Ontario ARC
Corporate Compliance

Policies and Procedures Manual

To Report a Corporate Compliance violation:

1 **Contact your supervisor; or**
2. **Contact a Corporate Compliance Committee member.**
3. **If you are uncomfortable reporting the violation to a supervisor or Corporate Compliance Committee member, call the hotline (585-393-5678).**

ONTARIO ARC
CORPORATE COMPLIANCE MANUAL
TABLE OF CONTENTS

SECTION: 1.2

MISSION

Ontario ARC is a not-for-profit organization
dedicated to assisting individuals with
developmental disabilities and their families.
We offer personalized services and supports that
promote independence, recognize individual
uniqueness and value quality of life.

VISION

We, at Ontario ARC, envision a community
where people with developmental disabilities are
welcomed, involved and respected. To achieve this,
we live by our values, creating opportunities for
individual growth, decision-making, choice
and access to services.

VALUES

Integrity
Having high standards of honesty, trust and sincerity.

Respect
Ensuring an atmosphere of dignity, recognition and appreciation.

Teamwork
Working together toward common goals.

Quality
Striving for excellence.

Commitment
Acting with dedication and responsibility.

Person-Centered
Building supports based on personal choice, ability and need.

Quality of Life
A personal sense of fulfillment.

SECTION: 1.2

SECTION: 1.3

SUBJECT: Corporate Compliance

TOPIC: Corporate Compliance Structure

POLICY

Ontario ARC is committed to maintaining high standards of ethical conduct related to its business and operational practices. This policy establishes an independent Corporate Compliance Program which serves as the basis on which a strong culture of compliance to laws and regulations can rest. Ontario ARC's Board delegates authority to the Corporate Compliance Officer and the Corporate Compliance Committee for the oversight of implementation and operation of the Corporate Compliance Program.

VALUES

Integrity, Commitment

STRUCTURE

1. CORPORATE COMPLIANCE OFFICER (CCO)

The CCO is responsible for the day-to-day operation of the Compliance Program and shall foster an environment of compliance. The CCO oversees and monitors the development and implementation of Ontario ARC compliance policies, the achievement and maintenance of compliance standards, including audits, training, and the investigation and response to all compliance concerns/reports. The CCO is directly responsible to the Executive Director, and, as necessary, to the Board of Directors. CCO Duties include:

Maintenance and Improvement of the Written Standards and Policies: Develops, oversees and monitors implementation of the written Corporate Compliance Plan and related policies and procedures and will recommend changes to or the development of new written documentation to support the Corporate Compliance Plan. Collaborates with and effectively utilize the resources of the NYSARC Compliance Resource Center to stay informed of the latest regulatory developments applicable to the chapter's operations and to develop new policies and procedures to address these changes.

Liaison to the Board, the Compliance Committee, Management and Employees: At least annually, appears before the Board to report the status of the Corporate Compliance Program and changes in compliance related issues. This report includes: a summary of oversight entities, new regulations and their impact, internal audit trends, summary of the types of possible non-compliance reports submitted to the CCO, the agency response to such reports, identification of current risk areas, agency response to risks and the Board's compliance responsibilities.

1.3 Corporate Compliance Structure, Corporate Compliance Officer, cont.

Liaison to the Board, the Compliance Committee, Management and Employees, cont.: At least quarterly, informs the Compliance Committee of any new allegations of non-compliance, current status of the report(s), whether an existing procedural system or operational policy is involved, specifying whether the complaint was referred to outside counsel, summary of related disciplinary action, and an evaluation of how effectively the disciplinary processes functioned in supporting and strengthening the Compliance Program.

Reports all 'major' compliance risks to the Executive Director in a timely manner. As determined to be necessary by the Executive Director and COO, the Board will be notified of emergent compliance issues.

Liaison with the NYSARC Board of Governors**:** Facilitates cooperation with the NYSARC Director of Compliance at the Compliance Resource Center in periodic reviews of Ontario ARC's Corporate Compliance Program, and works cooperatively with the Director to implement any corrective actions required by the NYSARC Board of Governors to improve the effectiveness of the agency's Corporate Compliance Program.

Background/Exclusion Checks: Works with the Human Resources Department to ensure that the agency does not hire or contract with an individual or entity who has been excluded or debarred from participation in Federal and State health programs, including Medicaid, in accordance with the policies and procedures established by the Human Resources Department.

Education and Training: Oversees the development of training seminars and for ensuring that these seminars are conducted in accordance with the Corporate Compliance Policy on Employee and Agent Education and Training. Leads the implementation of the Corporate Compliance Plan and will assist employees to interpret and follow the Plan.

Audit Responsibilities: Oversees compliance audits conducted by both internal staff and outside consultants. Ensures internal auditing is conducted in accordance with the Corporate Compliance Plan, Section 1.6, Service Documentation, Billing and Auditing.

Investigations and Receipt of Reports and Concerns: Pursues and promptly investigates any concerns or reports received via the Corporate Compliance Hotline or other methods of reporting, as detailed in the Corporate Compliance Plan on Reporting Concerns (Section 1.9 8) and Internal Investigations (Section 1.10 9) Documents all compliance concerns or reports brought by any party.

1.3 Corporate Compliance Structure, Corporate Compliance Officer, cont.

Discipline/Enforcement of the Corporate Compliance Plan: Ensures that the agency imposes appropriate sanctions against an individual employee or independent contractor for failure to comply with the Corporate Compliance Plan, the Code of Conduct and/or laws and regulations applicable to the agency. Evaluates whether misconduct is based on a lack of awareness or understanding of a regulatory obligation, policy or procedure and institutes a program of education and training of staff, as needed. Ensures that disciplinary action is taken in accordance with the Corporate Compliance Plan, Section 1.12 (1), Corrective Action.

Disclosure and Internal/External Corrective Action: Coordinates and oversees the detection, correction and prevention of non-compliance behaviors. When an internal investigation or report results in the identification of a violation of law, regulations or Ontario ARC policy or procedure, the Corporate Compliance Officer is responsible to work, as necessary, with the Board of Directors, the Executive Director, and/or outside counsel, the Corporate Compliance Committee and the management team to (a) ensure that the agency follows the Corporate Compliance Plan on Corrective Action & Reporting Violations and conducts the appropriate corrective action, such as making prompt restitution of any overpayment amounts, notifying the appropriate governmental agency and instituting whatever disciplinary action is necessary. Also, ensures that the agency identifies and implements changes to its day-to-day policies and procedures to prevent a similar violation from recurring in the future.

