

Attachment B: Telehealth Assessment For Use During Covid-19 Emergency

1915(c) Home and Community Based Medicaid Waiver
for Individuals with Intellectual and Developmental Disabilities

Participant Name	
Provider Agency	
Name & Title of Agency Staff completing the form	
Agency Staff Contact Phone & E-mail	
Date Completed	

TABLE 1. SERVICE(S)* VIA TELEHEALTH (check all that apply):

Service	Requested HOURS	Specify per DAY, WEEK, or MONTH
<input type="checkbox"/> Adult Day Health (ADH)		
<input type="checkbox"/> 1:1		
<input type="checkbox"/> Small Group		
<input type="checkbox"/> Personal Assistance/Habilitation (PAB) including CD		
<input type="checkbox"/> 1:1		
<input type="checkbox"/> Small Group		
<input type="checkbox"/> Individual Employment Supports (IES)		
<input type="checkbox"/> Job Coaching		
<input type="checkbox"/> Job Development		
<input type="checkbox"/> Discovery & Career Planning (DCP)		
<input type="checkbox"/> DCP - Benefits Counseling		

* See Table 3 for Training & Consultation, Waiver Emergency Services - Outreach

TABLE 2. ASSESSMENT OF APPROPRIATENESS FOR SERVICES

Instructions: When requesting multiple services via telehealth, the responses to the following questions must be TRUE for all services. If the response for any service is FALSE, that service cannot be delivered via telehealth and should not be checked in Table 1. This assessment must include all requested services the participant will receive from the provider completing the assessment.

TRUE	FALSE	PARTICIPANT ENGAGEMENT
<input type="checkbox"/>	<input type="checkbox"/>	1. The participant can engage in the service(s) without needing the worker to be physically present and/or to provide physical assistance to ensure the participant’s health and safety and to meet habilitative needs.
<input type="checkbox"/>	<input type="checkbox"/>	2. The participant can engage in the service(s) independently, with verbal/ visual cues and prompts, or with willing and available natural supports.
<input type="checkbox"/>	<input type="checkbox"/>	3. The participant can generally engage in activities via telehealth for sufficient time to benefit from the activities.



TRUE	FALSE	PARTICIPANT ENGAGEMENT
<input type="checkbox"/>	<input type="checkbox"/>	4. The service(s) via telehealth can meet the participant’s health, safety, and habilitative needs. Briefly describe how: _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	5. The service(s) via telehealth includes strategies and activities that align with the participant’s ISP outcomes in the following broad areas: <input type="checkbox"/> Skill Development <input type="checkbox"/> Community Resources/Experiences <input type="checkbox"/> Social Interaction <input type="checkbox"/> Self-Determination/Self-Advocacy <input type="checkbox"/> Communication <input type="checkbox"/> Job Discovery/Career Planning <input type="checkbox"/> Personal Interests <input type="checkbox"/> Employment <input type="checkbox"/> Physical Activity/Exercise <input type="checkbox"/> Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	6. The provider attests that the participant and family/guardian have the choice to change from receiving services by telehealth to in-person when applicable.
<input type="checkbox"/>	<input type="checkbox"/>	7. The participant has the materials needed for any activities (if applicable). This can be supplied by the provider or by the participant/family if using common household items that do not require special out-of-pocket expenses for the participant and family. If infection control supplies are required during waiver activities, the provider can use SMES to purchase those infection control supplies. Leave blank if N/A.

TRUE	FALSE	TELEHEALTH CAPACITY
<input type="checkbox"/>	<input type="checkbox"/>	8. The participant has the telehealth equipment required for the service(s) (check all that will be used): <input type="checkbox"/> Telephone <input type="checkbox"/> Computer, tablet or smart phone <input type="checkbox"/> Internet with sufficient bandwidth to support audio/video conferencing <input type="checkbox"/> Other technology: _____
<input type="checkbox"/>	<input type="checkbox"/>	9. The provider has the telehealth equipment required for the service(s).
<input type="checkbox"/>	<input type="checkbox"/>	10. The participant can use the telehealth equipment. This may include independent use, assistance for set-up and troubleshooting by willing and available natural supports, or remote technical assistance from the provider.

TRUE	FALSE	PRIVACY
<input type="checkbox"/>	<input type="checkbox"/>	11. The provider is using technology that is non-public facing and compliant with the Office of Civil Rights “Notification of Enforcement Discretion for Telehealth”. https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html
<input type="checkbox"/>	<input type="checkbox"/>	12. The provider has explained privacy requirements for telehealth service delivery and has obtained and documented permission from the participant or legal guardian.



TABLE 3: TRAINING & CONSULTATION

Service	Requested HOURS	Specify unit (DAY, WEEK, MONTH)
<input type="checkbox"/> Training & Consultation		
<input type="checkbox"/> Behavior Analyst		
<input type="checkbox"/> Psychologist		
<input type="checkbox"/> Registered Nurse		
<input type="checkbox"/> All Other Therapist (OT, PT, Speech, Family, Dietician)		
<input type="checkbox"/> Environmental Accessibility Adaptations		

TRUE	FALSE	PARTICIPANT ENGAGEMENT
<input type="checkbox"/>	<input type="checkbox"/>	1. Assessment - The participant can engage in the assessment independently or with physical assistance from natural supports or waiver staff while the T&C therapist conducts the telehealth assessment.
<input type="checkbox"/>	<input type="checkbox"/>	2. The service is within the scope of practice and license of the T&C therapist.
<input type="checkbox"/>	<input type="checkbox"/>	3. Supervision and Oversight of Plans – The participant and natural supports/DSWs can participate in the supervision session using telehealth.
<input type="checkbox"/>	<input type="checkbox"/>	4. The provider can provide in-person T&C based on the needs of the participant, while maintaining social distancing and infection control practices.

TRUE	FALSE	TELEHEALTH CAPACITY
<input type="checkbox"/>	<input type="checkbox"/>	5. The participant has the telehealth equipment required for the service (check all that will be used): <input type="checkbox"/> Telephone <input type="checkbox"/> Computer, tablet or smart phone <input type="checkbox"/> Internet with sufficient bandwidth to support audio/video conferencing <input type="checkbox"/> Other technology: _____
<input type="checkbox"/>	<input type="checkbox"/>	6. The provider has the telehealth equipment required for the service.
<input type="checkbox"/>	<input type="checkbox"/>	7. The participant can use the telehealth equipment. This may include independent use, assistance for set-up and troubleshooting by willing and available natural supports, or remote technical assistance from the provider.

TRUE	FALSE	PRIVACY
<input type="checkbox"/>	<input type="checkbox"/>	8. The provider is using technology that is non-public facing and compliant with the Office of Civil Rights “Notification of Enforcement Discretion for Telehealth”. https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html
<input type="checkbox"/>	<input type="checkbox"/>	9. The provider has explained privacy requirements for telehealth service delivery and has obtained and documented permission from the participant or legal guardian/personal representative (if applicable).

