

## Georgia Provider Information

### Provider Information

1 Provider Name

2 Main Office Street Address

3 Main Office City Location

4 Main Office Zip Code

5 Please identify the region(s) in which you serve people with MR/DD

- 1
- 2
- 3
- 4
- 5

6 Main Office Contact Person

7 Main Office Contact Person's Phone Number

8 Main Office Contact Person's Email Address (for

Delmarva's use only to verify information)

**9** Main Office Contact Person's Fax Number

**10** Provider's Website Address

**11** Additional Office Street Address

**12** Additional Office City Location

**13** Additional Office Zip Code

**14** Additional office: Please identify the region(s) in which you serve people with MR/DD

- 1
- 2
- 3
- 4
- 5

**15** Additional Office Contact Person

**16** Additional Office Contact Person's Phone Number

17 Additional Office Contact Person's Email Address (for Delmarva's use only to verify information)

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18 Please select the service(s) your organization provides.

- Support Coordination
- Respite
- Community Residential Alternative Services
- Community Living Supports
- Family Support
- Supported Employment
- Community Access - Group
- Community Access - Individual
- Prevocational Services
- Transportation
- Adult Occupational Therapy Services
- Adult Physical Therapy Services
- Adult Speech and Language Therapy Services
- Behavioral Support Consultation
- Community Guide Services
- Environmental Accessibility Adaptation Services
- Financial Support Services
- Individual Directed Goods and Services
- Natural Support Training Services
- Specialized Medical Equipment Services
- Specialized Medical Supplies
- Vehicle Adaptation Services
- Other, please specify



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## Georgia Provider Information

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## Provider Information, continued

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19 Do you have a newsletter?

YES  NO

If yes, please describe how individuals and/or families can access this newsletter.

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20 Which funding source do you currently provide services under?

- New Options Waiver Program (NOW)
- Comprehensive Supports Waiver Program (COMP)
- Grant in Aid (GIA)

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21 Date you began rendering services as a Medicaid approved provider delivering MRWP, CHSS, NOW/COMP waiver services, and/or GIA services. (example: 03/23/1971)

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22 How many years/months providing services (example: 10 yrs, 2 mos)

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23 Is your organization:

- Public
- Private Non-Profit
- Private For Profit

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24 What is your organization's mission statement?  
(If you do not have one, please enter "Our organization does not have a mission statement.")



25 Have you **just** been approved to provide services in the last 12 months?

YES  NO

26 Do you have a family member willing to provide a verbal reference?

YES  NO

Please provide the contact information for someone at your organization who will share the family member's contact information



27 Do you have the required accreditation or certification?

- Yes
- Pending (Provide anticipated date of accreditation or certification, in format mm/dd/yyyy)

28 Is your accreditation or survey report available for public review?

- Yes
- No
- N/A

29 Last date of accreditation or certification (MM/DD/YYYY)

30 Expiration date of accreditation or certification (MM/DD/YYYY)



## Georgia Provider Information

Individuals Served. **All numbers are to reflect the total number of individuals served as of today's date.**

- 31 Total number of individuals you support who are receiving Medicaid home & community based waiver services or state-funded (do NOT include private-pay individuals)

## Supported Employment

Please list the number of individuals you support, the average hourly wage for these individuals (include any stipends), and the average hours of paid & unpaid work per week.

- 32 Supported employment: number of individuals supported while in community employment

- 33 Supported employment: average hourly wage for individuals in community employment (if you serve more than five people for this service, include the information below, otherwise, leave blank)

- 34 Supported employment: average hours of paid work per week for individuals in community employment

- 35 Supported employment: Number of individuals in an enclave or mobile crew

- 36 Supported employment: Average hourly wage for individuals in an enclave or mobile crew (if you serve more than five people for this service, include the information below, otherwise, leave blank)

- 37 Supported employment: Average hours of paid work per week for individuals in an enclave or mobile crew

### Prevocational Supports

- 38 Prevocational supports: Number of individuals working in a facility based setting

- 39 Prevocational supports: average hourly wage for people working in a facility-based setting (if you serve more than 5 people for this service, include this information, otherwise, leave blank)

- 40 Prevocational supports: average hours of paid work per week for people working in a facility-based setting

- 41 Prevocational supports: average hours of unpaid work per week for people working in a facility-based setting

## Community Access - Individual

42 Community access - individual (doing volunteer activities):  
number of individuals supported

43 Community access - individual (doing volunteer activities):  
average hours of unpaid work per week

## Community Access - Group

44 Community access - Group (doing volunteer activities):  
number of individuals supported

45 Community access - group (doing volunteer activities):  
average hours of unpaid work per week

## Other

46 Other - please list (include the service provided, the number of individuals supported, average hourly wage if appropriate and more than 5 people served, and average hours of paid and/or unpaid work per week)

Other service 1 \_\_\_\_\_  
 Other service 2 \_\_\_\_\_  
 Other service 3 \_\_\_\_\_  
 Other service 4 \_\_\_\_\_  
 Other service 5 \_\_\_\_\_  
 Other service 6 \_\_\_\_\_

47 What types of jobs do people served have in the

community? (i.e., secretary, farmer, mechanic, etc.)