2. CORPORATE COMPLIANCE COMMITTEE (CCC)

The CCC is a Board committee and it serves as a resource for the CCO. The CCC continually fosters a culture of compliance within the agency at every level and in every department. The CCC has the authority to retain outside counsel and independent consultants, as needed, and is empowered to assure that appropriate allocation of resources for support of and effective implementation of the Corporate Compliance Program. The CCC provides strategic direction for the Corporate Compliance Plan.

a. Composition and Governance

Membership: The Corporate Compliance Committee is appointed by the Board; the Executive Director and will be comprised of not less than eight (8) individuals representing agency leadership and key departments, including: At least one (1) Board member, the Executive Director, Senior Associate Executive Director, all Associate Executive Directors**,** Director of Human Resources, Director for Information Services, Director for Quality Assurance/Staff Development**.** The composition of the Committee includes at least three (3) directors of the agency, two (2) of whom should be non-executive directors, free from any relationship that would interfere with the exercise of his or her independent judgment. A Board member serves as the Committee Chairperson**,** with the assistance of the Corporate Compliance Officer.

1.3 Corporate Compliance Structure, Corporate Compliance Committee, cont.

Meetings: Meeting dates, times and locations will be set by the Committee Chairperson; however, the Committee will meet not less than once per quarter of the calendar year and may meet more often as deemed necessary by the Chair or by a majority of the Committee. The CCC may invite non-members to meet with the Committee. The CCO communicates with the members of the Committee between meetings to inform the members of significant developments or to solicit input.

Agenda: The agenda for regular meetings will be set by the CCO and all members will be entitled to add items to the agenda of regular and called meetings as they deem appropriate. Agenda items should include the following: status of implementation of Corporate Compliance Plan; potential compliance violations that have been detected; investigations and responses to reported offenses; identification of risk areas and plans for risk reduction; internal, prospective audit reports; changes in related regulations and laws; evaluation of Corporate Compliance Plan. At the beginning of each meeting CCC members are informed to recuse themselves from any agenda item discussion that may pose or appear to be a conflict of interest for them.

Action: Actions of the CCC will require approval by a majority of the members, either by verbal or written consent. Members are not required to be physically present in the same location in order for the CCC to act and actions may be taken by telephone conferences, by written communications or by other means of communication.

Minutes: The CCC will maintain written minutes of meetings and actions. The Executive Assistant to the Executive Director, a non-member of the Committee, acts as secretary and prepares meeting minutes. The minutes will be posted on a secure shared website for Board members after they are accepted at the next CCC meeting. Minutes and reviewed materials will be maintained by the CCO, in a locked file and retained indefinitely.

Confidentiality: The Corporate Compliance Committee will have access to sensitive information regarding the operations of the agency. Each member shall take appropriate steps to safeguard this information from accidental or intentional disclosure and may be required to return or destroy documents related to matters discussed by the Corporate Compliance Committee. At the beginning of each CCC meeting, the COO makes a statement reminding all the attendees of their responsibility to ensure the confidentiality of all information shared during the meeting.

1.3 Corporate Compliance Structure, Corporate Compliance Committee, cont.

b. Duties of the Corporate Compliance Committee, shall be as follows:

Maintenance and Improvement of the Written Standards and Policies: Reviews the effectiveness of the Corporate Compliance Plan on an annual basis and will offer recommendations for improving and strengthening the agency's policies, procedures and commitment to compliance. Oversees and approves the continuing development and implementation of policies, procedures, directions, guidelines and communications that establish compliance standards and further the objectives of the Corporate Compliance Program. Analyzes the regulatory environment and legal requirements with which the agency must comply, and specific risk areas for the agency.

Liaison to the Board and Ontario ARC Management: Regularly communicates via the CCO to the Board and ARC Management on the operation of the Corporate Compliance Program. Areas reported on include, but are not limited to, training and education, hotline reports/disclosures of wrongdoing, potential or existing government investigations or litigation, internal and external audits by governmental agencies, and compliance risk assessment. Information reported may include information received from the NYSARC Board of Governors concerning operation of the compliance program.

Auditing: Recommends and monitors, in coordination with the relevant departments, the development of internal systems and controls to carry out the agency's standards, policies, and procedures as part of daily operations. The CCC evaluates internal and external audits and investigations for the purpose of identifying troublesome issues and deficient areas, and implementing corrective and preventive action.

Investigations and Receipt of Reports and Concerns: Ensures that the CCO has appropriate independence and support for the Corporate Compliance Program for investigations and matters related to compliance issues. Receives reports related to investigations and concerns under the Corporate Compliance Plan. Makes recommendations for additional investigation follow up.

Discipline/Enforcement of the Corporate Compliance Plan: Supports the CCO and other management to impose appropriate sanctions for violations of law, regulations and agency policies and procedures, including the Corporate Compliance Plan. Advises on whether additional training and education may be needed based on particular areas of risk that arise.

Disclosure and Internal/External Corrective Action: Provides input into any corrective action plan developed by agency, including self-disclosure to a governmental agency. Assists the CCO to identify and implement changes to day-to- day policies and procedures to prevent future violations of similar laws, regulations and policies.

1.3 Corporate Compliance Structure, cont.

3. BOARD OF DIRECTORS

The Board of Directors receives and respond to reports of the CCO and the CCC and is responsible for the effective implementation of the agency's Corporate Compliance Plan. The Board is responsible for taking any disciplinary actions of its own members relating to violations of law, regulations or Ontario ARC policies and procedures, including the Corporate Compliance Plan.

Refer to Policy 1.4 a Code of Conduct & Conflict of Interest – Board Members, for any issues related to potential Board member conflict of interest or related party transactions.

4. ANNUAL WORK PLAN

The Corporate Compliance Officer is responsible to prepare an Annual Work Plan for the agency to follow, addressing key areas of risk. The CCO will update and report progress on an annual basis. The CCC shall approve and assist the CCO to achieve the goals of the Work Plan.

