

**NYSDOH LHCSA P & P Review Tool  
PART A**

**NEW YORK STATE DEPARTMENT OF HEALTH**  
Division of Home and Community Based Services  
Licensed Home Care Services Agency Initial Review Tool  
Revised 1-17-17

**Agency Name:** \_\_\_\_\_

**Application #:** \_\_\_\_\_

**Date P & P Manual received by DOH:** \_\_\_\_\_

**Initial Review Start Date:** \_\_\_\_\_ **Initial Reviewer:** \_\_\_\_\_

**Initial Review Completion Date:** \_\_\_\_\_

**Date Materials & Review Tool Part A forwarded to Regional Office:** \_\_\_\_\_

**Agency Contact(s):** \_\_\_\_\_

**Name of Administrator:** \_\_\_\_\_

**Name of Responsible RN (if known):** \_\_\_\_\_

**Approved Counties:** \_\_\_\_\_

**LHCSA Applicant Worksheet submitted:** \_\_\_\_\_ (Yes/No)

**Does the application include the request to offer an Assisted Living Program (ALP)?**  
\_\_\_\_\_ (Yes/No)

**Instructions for reviewing the pre-licensure materials:**

**This tool must be used in conjunction with the PHHPC staff report.**

**Review the submitted materials and complete the Review Tool Part A.**

**When review is complete, notify the applicant of the outcome of the review, using template letter and enclosing a copy of the completed review tool pages 2-6.**

**Forward all submitted materials and a copy of the completed review tool to the Regional Office via interagency mail with an email notification to the Regional Office Program Manager.**

Agency Name: \_\_\_\_\_

Application Number: \_\_\_\_\_

### **Policy & Procedure Review:**

For the initial review, when reviewing each policy and procedure, check that the elements in the list below are present. If not, identify the policy, including manual page numbers that do not contain the required elements on the Review Tool Part A.

- **Agency Name:** The agency name must be written as it appears on the application approved by the Public Health and Health Planning Council.
- **Policy number:** Each policy must be discretely numbered. Policies may be organized into discrete sections within the same subject matter. Such as the different activities associated with Criminal History Record Checks requirements.
- **Title:** The title should be clear and concise. For example: “*Criminal History Record Checks*”
- **Policy Statement/Purpose:** Each policy should include a purpose which indicates the intent or objective of the policy.
- **Date:** Policy date and revision date should be clearly indicated.
- **Page Number:** Each page of the policy should be discretely numbered, e.g. 1 of 4 pages.
- **Authority:** Reference must be made to the guidance which governs the policy i.e., statute, regulation and policy.
- **Application:** Who or what the policy applies to should be distinctly identified, e.g. new employees or Criminal History Record Check (CHRC).
- **Responsible Party:** Identify the Title, Position or Department including contact information for individual, e.g. Director of Patient Services at XXX-XXXX.
- **Terminology:** All terminology unique to the policy should be defined so that it is easily understood in context of the policy, e.g. authorized person or temporary employee are two terms that must be defined in the CHRC policy.
- **Cross reference other agency policies on similar subjects:** At the end of the policy, cross reference other policies that may pertain to the subject matter. For example: *Aide Care Plan* may be a cross reference with *Aide Supervision*.
- **Procedure:** Each policy should include a procedure that describes a step by step process and actions needed to comply with a policy. The procedure may include:
  1. An overview of the procedure, if appropriate.
  2. Identification of any necessary skills and/or materials needed.

Agency Name: \_\_\_\_\_

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3. A logical sequence of steps and sub-steps in the order they should occur. Steps should be clear, concise and easy to follow.
4. Use of diagrams, illustrations or examples, if appropriate, that may increase the clarity of the steps identified. For example, computer snapshots, flow or organizational charts may be helpful.

Agency Name: \_\_\_\_\_

Application Number: \_\_\_\_\_

<b>Has the agency submitted the following:</b>		<b>YES</b>	<b>NO</b>	
Policy and Procedure Manual with Index/Table of Contents? If yes:				
• Does it contain listing of all agency policies?				
• Does the listing include:				
○ Policy Name				
○ Policy Number				
○ Initial/Revision Date				
• Does the Index/Table of Contents cross reference corresponding regulations				
• Is the manual paginated correctly?				
• Is the correct agency name used throughout the manual?				
<b>Using the staff report as a reference, was a job description and policy and procedure (P &amp; P) submitted for each service requested and approved by PHHPC:</b>	<b>Approved by PHHPC</b>	<b>Job Description (check if present)</b>	<b>P &amp; P Yes</b>	<b>P &amp; P No</b>
• Nursing	X			
• Home Health Aide				
• Personal Care Aide				
• Physical Therapy				
• Occupational Therapy				
• Respiratory Therapy				
• Speech/Language Pathology				
• Audiology				
• Medical Social Work				
• Physician Services				
• Nutrition				
• Homemaker				
• Housekeeper				
• Medical Supply Equipment/Appliances				
<b>At a minimum has the agency submitted a policy/procedure for:</b>		<b>Required Elements Present</b>	<b>P &amp; P</b>	<b>P &amp; P</b>
		<b>Yes/No</b>	<b>Yes</b>	<b>No</b>
• Patient Rights				
• Complaint Procedure				
• Admission				
• Discharge/Discharge Planning				
• Plan of Care				
• Assessment				
• Medical Orders				
• Clinical Supervision				
• Clinical Records				

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		Required Elements Present	Yes	No
		Yes/No		
• Quality Assurance and Quality Improvement Program				
• Contract Procedure				
• Health Commerce System				
• Personnel				
• Criminal History Record Check (if providing aide services)				
• Home Care Registry (if providing aide services)				
• Infection Control/ Blood borne Pathogen				
• Change of Ownership/Amendment of License				
• Governing Authority				
• Emergency Preparedness				
• Others as applicable				
<b>Has the agency submitted:</b>				
• Federal Tax Identification Number				
• Emergency Preparedness Plan				
• Admission packet/Start of Care packet				
• Agency brochure				
• Patient "Bill of Rights"				
• Name and titles of the Quality Improvement Committee members				
• Clinical record forms:				
Assessment/Reassessment				
Plan of Care				
Physician Orders				
Aide Activity Sheet (if applicable)				
"Aide Care Plan" (if applicable)				
Personnel record forms				
Assisted Living Program - Medical Evaluation Form (if applicable)				
Sample Vendor Contract (required for ALP)				

Agency Name: \_\_\_\_\_

Application Number: \_\_\_\_\_

**Reviewer Comment Worksheet for Initial Review Tool Part A:**

**Date:** \_\_\_\_\_

**Reviewer Name:** \_\_\_\_\_

Reviewer should use this worksheet to identify concerns/issues to address with submission, including the elements missing, and the Title of the Policy and page number when available.