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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-62536 (11/2018) | | | | | | | | | | | | **STATE OF WISCONSIN**  Wis. Admin. Code ch. DHS 133  Page 1 of 2 | | | | | |
| **HOME HEALTH AGENCY (HHA)**  **ACCS INITIAL APPLICATION / PRE-LICENSURE DESK REVIEW CHECKLIST** | | | | | | | | | | | | | | | | | |
| Name – Agency | | | | | | | | | | | | | | | | | |
| Name – Agency Contact | | | | | | | Email Address – Agency Contact | | | | | | | | | | Phone No. – Agency Contact |
| Name – Nurse Surveyor | | | | | | | Surveyor No. | | | Date – Received *(MM/dd/yyyy)* | | | | Date – Completed / to ACCS Supv. | | | |
| ***All information received must be reviewed within 30 days of receipt by the Acute Care Compliance Section (ACCS) surveyor, unless otherwise directed by the ACCS supervisor.*** | | | | | | | | | | | | | | | | | |
| **Meets**  **Reg** | | **Policy or Docu-mentation** | | **Survey**  **Tag** | | **DHS**  **Admin. Code** | | **Regulation Section** | | | | | | | | **Comments** | |
|  | | P | | T107 | | 133.05(1)(a) | | Governance | | | | | | | |  | |
|  | | D | | T108 | | 133.05(1)(b) | | Governance | | | | | | | |  | |
|  | | D | | T110 | | 133.05(1)(d) | | Governance | | | | | | | |  | |
|  | | D | | T111 | | 133.05(1)(e) | | Governance | | | | | | | |  | |
|  | | D | | T112 | | 133.05(2)(a) | | Professional Advisory Board | | | | | | | |  | |
|  | | P | | T120-21 | | 133.06(3)(a-b) | | Personnel plan | | | | | | | |  | |
|  | | P | | T122 | | 133.06(4)(a) | | Orientation | | | | | | | |  | |
|  | | P | | T123-27 | | 133.06(4)(a)(1-5) | | Orientation | | | | | | | |  | |
|  | | Either | | T129 | | 133.06(4)(c) | | Evaluation | | | | | | | |  | |
|  | | P | | T132 | | 133.06(4)(d)3 | | Surveillance | | | | | | | |  | |
|  | | Either | | T133 | | 133.06(4)(e) | | Continuing training | | | | | | | |  | |
|  | | P | | T248 | | 133.06(4)(g) | | Background checks, misconduct reporting | | | | | | | |  | |
|  | | Either | | T249-51 | | 133.06(5)(a-c) | | Infection control | | | | | | | |  | |
|  | | Either | | T136 | | 133.07(2) | | HHA Program Evaluation | | | | | | | |  | |
|  | | Either | | T139 | | 133.08(1) | | Patient Rights | | | | | | | |  | |
|  | | P | | T140 | | 133.08(2) | | Patient Rights | | | | | | | |  | |
|  | | P | | T141-48  T252-53 | | 133.08(2)(a-j) | | Patient Rights *(prototype required)* | | | | | | | |  | |
|  | | P | | T149 | | 133.08(3) | | Complaints | | | | | | | |  | |
|  | | P | | T150 | | 133.09(1) | | Patient Acceptance | | | | | | | |  | |
|  | | D | | T152 | | 133.09(2) | | Service Agreement *(prototype required)* | | | | | | | |  | |
|  | | P | | T153-61 | | 133.09(3)(a)(1-5) | | Patient Discharge | | | | | | | |  | |
|  | | Either | | T170 | | 133.13 | | Emergency Notification | | | | | | | |  | |
|  | | D | | T202 | | 133.17(3) | | Aide Assignments *(prototype required)* | | | | | | | |  | |
|  | | Either | | T214-15 | | 133.18(1-2) | | Supervisory Visits | | | | | | | |  | |
|  | | D | | T216-22 | | 133.19(1)(a-f) | | Contract Services *(if applicable)* | | | | | | | |  | |
|  | | D | | T223 | | 133.19(2) | | Contract Services *(if applicable)* | | | | | | | |  | |
|  | | Either | | T224 | | 133.20(1) | | Plan of Care *(prototype required)* | | | | | | | |  | |
|  | | Either | | T225-26 | | 133.20(2)(a-b) | | Plan of Treatment | | | | | | | |  | |
|  | | P | | T231-46 | | 133.21(1-6) | | Medical Records | | | | | | | |  | |
|  | | P | | T247 | | 133.21(7) | | Record Abbreviations | | | | | | | |  | |
|  | | P | | Z | | 13.05(3) | | Policy on Misconduct Reporting, Investigation, and documentation | | | | | | | | | |
| **Submission and Review of Job Descriptions** | | | | | | | | | | | | | | | | | |
| **Done** | **Title** | | | | | | | | | | | | **Comments** | | | | |
|  | Administrator [§ DHS 133.06(2)(a-c) – T117-19] | | | | | | | | | | | |  | | | | |
|  | Substitute Administrator [§ DHS 133.06(2) (a-c) – T117-19] | | | | | | | | | | | |  | | | | |
|  | Director of Nursing / Supervising Nurse (if applicable) | | | | | | | | | | | |  | | | | |
|  | Registered Nurse (RN) | | | | | | | | | | | |  | | | | |
|  | Licensed Practical Nurse (LPN), (if applicable) | | | | | | | | | | | |  | | | | |
|  | Therapists – PT, OT, ST, Other (if applicable) | | | | | | | | | | | |  | | | | |
|  | Medical Social Worker (if applicable) | | | | | | | | | | | |  | | | | |
|  | Home Health Aide | | | | | | | | | | | |  | | | | |
|  | Personal Care Worker (PCW) (if applicable) | | | | | | | | | | | |  | | | | |
|  | Other: | |  | | | | | | | | | |  | | | | |
|  | Other: | |  | | | | | | | | | |  | | | | |
| **Telephone Contact(s) Made with Agency** | | | | | | | | | | | | | | | | | |
| **Date** *(MM/dd/yyyy)* | | | | | **Name of Contact** | | | | | | **Topic(s) Discussed** | | | | | | |
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| **Written Correspondence** | | | | | | | | | | | | | | | | | |
| *Nurse surveyor should attach all written correspondence to and from applicant agency.* | | | | | | | | | | | | | | | | | |
| Date(s) of Written Correspondence **TO** the Applicant | | | | | | | | | | | | Date(s) of Written Correspondence **FROM** the Applicant | | | | | |
| **Nurse Surveyor Comments and Recommendation** | | | | | | | | | | | | | | | | | |
| **Additional Comments** | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **Recommendation Regarding Provisional Licensure of Applicant** | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **SIGNATURE** – Nurse Surveyor | | | | | | | | | | | | | | | Date Signed *(MM/dd/yyyy)* | | |
| **ACCS Supervisor Recommendation to Licensing, Certification and CLIA Section (LCCS)** | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
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| **SIGNATURE** – ACCS Supervisor | | | | | | | | | Recommended Effective Date | | | | | | Date Submitted to LCCS | | |