SECTION: 1.4a

SUBJECT: Corporate Compliance

TOPIC: Code of Conduct & Conflict of Interest – Board Members

POLICY

All Board members must know, understand and follow the agency Code of Conduct and Conflict of Interest policy so that they may lead and represent the organization in a positive and ethical manner.
Given the influence each Board member has in directing agency wide decisions, they are responsible to identify and report their own potential conflicts between their personal interests and the best interest of the agency. If any such circumstances are identified, Board members must recuse themselves from deliberations and votes regarding related matters and they are not allowed to improperly influence such deliberations or votes.

A conflict of interest is defined as: Any situation in which financial or other personal considerations may compromise or appear to compromise (1) an employee's or Board member's business judgment; (2) delivery of services; or (3) ability for an employee or Board member to complete his/her duties. An actual or potential conflict of interest occurs when an employee or Board member is in a position to influence a decision that may result in a personal gain for that person or for his/her relative, as a result of business dealings.

Our Code of Conduct/Conflict of Interest Sign Off is referenced as Attachment A in the Corporate Compliance Plan manual.

VALUES
Integrity, Commitment, Quality

PROCEDURE

Person(s)	**Responsibility**
	<u>New Board Members</u>
Executive Director	Prior to the initial election of a new Board member, reviews the agency Code of Conduct and Conflict of Interest Statement with the potential Board member. Addresses any questions.
Potential Board Member	Reviews and signs off on the Code of Conduct/Conflict of Interest Statement, indicating his or her understanding of and commitment to the Code of Conduct. Writes on the statement any family members employed by the agency, any contractors/business associates working with the agency or personal business relationship with the agency which may be considered a conflict of interest. Submits signed statement to the Corporate Compliance Officer. Provides any additional explanation, if requested, regarding potential conflicts.

1.4 a Code of Conduct/Conflict of Interest- Board Members, cont.

PROCEDURE

Person(s)	Responsibility
Executive Director	Ensures that the potential Board member has completed and signed the Conflict of Interest Statement, forwards the original to the Executive Assistant, action on behalf of the Secretary of the Board.
	<u>Current Board Members</u>
Corporate Compliance Officer	Conducts annual Board Corporate Compliance training. Upon completion of the training, requests members to review, complete and sign the Conflict of Interest Statement.
Executive Assistant	Collects completed statements and forwards the Conflict of Interest Statement to those Board members who were not present at the meeting. When Statements are received from all Board members, sends a scanned copy to the Corporate Compliance Officer and files the originals in each Board members files, to be retained indefinitely. Forwards all completed and signed statements along with the summary to the Audit Committee Chairperson.
Audit Committee Chairperson	Reviews all completed Conflict of Interest Statements and signs one statement, documenting the date of this review. Returns completed statements with original signature to Executive Assistant, on behalf of the Board Secretary, for filing, to be retained indefinitely.
Executive Assistant	Compiles a summary of any Board members' identified conflicts of interest.
Audit Committee Chairperson	Provides a written summary to the full Board.
Board Members	Must promptly report any changes in potential conflicts of interest or new conflicts to the Audit Committee Chairperson.
Board President	Ensures that any Board member with an identified conflict of interest not be present or participate in Board or Board Committee deliberations or vote on the matter related to the conflict.

1.4 a Code of Conduct/Conflict of Interest- Board Members, cont.

PROCEDURE

Person(s)	**Responsibility**
	<u>Addressing Conflicts of Interest</u>
Audit Committee Chairperson	Consults with Board Executive Committee to discuss the implications of the Board member's conflict, determining if any action above and beyond the member recusing themselves from deliberations and votes are needed.
Audit Committee Chairperson	If deemed necessary by the Executive Committee, may conduct an or Designee investigation as to any potential Board members violation of this Conflict of Interest policy. Provides a written summary of investigation and findings to the Executive Committee.
Board President	Informs the involved Board member that the matter is being reviewed.
Executive Committee	Reviews investigative summary and refers any questions to the Audit Committee Chairperson. Renders a decision regarding follow up action, if any, that is necessary, (up to and including removal from Board membership.
Board President	Informs the full Board of any follow up action that was required as a result of the confirmed conflict of interest. Ensures this information is documented in Board minutes.
	<u>Related Party Transactions</u>

Related Party Definition:

Any agency Director, Officer or Key Employee or Affiliate
Any relative of the above listed
Any entity in which any person described above has 35% or > ownership or beneficial corporation, a direct or indirect ownership interest >5%.

Board Members	Must inform the Board President and Audit Committee Chairperson of any interest they may have in a related party transaction. Provides the material facts of their interest in the transaction.
Audit Committee	Reviews the related party transaction to determine Alternative transactions (if available) prior to entering into the transaction. Determines if the transaction is fair, reasonable and in the best interest of the agency. Completes vote on the transaction, requiring a majority vote for approval.

1.4 a Code of Conduct/Conflict of Interest- Board Members, cont.

PROCEDURE

Person(s)	**Responsibility**
Audit Committee Chairperson	Ensures the committee meeting minutes include the basis for the transaction approval, including any alternatives considered.
Board President	Informs other Board members by ensuring the Audit Committee minutes are included in the next Board meeting packet.

SECTION: 1.4

SUBJECT: Corporate Compliance

TOPIC: Code of Conduct & Conflict of Interest - Staff and Contractors

POLICY

All employees and independent contractors must know, understand and follow the agency Code of Conduct and Conflict of Interest policy so that they may represent the organization in a positive and ethical manner. All employees should avoid situations involving a conflict between their personal interests and the interests of the agency, avoiding outside business interests that could compromise their commitment to the agency.

A conflict of interest is defined as: Any situation in which financial or other personal considerations may compromise or appear to compromise (1) an employee's or Board member's business judgment; (2) delivery of services; or (3) ability for an employee or Board member to complete his/her duties. An actual or potential conflict of interest occurs when an employee or Board member is in a position to influence a decision that may result in a personal gain for that person or for his/her relative, as a result of business dealings.

Our Code of Conduct/Conflict of Interest Sign Off is referenced as Attachment A in the Corporate Compliance Plan manual. These topics are also addressed in the Personnel Policies and Procedures.

