Print Form

N.C. Department of Health and Human Services – Division of Medical Assistance

# INTERNAL QUALITY IMPROVEMENT PROGRAM ATTESTATION FORM

Completed form should be submitted via email to NC - Division of Medical Assistance DMA.PCSQualityImprovement@lists.ncmail.net For questions, contact 919-855-4360 or send an email to PCS_Program_Questions@dhhs.nc.gov

## SUBMISSION REQUIREMENTS

PCS Providers shall submit this Attestation to DMA by December 31st of each year certifying compliance with "a" through "d" of Clinical Coverage Policy 3L Section 7.7 by initialing each of the items described below.

## PROVIDER TYPE (select one)

☐ Home Care Agency ☐ Family Care Home ☐ Adult Care Home ☐ Adult Care Bed in Nursing Facility ☐ SLF-5600a

☐ SLF-5600c ☐ Special Care Unit (stand-alone Special Care Unit or SCU bed) ☐ Non-Provider: _____

## SUBMITTER INFORMATION

**NPI:** _____

**Provider Name:** _____

**Address:** _____ **City:** _____

**County:** _____ **Zip:** _____(zip code + 4 digit extension) **Phone:** _____

**Suite:** _____ **Email:** _____ **Fax** (If Applicable)**:**_____

| INTERNAL QUALITY IMPROVEMENT REQUIREMENTS CLINICAL COVERAGE POLICY 3L SECTION 7.7 | INITIAL |
|---|---|
| a. Develop, and update at least quarterly, an organizational Quality Improvement Plan or set of quality improvement policies and procedures that describe the PCS CQI program and activities; | _____ |
| b. Implement an organizational CQI Program designed to identify and correct quality of care and quality of service problems; | _____ |
| c. Conduct at least annually a written beneficiary PCS satisfaction survey for beneficiaries and their legally responsible person; | _____ |
| d. Maintain complete records of all CQI activities and results | _____ |

Person Completing this Form:

_____ _____

Name (Printed) Title

SIGNATURE DATE (mm/dd/yyyy)

_____ (_____/ _____/_____)

(LEGIBLY SIGN YOUR NAME (STAMPS and ELECTRONIC SIGNATURES ARE NOT ACCEPTABLE FOR THIS FORM.)

I hereby attest that I am in compliance with the items described in Clinical Coverage Policy 3L Section 7.7. I also agree to provide any of the referenced documents to DMA or a DHHS designated contractor upon request in conjunction with any on-site or desktop quality improvement review.