CONSUMER-DIRECTION SERVICES MANAGEMENT QUESTIONNAIRE

(Questions to consider if you want to manage consumer directed (CD) services on behalf of a family member)

Recipient's Name *(Print)*: _____ Medicaid ID #: _____

1. Do you and your family member who is going to receive CD services generally agree on how personal care will be provided?

2. How would you describe the concepts of personal care to the family member who needs personal care?

3. How will you be able to determine the quality of work the personal assistant/aide performs?

4. If an assistant/aide did not fulfill his/her job duties adequately, what would you do?

5. What are some examples of the assistant/aide not performing his/her job duties?

6. Who would you contact if your family member was injured or mistreated by the assistant/aide?

   b. What type of action would you take if you were suspicious of mistreatment to your family member?

   c. What actions would you take once that you have discovered that your family member was injured or mistreated by the assistant/aide, even if the aide is a family member?

   b. Would you report an incident to Adult Protective Services, Child Protective Services, or another authority, even if the assistant/aide were a family member?

   ☐ Yes ☐ No

7. Would there be a reason that a family member would be hired to be the assistant/aide? If so, what would be the reason? What efforts would you make to find non-family members to be assistant/aides before you hired a family member?

8. What is your experience providing services, hiring staff, or monitoring personal care services?

9. If your family member who is receiving CD services wants you to hire other individuals or fire an assistant/aide, could you and would you?

b. Would you fire a family member? _____

Print name of family member who requests managing services: _____

Check (√) the box of the relationship that this person has with the recipient (must be one of the following):

☐ Legal Guardian ☐ Spouse ☐ Parent of a minor (under 18 yrs. old) ☐ Adult Child (18 yrs old +)

Recipient's Name *(Print)*: _____ Medicaid ID #: _____

Person completing this form *(Print name):* _____

Signature of person completing this form: _____ Date: _____

Service Facilitation Provider: _____