VALUES

Integrity, Commitment, Quality

PROCEDURE

Person(s)	Responsibility
	All Staff
Human Resources Staff	Provides a copy of the Code of Conduct/Conflict of Interest Statement to all newly hired employees, at the time of fingerprinting and receipt of their ID badge.
All New Employees	Upon receipt of the Hire Packet, reviews the Code of Conduct and Conflict of Interest Statement. Addresses any questions to their assigned supervisor. Signs off on the Code of Conduct/Conflict of Interest Statement, indicating his or her understanding of and commitment to the Code of Conduct. Writes on the statement any family members employed by the agency and any situation in which financial or other personal considerations may be considered a conflict of interest. Submits signed statement to their supervisor.

1.4 Code of Conduct/Conflict of Interest, cont.

PROCEDURE

Person(s)	**Responsibility**
Supervisor	Addresses any staff questions and forwards the signed statement to Human Resources for filing. Sets an example of ethical conduct. Creates an environment where all employees feel free to raise concerns. Ensure their employees have sufficient information to comply with laws, regulations and agency policies and procedures.
	<u>All Management Team members, Finance Staff, Maintenance Staff and Transportation Supervisors</u>
Management Team, Finance Staff, Maintenance Staff and Transportation Supervisors	Reviews and signs the Code of Conduct/Conflict of Interest Statement annually, indicating his or her understanding of and commitment to follow the Code of Conduct/Conflict of Interest. Writes on the statement any family members employed by the agency and any situation in which financial or other personal considerations may be considered a conflict of interest. Submits signed statement to the Corporate Compliance Officer. Corporate Compliance Officer submits his/her signed statement to the Executive Director. A scanned copy of all signed statements are maintained by the Corporate Compliance Officer.
Corporate Compliance Officer	Coordinates annual review of the Code of Conduct/Conflict of Interest Statement for Board members and all staff listed above. Maintains a scanned copy of the signed statement.
	<u>Contractors</u>
Purchasing Agent	Provides independent contractors with a copy of the Code of Conduct/Conflict of Interest Statement at the time of entering into a written agreement with the agency. Ensures receipt of signed statement, prior to starting work with the agency (exceptions for emergencies only). Retains original signed copy of Code of Conduct/Conflict of Interest Statement in the contractor/vendor's file.

1.4 Code of Conduct/Conflict of Interest, cont.

PROCEDURE

Person(s)	**Responsibility**
	<u>Conflict of Interest Concerns</u>
All Staff and Contractors	Must promptly report any changes in potential conflicts of interest or new conflicts to a supervisor or Corporate Compliance Officer.
Supervisor/Director	Immediately report the concern to the Corporate Compliance Officer.
Corporate Compliance Officer	Make a determination and, if necessary, conduct an investigation as to any violation of this Conflict of Interest policy. Any disciplinary action taken or contingencies to be put in place to resolve the conflict shall be documented and reviewed by the Corporate Compliance Committee.

DATE: 9/14/09
REVISION: 6/13/11, 5/17/12, 4/11/13, 7/17//14

SECTION: 1.5

SUBJECT: Corporate Compliance

TOPIC: Compliance Education and Training

POLICY
Ontario ARC is committed to ensuring that staff, Board members and contractors are informed of the agency's ethical standards and aware of their personal responsibility to adhere to these standards. Participation in Corporate Compliance training is mandatory and a condition of continued employment and/or business relationship with the agency.

VALUES
Integrity, Quality

PROCEDURE

Person(s)	**Responsibility**
Director, Staff Development	Ensures that Corporate Compliance refresher training is available on our online training system, that the system alerts staff and their supervisor when this training is due each year and if any staff are overdue for the training.
Supervisor	<u>Newly Hired Staff</u> Upon hire, provides the employee with information regarding where to reference the Corporate Compliance Plan on the staff webpage. Provides the employee with the Code of Conduct/Conflict of Interest for review and sign off. Forwards sign off to the Human Resources Department, to be filed in their personnel file. Schedules newly hired staff for the following trainings: -Corporate Compliance (during initial Orientation) -Program specific training through their Coaching Plan, (including our Documentation Standards) Maintains the completed Coaching Plan, with staff initials and training dates in their supervisory file. Forwards a copy of the completed Coaching Plan sign off sheet to the Staff Development office. Schedules staff for position specific training, in regards to any pertinent compliance information. (i.e. Changes in regulations, documentation standards, billing procedures, etc.)

1.4 Compliance Education and Training, cont.

Person(s)	Responsibility
	Annual Training
Supervisor	Schedules time for staff to complete annual online Corporate Compliance refresher training, on or before training due date.
All Staff	Complete the documentation training, as scheduled.
Corporate Compliance Officer	Maintains a current posting of the Corporate Compliance Plan on the agency website and staff website, for viewing by anyone who visits the site.
	Board of Directors
Corporate Compliance Officer	Conducts annual Corporate Compliance training for the Board of Directors. Any members not attending the meeting will receive a complete copy of the presentation and be required to sign off that they have received and reviewed the information.
Corporate Compliance Officer	Contractors Annually sends a letter and training materials regarding our Corporate Compliance Plan to all contractors who conduct over $500 of business with the agency, within a calendar year. Directs contractors to the agency website to review the complete Corporate Compliance Plan.
Purchasing Specialist	New Contractors Ensures that all newly awarded contract bids receive a letter in their award packet that explains we have a Corporate Compliance Plan and our expectations that they adhere to our standards of integrity and ethical business practices. The letter also directs the contractor to review our Compliance Plan, including our Code of Conduct, on our agency website.

Topics Covered in Training Programs

Compliance education programs, at a minimum, will include information on the following aspects of the Corporate Compliance Program: (a) the Code of Conduct; (b) internal communications channels (e.g., access to the Corporate Compliance Officer, the Hotline); (c) organizational expectations for reporting problems and concerns; (d) the non-retaliation and non-intimidation policy for reporting made in good faith; and (e) the False Claims Act and HIPAA/HITECH confidentiality policies.

