HCA / DDSD REQUIREMENTS for Medically Fragile Waiver: Home Health Aide (HHA) and Respite HHA – SURVEY TOOL

AGENCY / REGION: **DATE OF SURVEY:**
SURVEYOR:

Surveyor Instructions:

NMAC - 8.370.5 CCHS Requirement*: This "CANNOT BE MET" if :1) agency personnel do not have CCHS letter on file that is specific to the agency and their current term of employment or 2) no CCHS letter found or 3) agency personnel are found to have a disqualifying conviction, and they are currently employed. If found to have disqualifying conviction team leader is to notify the Agency immediately, as personnel must be terminated until resolved.*

NMAC - 8.370.8 - Employee Abuse Registry: *If the EAR check is not required as determined by NMAC 8.370.8 please document the licensure held by the staff. This "CANNOT BE MET" if: 1) agency personnel do not have an EAR that was completed prior to hire or on the date of hire or 2) no evidence of the EAR being completed or 3) if an employee is found on the registry and employed.*

Training Requirements: *HHA Personnel are required to complete 12 hours of annual training. For this to be "MET" the surveyor will review 12 months of training to determine if 12 hrs. have been completed. If less than 1 year of employment mark "NA".*

NMAC 7.1.14.9 – Incident Management System Requirements: *All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner. For this to be met, there must be evidence that training occurred for required agency personnel.*

						MET	NOT MET
Agency Personnel and Title	**DOH** DATE	**EAR** DATE	**CCHS** DATE	**ANE** Expiration Date	**12 hrs. Annual Training** ***(doc total hrs. for 12-month period)***	*Surveyors: Document met or not met and any additional notes specific to staff reviewed after reconciliation is complete. Any area deficient must be circled.*	
Notes:							
Notes:							
Notes:							
Notes:							

***Agency Representative Name/Signature, Title & Date Received:**_____

Training Evidence Must be provided to Survey Team by: **DATE:** _____ **TIME:** _____

Original copy to Survey Team Lead & Copy to Provider Representative
Rev 10/2016; 6/2020; 12/2021;2/2024;3.2025

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