



Provider Setting Final Rule Checklist-Childcare/Respite

The purpose of this survey is to ensure that Medicaid HCBS participants are given the same quality of service, as individuals who receive the same service without Medicaid as the funding source, per Center for Medicare and Medicaid Services (CMS) guidelines. Information about the federal requirements can be found at <https://www.medicaid.gov/medicaid/hcbs/guidance/index.html>.

Name of Provider: _____

Provider ID Number: _____ Date: _____

Provider Staff Name: _____

Resource Developer Completing Validation: _____

1. Is the business your own home or a commercial setting?

2. What aged and disabled waiver services are you providing?

- Respite Care
- Disabled Related Child Care

3. Are you related to the individual for whom you will be providing this aged and disabled waiver service?

- Yes
- No

4. Do you provide services to children without physical disabilities in addition to children with physical disabilities?

- Yes
- No Evidence: _____

5. How long have you been providing services to children?

- Less than six months
- Six months to one year
- One to two years
- More than two years

6. How old are the children receiving care in your setting? (check all that apply)

- 0-12 months
- 13-36 months
- 3-5 years
- 6+ years

7. Do you provide a schedule to parents focusing on activities of each child?
 Yes
 No Evidence: _____
8. Do you provide the opportunity for the child to move about the inside and outside of the setting as appropriate for the child's age and supervision level?
 Yes
 No Evidence: _____
9. Are all children regardless of payment source able to play together?
 Yes
 No Evidence: _____
10. Are all children able to participate in the same activities, as children of similar ages?
 Yes
 No Evidence: _____
11. Are all children able to participate in field trips?
 Yes
 No Evidence: _____
12. Have the parents requested you restrict the child's access to areas of the building or activities? (such as preventing child's movement with a brace, not medically ordered)
 Yes
 No Evidence: _____
13. Do you have policy stating the child's needs are addressed based off the services authorization?
 Yes
 No Evidence: _____
14. Do you provide activities that are responsive to the child's goals, interests and needs?
 Yes
 No Evidence: _____
15. Are all children given access to food at the same time? (outside of doctor ordered dietary restrictions)?
 Yes
 No Evidence: _____
16. Are the tables and chairs accessible for children?
 Yes
 No Evidence: _____

Resource Developer Signature: _____ Date: _____
Provider Signature: _____ Date: _____