Specialized areas for education and training include: (a) government reimbursement principles; (b) government initiatives related to the services provided by the agency; (c) the general prohibition on paying or receiving remuneration for referrals of clients; (d) requirements for billing and documentation of services, including a prohibition against signing for the work of another individual and alterations to service documentation; and (e) confidentiality laws.

Specialized education and training will be provided to staff with the following responsibilities: direct submission of billing, internal auditing and oversight of the Fiscal Department.

DATE: 9/14/09
REVIEW/REVISION: 8/18/11, 6/21/12, 4/11/13, 6/12/14, 5/14/15

SECTION: 1.6

SUBJECT: Corporate Compliance

TOPIC: Service Documentation, Billing and Auditing

POLICY
Ontario ARC adheres to the legal and ethical standards for documenting the services we provide. All staff are required to complete their documentation in an accordance with the agency's formal written Documentation Standards. Quality documentation is the basis of our service billing.

VALUES
Integrity, Quality

PROCEDURE

Person(s)	**Responsibility**
Program Director	Ensures that there are written program procedures to provide checks on the staff documentation quality and accuracy, prior to billing submission. Adheres to the Supervisory Incentives and Corrective Action policy if there are concerns with documentation. Ensures that there are written procedures for the confirmation of service provision, prior to submission of billing to the Accounts Receivable Specialist.
Assistant Director, Fiscal Services	Assigns a second business department staff person to complete quality check of billing data prior to the submission for payment. Tracks all billing voids to identify the cause of incorrect billing. Tracks all billings submitted 90 days after the date of service. Identifies if any procedural changes are necessary. Monitors billing staff to ensure that there are no inducements for submittal of false billing information.
Corporate Compliance Officer	Ensures that the audit tools address the current regulatory requirements and program standards. Ensures that audits are completed for individuals, by the internal audit staff, and each program is included in these audits at least twice per year. Audits will be completed more frequently if there are significant concerns with the site documentation **or changes in regulations have occured.** Presents audit findings at each Corporate Compliance Committee meeting and a quarterly summary of billing voids and billings submitted 90 days after the date of service.
Program Director	Ensures that any action items identified in the internal audit memo have a written response forwarded to the internal auditor, with related follow up information, within 30 days.

1.6 Service Documentation, Billing and Auditing, cont.

PROCEDURE

Person(s)	**Responsibility**
Corporate Compliance Committee	Makes recommendations for any additional follow up and preventative measures based on audit findings and quarterly summaries of billing voids and billings submitted 90 days after the date of service.
Compliance & Records Coordinator	Compiles an annual summary of all program and cash audits. Presents findings/recommendations to the Corporate Compliance Committee within the first quarter of the following calendar year.
Corporate Compliance Officer	Includes significant trends and recommendations in the annual Chapter Board Corporate Compliance training.

DATE: 9/14/09
REVIEW/REVISION: 8/18/11, 6/21/12, 5/16/13, 6/1214, 5/14/15

SECTION: 1.7

SUBJECT: Corporate Compliance

TOPIC: False Claims

POLICY

It is the policy of Ontario ARC to detect and prevent fraud, waste and abuse. Ontario ARC employees, contractors, or anyone working on behalf of the agency will not make or submit any false or misleading entries on any bills or claim forms. No employee, contractor, or agency representative will participate in any activity, either voluntarily or at the direction of another person including any supervisor or manager, which results in submitting a false claim.

VALUES

Integrity, Quality

PROCEDURE

1. Ontario ARC will adhere to the Federal False Claims Act which is a law used to detect fraud, waste and abuse in federal health care programs. The False Claims Act states that anyone who "knowingly" submits false claims to the Government may be held personally responsible and be required to pay back up to three times the amount of the error and an additional penalty of $5,500 to $11,000 for each false claim submitted. "Knowingly" means that a person;
   - has actual knowledge of the false claim;
   - acts in deliberate ignorance of the truth or falsity of the information; or
   - acts in reckless disregard of the truth or falsity of the information.

2. Should the Government, or an individual citizen acting on behalf of the Government bring actions under the False Claims Act, Ontario ARC will immediately respond and allow an investigation. Should an individual who has knowledge of a false claim file a lawsuit on behalf of the government that is successful, that individual may receive an award ranging form 15% to 30% of the amount recovered.

3. Ontario ARC will not discriminate against an employee for taking or bringing an action under the False Claims Act. (Refer to Section 1.9, Reporting Compliance Concerns/Anti-Retaliation Policy and Procedure).

4. Ontario ARC will provide training to all its employees, contractors and agents regarding this policy.

5. Billing activities will be performed in a manner consistent with Medicare, Medicaid and other payor regulations and requirements in accordance with the agency's Corporate Compliance Plan.

1.7 False Claims, cont.

PROCEDURE, cont.

6. Ontario ARC has established regular audit and monitoring procedures to assist in efforts to detect and prevent fraud, waste and abuse. (Refer to Section 1.6, Service Documentation, Billing & Auditing Policy and Procedure).

7. Any Ontario ARC employee, contractor or agency representative who has any reason to believe that anyone is engaging in false billing practices will immediately report the practice in accordance with Ontario ARC's Corporate Compliance Plan to the Corporate Compliance Officer, at 585-919-2120, or to the Corporate Compliance Hotline. The Hotline telephone number is 585-393-5678.
   Anonymous and confidential messages can be left at this Hotline number.

8. Any employee, contractor or agency representative found to have committed false claims may face additional disciplinary action up to and including termination of employment/ contract and/or other penalties including criminal prosecution.

9. This policy will be included in all employee handbooks and attached to any contracts with outside contractors or agents.

   The Purchasing Specialist will ensure that all newly awarded contract bids receive a letter in their award packet that explains we have a Corporate Compliance Plan and our expectations that they adhere to our standards of integrity and ethical business practices. The letter also directs the contractor to review our Compliance Plan, including our Code of Conduct, on our agency website.

DATE: 9/24/08
REVIEW/REVISION: 9/14/09, 8/18/11, 6/21/12, 5/16/13, 8/14/14, 5/14/15

SECTION: 1.8

SUBJECT: Corporate Compliance

TOPIC: Gifts

POLICY

Ontario ARC representatives (Board members and employees) will generally not accept gifts, hospitality or entertainment of more than $25.00 from any outside parties with whom we conduct business. We expect all agency representatives to abide by this gift guideline, to avoid the appearance of possible influence of business decisions.

