1	Location 2	Location 3
Location Name			
Location Address			
City			
State			
NPI-Legacy Number			
Director/Administrator, Credentials			
	Location 4	Location 5	Location 6
Location Name			
Location Address			
City			
State			
NPI-Legacy Number			
Director/Administrator, Credentials			
	Location 7	Location 8	Location 9
Location Name			
Location Address			
City			
State			
NPI-Legacy Number			
Director/Administrator, Credentials			

III. SELF-ASSESSMENT QUESTIONNAIRE

A. ORGANIZATIONAL STANDARDS

To provide quality services to members, organizations must have sound administrative and organizational practices and a high degree of accountability and integrity.

Organizations should have a planned, systematic, organization-wide approach to designing, measuring, evaluating, and improving its level of performance. Use this section to tell us what your organization has in place or is working to put in place related to basic standards required by law, rule, industry standards, or best practice.

1. PURPOSE AND MISSION

Does your organization...

- | | |
|---|--|
| a) Have a mission statement that aligns with the needs, ability, and desires of the members served? | <input type="checkbox"/> Yes
<input type="checkbox"/> No
<input type="checkbox"/> NA |
|---|--|

If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.

2. FISCAL ACCOUNTABILITY

Does your organization...

- | | |
|---|--|
| a) Ensure fiscal stability and accountability? | <input type="checkbox"/> Yes
<input type="checkbox"/> No
<input type="checkbox"/> NA |
| b) Maintain fiscal and corresponding clinical records for a minimum of five years after the date of the last claim? | <input type="checkbox"/> Yes
<input type="checkbox"/> No
<input type="checkbox"/> NA |

If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.

3. ORGANIZATIONAL OVERSIGHT

Does your organization...

- | | |
|--|--|
| a) Have a committee, board, or advisory board to oversee operations? | <input type="checkbox"/> Yes
<input type="checkbox"/> No
<input type="checkbox"/> NA |
| b) Ensure it receives and uses input from local community stakeholders, employees and members participating in services? | <input type="checkbox"/> Yes
<input type="checkbox"/> No
<input type="checkbox"/> NA |
| c) Maintain committee or board meeting minutes to demonstrate oversight and active engagement in the organization? | <input type="checkbox"/> Yes
<input type="checkbox"/> No
<input type="checkbox"/> NA |

If indicating “No”, you must describe a plan to meet the standard(s). Attach additional information as necessary.

4. QUALITY IMPROVEMENT (QI) PROCESSES

Does your organization...

a) Have an established systematic, organization-wide, planned approach to designing, measuring, evaluating, and improving the level of its performance, including the efficiency and effectiveness of service provision?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
b) Ensure results of satisfaction or experience surveys are shared with the public?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
c) Ensure QI activity reports and results are shared with the committee, board, or advisory board at least annually.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA

Does the QI process include...

d) Discovery (collection and review) of the following minimum information and data topics? <ul style="list-style-type: none"> ▪ Members’ preadmission location of service ▪ Members’ length of stay ▪ Discharge location ▪ Reason for discharge ▪ Access to services ▪ Incident data ▪ Quarterly review of organizational activities and services ▪ Satisfaction and experiences with services with members, caregivers or involved family of members, employees, and other stakeholders ▪ Review of records at regular intervals to include service documentation, medication records, incident reports, abuse reports, appeals and grievances, and personnel records 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
e) Remediation of areas found through the QI process to be in need of improvement?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
f) Improvement, meaning the demonstration of outcomes of discovery and remediation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA

If indicating “No”, you must describe a plan to meet the standard(s). Attach additional information as necessary.

Is there anything else you would like to highlight about your organization that would demonstrate how you exceed the basic requirements outlined under organizational standards?

B. PERSONNEL AND TRAINING

Organizations must have qualified employees commensurate with the needs of the members served and requirements for the employee’s position. Employees should be competent to perform duties and interact with members. Use this section to tell us what your organization has in place or is working to put in place related to personnel and training standards required by law, rule, industry standards, or best practice.

I. EMPLOYEE SCREENING AND EVALUATION

Does your organization...

a) Complete child and dependent adult abuse background checks prior to hiring an applicant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
b) Complete criminal background checks prior to hiring an applicant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
c) Solicit an evaluation and follow recommendations for hire when a hit is found on a background check?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
d) Screen potential employees for exclusion from participation in Federal insurance programs prior to hire?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
e) Ensure employees are minimally qualified by age, education, certification, experience, and training required or recommended for CNRS?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
f) Complete performance evaluations at least annually to ensure employees are competent to perform duties and interact with members?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA

If indicating “No”, you must describe a plan to meet the standard(s). Attach additional information as necessary.