**Living Arrangement**

Please provide the total number of individuals supported in the following types of living situations as of today's date.

48 Group home

49 Agency operated / leased apartment type setting

50 Person's own home

51 Person's leased apartment

52 Host home

53 Parent/relative's home

54 Other - please list the home type and total number of people served in the residential setting

Other home type 1

Other home type 2

Other home  
type 3  
Other home  
type 4

55 Total number of individuals who receive Self-Directed supports and services

56 Total number of individuals who are served through a co-employer



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## Georgia Provider Information

### Support / Services

Please provide the number of individuals served by your organization as of today's date. These are services your organization is currently billing to the waiver and/or state.

57 Support Coordination

58 Respite

59 Community Residential Alternative Services

60 Family Support

61 Community Living Supports

62 Supported Employment

63 Community Access - Group

64 Community Access - Individual

65 Prevocational Services

66 Transportation

67 Adult Occupational Therapy Services

68 Adult Physical Therapy Services

69 Adult Speech and Language Therapy Services

70 Behavioral Support Consultation

71 Community Guide Services

72 Environmental Accessibility Adaptation Services

73 Financial Support Services

74 Individual Directed Goods and Services

75 Natural Support Training Services

76 Specialized Medical Equipment Services

77 Specialized Medical Supplies

78 Vehicle Adaptation Services



### Georgia Provider Information

## Employee Information (as of today's date)

79 Total number of full-time employees

80 Total number of part-time employees

Length of employment: This includes staff who work directly with the individuals served.

81 Number of Direct Support Professionals/Staff (DSPs) employed less than one (1) year

82 Number of DSPs employed one to two (1-2) years

83 Number of DSPs employed three to four (3-4) years

84 Number of DSPs employed five (5) or more years

85 Number of DSP vacancies per year

86 Identify any training provided to staff, **other than** the following State-required training:

- Rights & Responsibilities of Individuals
- Recognizing & Reporting Suspected Abuse, Neglect or Exploitation
- Person-Centered Values, Principles, and Approaches

- Holistic Care of the Individual
- Medical, Physical, Behavioral and Social Needs and Characteristics of Persons Served
- Promoting Positive, Appropriate, and Responsive Relationships with Persons Served and their Families
- Utilization of Positive Communication, Positive Behavioral Supports, and Techniques to De-Escalate Challenging and Unsafe Behaviors
- Nationally Benchmarked Techniques for Safe Utilization of Emergency Interventions of Last Resort
- Ethics, Cultural Preferences and Awareness
- Fire Safety
- Emergency and Disaster Plans and Procedures
- Techniques of Standard Precautions Including Preventative Measures to Minimize Risk of HIV, Current Information as Published by CDC and Approaches to Individual Training
- Basic Cardiac Life Support
- First Aid & Safety
- Common & Specific Individual Medications and Side Effects



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**87** How does your organization evaluate staff training needs?



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**88** How often does your organization evaluate staff training needs?



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### Quality of Life Enhancement Activities

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**89** How does your organization promote and increase the quality of life for individuals served by addressing what is important to each individual?



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## Quality Assurance Activities

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90 Does your organization have a complaint and/or grievance procedure for individuals receiving services and their families?

- Yes  
 No

91 Does your organization have a process to determine individual's satisfaction with the services individuals receive?

- Yes  
 No

92 Does your organization have critical incident tracking and trending procedures?

- Yes  
 No

93 How does your organization use information from complaints and grievances, satisfaction determinations, and critical incidents to improve your supports and services?

 SUBMIT

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## Georgia Provider Information

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94 Are results from your internal quality assurance activities available for public review?

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- 95 If yes to #94, please provide the name of the person who can be contacted about the quality assurance activities.

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- 96 If yes to #94, please provide the phone number of the person who can be contacted about the quality assurance activities.

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- 97 Number of individuals who left your organization in the last 12-month period as of today.

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- 98 Please mark the reasons why individuals left the organization

- Dissatisfaction with services
- Service discontinued
- Individual needing higher level of service
- Individual needing lower level of service
- Geographic relocation
- No longer needing services
- N/A
- Other, please specify