Likewise, agency employees and Board members will not accept gifts from family members of any individual we support. The individuals we support may occasionally offer nominal items to staff as a personal gift (i.e. items they have made) however, such items should only be accepted if they do not have any cash value.

Occasional consumable gifts, such as a gift basket, which are not extravagant, may be accepted as long as the items are shared among a group of employees and/or participants. Small business advertising items (i.e. calendars, pens) may be accepted.

Likewise, Ontario ARC representatives will not offer or provide any gift, hospitality or entertainment of more than $25.00 to any person receiving services from our agency. Examples of permissible items include pens, T-shirts, water bottles, etc., as long as such items are not offered or provided to influence support services or health care decisions by an individual, family member, or responsible party.

For fundraising, the Director of Development or Director of Community Relations contacts vendors throughout the community, including those with whom we conduct business, as well as those with whom we do not have a business relationship, to solicit donations. The level of donation is not a factor in our selection of vendors.

VALUES

Integrity

PROCEDURE

Person(s)	Responsibility
	<u>Gift Acceptance</u>
Board Members	Informs the Corporate Compliance Officer of any gifts offered to them for a value over $25.00.
Staff Members	Informs their supervisor of any gifts received with a value under $25.00 and those offered, and declined, above $25.00 value.
Supervisor	Informs Corporate Compliance Officer of any gifts offered to staff above a value of $25.00.

PROCEDURE Person(s)	Responsibility
	<u>Gift Giving to Individuals, Families and Responsible Parties</u>
Directors	Consults with the Corporate Compliance Officer prior to approving the offering any gift, hospitality or entertainment to individuals served, their immediate family members or responsible party, with a value over $25.00.
Corporate Compliance Officer	Tracks the giving of gifts and entertainment on the Gifts and Entertainment Log, to ensure that the annual aggregate value of such gifts and entertainment does not exceed the IRS limit.

DATE: 02/08/10
REVIEW/REVISION: 9/15/11, 07/19/12, 5/16/13, 8/14/14, 3/12/15

SECTION: 1.9

SUBJECT: Corporate Compliance

TOPIC: Reporting Compliance Concerns/Whistleblower/Anti-Retaliation

POLICY

Ontario ARC requires all employees, Board members and volunteers to promptly report any known or suspected violations of the Corporate Compliance Plan, Code of Conduct, policies and procedures or any of the laws, rules or regulations by which the agency is governed. Ontario ARC provides an environment that encourages individuals to report any possible violations without fear of retaliation or retribution. Intimidation or retaliation will not be permitted against anyone who in good faith participates in the Compliance Plan, to include, but not limited to: reporting potential issues, investigating issues, self-evaluations, audits and remedial actions and reporting to appropriate officials. If an employee engages in such actions of retaliation or intimidation, it may result in disciplinary action, up to and including termination.

VALUES

Integrity, Commitment

PROCEDURE

Person(s)	Responsibility
All Employees, Board Members and Volunteers	Report any known or possible violations of the Corporate Compliance Plan, Code of Conduct, policies and procedures or any of the laws, rules or regulations by which agency is governed to their supervisor, the Corporate Compliance Officer or through the agency's Compliance Hotline. To reach the Compliance Hotline, calls (585) 393-5678. May report the compliance concerns confidentially to this Hotline. Callers will not be required to disclose his or her identity and no attempt will be made to trace the source of the call or identity of the caller when the caller requests anonymity. It may not be possible to maintain the caller's anonymity if the caller identifies themselves, provides other information which identifies them, the investigation reveals their identity or they inform people that they have called the Compliance Hotline. The Hotline recording informs callers that the agency is legally required to report certain types of crimes or potential crimes and infractions to external governmental agencies.

1.9 Reporting Compliance Concerns/ Whistleblower/Anti-Retaliation, cont.

Person(s)	Responsibility
Corporate Compliance Officer	Checks the Corporate Hotline, at least two times per week. If a caller has revealed his or her identity, maintains their confidentiality to the extent practicable and allowed by law. Posts the Compliance Hotline telephone number on the internal staff website, agency community website and at each program site.
Any Supervisor	Upon receipt of a reported compliance concern, immediately informs the Corporate Compliance Officer and their Program Director. Does not impose any disciplinary or other action in retaliation against individuals who make a report or complaint in good faith regarding a practice that the individual believes may violate the agency Compliance Plan. Other prohibited actions include intimidation, harassment and discrimination.
Program Director, or Designee	Informs the appropriate Associate Executive Director of the compliance report. Upon review with the Human Resource Director, Corporate Compliance Officer and Executive Director, if necessary, determines disciplinary actions to be taken against an employee who reports his or her own wrongdoing. Such actions will be a result of the wrongdoing itself, not the reporting of such, therefore, are not to be considered retaliation or retribution. Self-reporting may be taken into account in determining the appropriate disciplinary action to be taken. (Refer to Section 1.12, Supervisory Incentives and Corrective Actions Policy and Procedure). Determines if confidentiality of information regarding the report is needed, based upon any of the following factors: (1) a witness needs protection; (2) evidence is in danger of being destroyed; (3) testimony is in danger of being fabricated; or (4) there is a need to prevent a cover up. If confidentiality is indicated, explains the reason for requested confidentiality to the staff person.
All Employees, Board Members and Volunteers	Maintains confidentiality of report information, if deemed necessary.

1.9 Reporting Compliance Concerns/ Whistleblower/Anti-Retaliation, cont.

Person(s)	Responsibility
Employee	If an employee believes in good faith that he or she has been retaliated against for initiating a report or complaint or for participating in any investigation related to such report or complaint, then the employee should report the retaliation to his or her supervisor, the Corporate Compliance Officer or Compliance Hotline as soon as possible. The report should provide a thorough account of the incident(s) and should include names, dates of specific events, the names of any witnesses and the location or name of any document in support of the reported retaliation.
Corporate Compliance Officer	(Refer to Section 1.10, Internal Investigation Policy and Procedures for additional follow up).