2. TRAINING AND QUALIFICATIONS

Does your organization train employees on the following required or recommended topics within the identified timeframes?

a) Prior to the commencement of direct service provision:	
1) The designated Traumatic Brain Injury Training (modules 1-2)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
2) Members’ rights	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA

3) Confidentiality and privacy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
4) Individualized rehabilitation treatment plans	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
5) Major mental health disorder basics	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
a) Within 30 days of the commencement of direct service provision:	
1) Cardiopulmonary resuscitation (CPR)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
2) First-aid	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
3) Fire prevention and reaction	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
4) Universal precautions	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
5) The organization's policy related to identifying and reporting abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
b) Within the first 6 months of the commencement of direct service provision:	
1) The promotion of a program structure and support for persons served so they can relearn or regain skills for community inclusion and access	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
2) Compensatory strategies to assist in managing ADL's (activities of daily living)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
3) Quality of life issues	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
4) Behavioral supports and identification of antecedent triggers	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
5) Health and medication management	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
6) Dietary and nutritional programming	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
7) Assistance with identifying and utilizing assistive technology	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
8) Substance abuse and addiction issues	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA

9) Self-management and self-interaction skills	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
10) Flexibility in programming to meet members' individual needs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
11) Teaching adaptive and compensatory strategies to address cognitive, behavioral, physical, psychosocial, and medical needs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
12) Community accessibility and safety	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
13) Household maintenance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
14) Support to the member's family or support system related to the member's neurobehavioral care	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
15) The designated Child and/or Dependent Adult Abuse and Mandatory Reporting training (within 6 months of hire or by having proof of the completion of the training prior to hire)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
c) Within 12 months of the commencement of direct service provision:	
1) An approved, nationally recognized certified brain injury specialist training	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
d) Annually or as otherwise required:	
1) Fire prevention and reaction	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
2) Universal precautions	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
3) Cardiopulmonary resuscitation (CPR) (prior to expiration of the certification)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
4) First-aid	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
5) The designated Child and/or Dependent Adult Abuse and Mandatory Reporting additional training at least every 3 years after the initial training	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
e) Does the organization ensure that the program administrator is a Certified Brain Injury Specialist Trainer (CBIST) through the Academy of Certified Brain Injury Specialists or a certified brain injury specialist under the direct supervision of a CBIST or a qualified brain injury professional as defined in rule 441 IAC 83.81 (249A) with additional certification as approved by the department?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA

<p>g) Does the organization ensure that a minimum of 75% of the organization's administrative and direct care personnel:</p> <ul style="list-style-type: none"> • have a bachelor's degree in human services-related field; or • have an associate degree in human services with two years of experience working with individuals with brain injury; or • are in the process of seeking a degree in the human services field with two years of experience working with individuals with brain injury; or • are a certified brain injury specialist or have other brain injury certification as approved by the department. 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
<p>If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.</p>	
<p>Is there anything else you would like to highlight about your organization that would demonstrate how you exceed the basic requirements outlined under personnel and training?</p>	

C. POLICIES AND PROCEDURES

Organizations should have a core set of policies and procedures based on the services for which they are enrolled to provide. The policies and procedures are the foundation of an organization’s performance and guide them in the provision of services. Policies and procedures should outline the organization’s day-to-day operations, ensure compliance with laws and regulations, and give guidance to staff. Organizations must carry out their policies and procedures so that members receive fair, equal, consistent, and positive service experiences. Use this section to tell us what your organization has in place or is working to put in place related to topics listed below required by law, rule, industry standards, or best practice.

1. INCIDENTS AND INCIDENT REPORTING

a) Does your organization have written policies or procedures related to recognizing and reporting major and minor incidents in accordance with applicable IAC?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
b) Does your organization maintain evidence incidents are reported according to the policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
c) Does your organization track and analyze data at least annually, related to incidents and unexpected occurrences involving death, serious physical or psychological injury, or the risk thereof to identify trends and to ensure the health and safety of members?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA

If indicating “No”, you must describe a plan to meet the standard(s). Attach additional information as necessary.

2. APPEALS AND GRIEVANCES

a) Does your organization have written policies and procedures related to filing and resolving appeals and grievances?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
b) Does your organization ensure that members or their legal representatives receive information about the organization’s appeals and grievance processes at admission and annually thereafter?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA

If indicating “No”, you must describe a plan to meet the standard(s). Attach additional information as necessary.

3. TREATMENT PLANNING	
a) Does your organization have written policies and procedures related to treatment planning?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
b) Does your organization ensure that treatment plans:	
1) Are individualized and mutually developed by the member and the member's treatment team?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
2) Include the member's strengths, barriers, and interests?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
3) Include goals which are based on the member's need for services?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
4) Include neurobehavioral challenges and environmental needs as identified in the member's individual standardized comprehensive functional neurobehavioral assessment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
5) Are evaluated by the member and the member's treatment team for progress towards treatment goals regularly and no less than quarterly?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
6) Are revised as the member's status or needs change to reflect the member's progress and response to treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
7) Are submitted to Iowa Medicaid for approval within 30 days of admission (initial plan only)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
8) Do not exceed 180 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.	
4. RESTRICTIVE INTERVENTIONS	
a) Does your organization have written policies and procedures related to the use of restrictive interventions, specifically restraints, rights restrictions, crisis intervention and behavioral intervention in accordance with applicable IAC?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
b) If your organization allows for the use of physical holds, restraints, or other physical intervention techniques, do policies and procedures governing their use include all the following? <ul style="list-style-type: none"> • Definitions of the use of physical restraint such as the specific types of interventions allowed and specific circumstances when physical intervention may be used. • Designation of and qualifications and special training required for staff who may authorize or administer restraints. • A description of methods used to monitor and control the use of restraints. 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA

c) Are restrictive interventions implemented in accordance with applicable IAC which requires that members always receive kind and considerate care and are free from mental, physical, sexual, and verbal abuse, exploitation, neglect, and physical injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
d) When a physical restraint is used, is it documented including all the following information? <ul style="list-style-type: none"> • A general description of the circumstances leading to the use of the restraint and what happened during and after the use of the physical restraint. • Rationale for the use of the restraint. • A description from the responsible staff of the staff's actions and procedures used to protect the member's rights and ensure safety. • Identification of who authorized the restraint. • Identification of when the use of the restraint was authorized (i.e., prior to or immediately after). 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
e) Does your organization ensure that the member's primary care provider, Interdisciplinary Team (IDT), and the member's responsible party are notified when a physical restraint is used?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
f) Does your organization ensure that members or their responsible parties are provided informed consent for any restrictive interventions that may be required to protect the health and safety of the member?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.	
5. MEMBERS' RIGHTS AND RESPONSIBILITIES	
a) Does the organization have written policies and procedures related to member rights and responsibilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
b) Does the policy address the member's right to be fully informed of their rights and responsibilities as a resident and of all rules governing their conduct and responsibilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
c) Are member rights and responsibilities communicated in writing within 5 days of admission member and staff expectations.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
d) Are member rights and responsibilities presented in a language understandable the individual member?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
e) Are members made aware of their rights with 5 days of admission and within 30 days of changes to the written rights and responsibilities? <i>(A statement must be signed by the member or the member's responsible party and maintained in the member's record indicating an understanding of rights and responsibilities.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA

f) Is the list of member's rights prominently posted in written format, in a location that is available to all members?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.	
6. DOCUMENTATION OF SERVICES	
a) Does your organization have written policies and procedures related to service documentation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
b) Does service documentation identify the specific service(s) being provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
c) Does service documentation identify the member receiving the service(s), including the first and last name?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
d) Is the complete date and time of the service documented, including the beginning and ending time and beginning and ending date if the service(s) is rendered over more than one day?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
e) Is the location where the service(s) was provided documented as applicable?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
f) When transportation is provided as part of the service(s), is the name, date, purpose of the trip, and total miles documented?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
g) Are incidents, illnesses, unusual or atypical occurrences that occur during service provision documented when applicable?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
h) When medication is administered or supplies are dispensed as part of the service(s), is the name, dosage, and route of administration documented?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
i) Does service documentation legibly identify the person providing the service(s) including first and last name, any applicable credentials and signature or initials if verifiable to a signature log?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
j) Does the service documentation demonstrate that the service is provided as defined and authorized?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
k) Does service documentation for each service provide information necessary to substantiate that the service was provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.	

7. MEMBER OUTCOMES

a) Does the organization have written policies and procedures related to outcome-based standards?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
b) Does the organization maintain evidence that members are valued?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
c) Do members or their responsible party provide consent regarding which personal information is shared and with whom?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
d) Does the organization maintain evidence that members receive assistance with accessing financial management services as needed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
g) Does the organization maintain evidence that members receive assistance with obtaining preventative, appropriate, and timely medical and dental care?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
h) Does the organization maintain evidence that the members' living environment is reasonably safe and located in the community?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
i) Does the organization maintain evidence that each member's desire for intimacy is respected and supported?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.	
Is there anything else you would like to highlight about your organization that would demonstrate how you exceed the basic requirements outlined under policies and procedures?	

IV. GUARANTEE OF ACCURACY

In submitting this CNRS Provider Quality Self-Assessment and signing this Guarantee of Accuracy, the organization and all signatories jointly and severally certify that the information and responses on contained within are true, accurate, complete, and verifiable. Further, the organization and all signatories each acknowledge (1) familiarity with the laws and regulations governing the Iowa Medicaid program; (2) the responsibility to request technical assistance from the appropriate regional HCBS Specialist in order to achieve compliance with the standards listed within this assessment; (3) the Department, or an authorized representative, may conduct desk or on-site reviews on a periodic basis, as initiated by random sampling or as a result of a complaint.

NOTICE: Any person that submits a false statement, response, or representation, or any false, incomplete, or misleading information, may be subject to criminal, civil, or administrative liability.

Identify the licensure or accreditation held for each location. Include only those which qualify your agency to provide CNRS including the start and end dates of each.

Location	Accreditation/Licensure	Start Date	End Date
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

Is your organization in good standing with the identified accreditation or licensing entity?

Yes No

*If your organization received less than the maximum level of accreditation or licensure with the identified accreditation or licensing entity, you must also provide the review results and any remediation plans when submitting this CNRS Provider Quality Self-Assessment.

PRINTED NAME of Organization

PRINTED NAME of Executive Director

PRINTED SIGNATURE* of Executive Director

Date

***By typing my name, I am electronically signing this document in accordance with Iowa Code Chapter 554D.**