N.C. Department of Health and Human Services – NC Medicaid INTERNAL QUALITY IMPROVEMENT PROGRAM ATTESTATION FORM

Completed form should be submitted via email to NC Medicaid at Medicaid.PCSQualityImprovement@lists.ncmail.net. For questions, contact 919-855-4360 or send an email to PCS Program Questions@dhhs.nc.gov.

SUBMI	SSION REQUIREMENTS			
PCS Providers shall submit this Attestation to NC Medicaid 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.				
	DER TYPE (select one)			
☐ Hom ☐SLF-5	e Care Agency	Home Adult Care H Unit (stand-alone Special Care	<u> </u>	SLF-5600a
SUBMITTER INFORMATION				
NPI:			_	
Provide	Name:			
Address	:		City:	
County:		Zip:	(zip code + 4-digit extension) Phone:	
Suite:	E	mail:	Fax (If Applicable):	_
INTERN	IAL QUALITY IMPROVEMENT R	EQUIREMENTS CLINICAL C	OVERAGE 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.	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 C	completing this Form:			
Name (Printed)		-	Title	
Signature		_		

(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 NC Medicaid, or a DHHS designated contractor upon request in conjunction with any on-site or desktop quality improvement review.