DATE: 09/14/09
REVIEW/REVISION: 09/15/11, 07/19/12, 11/1/12, 7/18/13, 10/10/13, 7/17/14, 6/11/15

SECTION: 1.10

SUBJECT: Corporate Compliance

TOPIC: Internal Investigations

POLICY
Ontario ARC is committed to investigating possible violations of laws**,** regulations or the agency Corporate Compliance Plan. We will respond to reports or reasonable indications of possible noncompliance by conducting an investigation of the allegations to determine whether a violation has, in fact, occurred. Investigations will be initiated within 48 hours of receipt of the report.

VALUES
Integrity, Commitment

PROCEDURE

Person(s)	**Responsibility**
Corporate Compliance Officer	Oversees the conduct of internal investigations of compliance issues. Engages outside counsel or other consultants, as needed. Confirms legal and regulatory requirements regarding the compliance issue. Determines personnel who have the required skills to examine the particular issue(s). Works with the investigator(s) to develop a strategy for reviewing and examining the facts surrounding the possible violation, which may include, but not be limited to an audit of billing practices and interviews of staff, volunteers, contractors, people we support and their family members. Assesses thoroughness of the investigation, requesting additional follow up, as needed. Reviews investigation findings and recommendations to the Executive Director and Corporate Compliance Committee. Contacts the appropriate law enforcement agency if the investigation indicates that a legal infraction may have occurred. Follows the Self-Disclosure and Overpayment Policy and Procedure, #1.17, if indicated.

1.10 Internal Investigations, cont.

PROCEDURE

Person(s)	**Responsibility**
Assigned Director	Refer to Supervisory Incentives and Corrective Actions Policy and Procedure, #1.12, for guidelines to determine supervisory follow up.
Corporate Compliance Officer	Tracks the investigation in the Corporate Compliance Log. Maintains all investigation documents in the central Corporate Compliance file and a scanned version in the CCO's computer X drive. Following completion of the investigation, informs the party who reported the compliance concern that the matter was looked into and has been concluded. Does not disclose any details or confidential information. Sends a follow up letter to staff who are subject of the investigation, summarizing the findings, without disclosing information regarding anyone else involved in the investigation. Forwards a copy of the letter to the Program Director, Associate Executive Director and the Human Resource Director, to add the letter to the staff person's personnel file.

DATE: 09/14/09
REVIEW/REVISION: 09/15/11, 07/19/12, 7/18/13, 8/14/14, 6/11/15

SECTION: 1.11

SUBJECT: Corporate Compliance

TOPIC: Responding to Government Inquiries

POLICY
Ontario ARC will fully cooperate with reasonable requests of government officials. The purpose of this policy is to provide a uniform method by which agency employees are to respond in the event that any government employee (federal or state) contacts an employee for information regarding Ontario ARC.

VALUES
Integrity, Commitment

PROCEDURE

Person(s)	**Responsibility**
<u>SEARCH WARRANTS</u>	
All Agency Employees	Immediately notifies his/her supervisor upon receipt of a search warrant, related to Ontario ARC activities. If a government representative appears in person, requests to see and make a copy of his or her identification and business card. If these materials are unavailable, asks for the person's name and office, address and telephone number, and identification number. Calls the government representative's office to confirm his or her identity and authority. If more than one representative appears, determines which representative is in charge and ask for his or her identifying information. Does not remove, alter, create or destroy any form of documents or records, in anticipation or during an investigation. Does not release or copy any documents in connection to a governmental inquiry, without the authorization of the Corporate Compliance Officer or Executive Director or an Associate Executive Director, if the Corporate Compliance Officer is not available.
Employee's Supervisor	Immediately notifies the Corporate Compliance Officer. If the Corporate Compliance Officer cannot be reached, the employee must immediately notify the Executive Director.

1.11 Responding to Government Inquiries, Search Warrants, cont.

PROCEDURE

Person(s)	**Responsibility**
Corporate Compliance Officer	Ensures that no search of the premises and/or seizing of property occurs without a legally valid search warrant. Secures a copy of the search warrant and confirms it's validity. Appoints someone on site to be responsible for communicating with the government representative. Travel to the site, if possible, to assist with the inquiry.
Assigned On-Site Staff	Required to answer questions concerning the location of documents, if they know the location of the documents in question. Does not answer other questions and informs the government representative that he/she prefers to wait until counsel is present. If asked to sign an affidavit of any kind, does not comment as to the validity of its contents and explains that he/she is not authorized to sign any document prior to review by agency's legal counsel. Immediately reports any concerns of investigation interference to the Corporate Compliance Officer, such as alteration or destruction of documents sought in an investigation; staff falsely denying knowledge of information; corrupt influence of another person to exercise the privilege against self-incrimination; or intimidation of a witness with the intent of influencing behavior. Develops a list of all documents that the government representative is seizing or copying. Accompanies each government representative during his or her search. Takes notes of everything the government representatives inspect and conversations between or among the government representatives.

PROCEDURE

Person(s)	**Responsibility**
Corporate Compliance Officer	Requests a detailed receipt stating all documents and items of which the government has obtained a copy, including the number of pages copied for reimbursement purposes. If the government representative wishes to take original documents, asks if those documents may first be copied. If the representative wants to seize any computers, requests to make copy of all files. If the government representative wishes to seize the records of an individual we support, asks if those records may be copied so that the person's care and/or confidentiality will not be compromised.

REQUESTS FOR INTERVIEWS (For any corporate compliance related issue)

Any Agency Employee	Has the right to decline to be interviewed altogether or schedule an appointment at a later time to speak with the government representative. May request to have someone with them during an interview with a government representative. Corporate Compliance Officer will arrange to have the organization's attorney present at no cost to the employee, or the employee may choose to consult an attorney separately at his or her own expense. Encouraged to take notes during the interview. During the interview, employees should follow these guidelines: 1. Always tell the truth. If unable to recall something, are uncertain or have no knowledge about the topic being discussed, say so. 2. Answer questions completely, accurately, and concisely to avoid misunderstandings as to what you are saying. Indicate whether the information provided is first-hand knowledge, something you have heard, or speculation. 3. Contact the Corporate Compliance Officer as soon as possible, after the interview.

1.11 Responding to Government Inquiries, cont.

PROCEDURE

Person(s)	**Responsibility**
<u>SUBPOENA OR INVESTIGATION DEMAND LETTER</u>	
All Agency Employees	Immediately notifies his/her supervisor upon receipt of a subpoena or investigation demand letter, related to Ontario ARC activities.
Employee's Supervisor	Immediately notifies the Corporate Compliance Officer. If the Corporate Compliance Officer cannot be reached, the employee must immediately notify the Executive Director.
Corporate Compliance Officer	Consults with NYSARC Compliance Attorney to determine our follow up to the subpoena or Investigation demand letter.
<u>COMMUNICATIONS REGARDING A GOVERNMENT INQUIRY</u>	
Any Agency Staff	Does not discuss this matter with anyone if the Corporate Compliance Officer has determined and communicated that (1) a witness needs protection; (2) evidence is in danger of being destroyed; (3) testimony is in danger of being fabricated; or (4) there is need to prevent a cover up. If staff is contacted by a media representative or any person or organization seeking a comment on behalf of Ontario ARC, refer that person to the Corporate Compliance Officer. Does not attempt to provide any additional explanation.
Executive Director	Informs Board of Directors Executive Committee members of any search warrants, request for interview, subpoena or investigation demand letter from a governmental entity.

DATE: 9/14/09
REVISION: 10/27/11, 8/16/12, 7/18/13, 9/10/14, 6/11/15

SECTION: 1.12

SUBJECT: Corporate Compliance

TOPIC: Supervisory Incentives and Corrective Actions

POLICY
Ontario ARC is committed to creating and fostering a culture in which compliant behavior is encouraged and rewarded. We provide recognition for employees and independent contractors who uphold these agency standards. Employees and independent contractors who, upon investigation, are found to have committed violations of applicable laws and regulations, the Corporate Compliance Plan, the Code of Conduct or the agency policies and procedures will be subject to appropriate disciplinary action.

VALUES
Integrity, Commitment, Quality

PROCEDURE

Person(s)	**Responsibility**
<u>INCENTIVES</u>	
Assigned Supervisor	Monitors performance of assigned staff members. Provides incentives to reward and recognize behavior that is consistent with our policies and values. Incentives may include, but are not limited to: 1. Written notes of appreciation; 2. Recognition in publications (newsletters, staff website, etc.); 3. Celebration of team successes; 4. Reward and Recognition gift certificates; 5. Performance Reviews and positive feedback; 6. Awards and certificates.
Assigned Director	Monitors supervisors' use of employee incentives, including quarterly Reward and Recognition gift certificate accounts, to ensure that they are being used effectively and fairly by assigned supervisors.

1.12 Supervisory Incentives and Corrective Actions, cont.

PROCEDURE

Person(s)	**Responsibility**
CORRECTIVE ACTION	
Assigned Director	Informs Corporate Compliance Officer of compliance report. Upon completion of an investigation regarding the reported non-compliance, determines level of supervisory action to be recommended, considering the following factors of severity: 1. Violation was committed knowingly; 2. Individual was dishonest during the investigation; 3. There is a pattern of misconduct; 4. Individual attempted to cover up the violation; 5. Violation involved retaliation against other person(s) who reported violations in good faith; 6. Employee deliberately failed to check whether a particular course of action was prohibited; 7. Violation was criminal in nature; 8. Individual was uncooperative with the investigation; 9. Individual received personal benefit; 10. Individual did not voluntarily report the violation; 11. Serious damage was caused by violation; 12. An individual we support was, or could have, been harmed as a result of the violation.
Assigned Director	Determines progressive discipline consistent with the violation. Supervisory action may include, but is not limited to: 1. Verbal counseling or warning; 2. Counseling with a written warning; 3. Retraining; 4. Job or location reassignment ; 5. Demotion; 6. Suspension without pay; 7. Termination of employment or service arrangement with a contractor.

1.12 Supervisory Incentives and Corrective Actions, cont.

PROCEDURE

Person(s)	**Responsibility**
Assigned Director	Consults with Director of Human Resources to ensure that supervisory action is consistent with the agency Personnel Policies and practices.
Director for Human Resources	Informs Corporate Compliance Officer of any reported violations of the Corporate Compliance Plan. (Refer to Internal Investigation Policy and Procedure for additional follow up).
Assigned Director	Informs appropriate Associate Executive Director and Senior Associate Executive Director of recommended supervisory action for employee and/or contractor.
Associate Executive Director	Determines if supervisory action warrants notification to Executive Director. All recommendations for employee suspension or termination must receive prior verbal approval from the Executive Director. Ensures that disciplinary actions are being applied consistently throughout the agency.
Corporate Compliance Officer	Updates Corporate Compliance Committee of the violation and supervisory action at the next regularly scheduled meeting, or prior to the meeting, if seriousness of the violation requires more immediate consultation. Tracks disciplinary actions and follow up on Corporate Compliance Report Log.
Assigned Supervisor	Ensures that formal documentation of supervisory measures are forwarded to Human Resources, to be filed in the employee's personnel file.

DATE: 9/14/09

REVISED: 10/27/11, 8/16/12, 8/22/13, 9/10/14, 7/9/15, 10/13/16

SECTION: 1.13

SUBJECT: Corporate Compliance

TOPIC: Political Contributions and Lobbying

POLICY
Ontario ARC is a not for profit organization operated exclusively for charitable purposes and is exempt from federal income taxation. Therefore, our agency may not engage in any political campaign activities and may not engage in a substantial amount of lobbying. We may engage in some lobbying to advocate our position on public issues and Medicaid funds cannot be used for this lobbying.

Ontario ARC also adheres to state laws regarding lobbying and procurement of government contracts.

VALUES
Integrity

PROCEDURE

Person(s)	**Responsibility**
POLITICAL CAMPAIGNS	
Executive Director and Board of Directors	**Political Campaign Involvement** Under no circumstances will Ontario ARC directly or indirectly participate in, or intervene in, any political campaign on behalf of or in opposition to any candidate for elective public office. Ontario ARC will also not make contributions to political campaign funds or public statements of position in favor of or in opposition to any candidate for public office.
All Staff, Board Members and Agency Representatives	**Personal Involvement in Political Campaign Activities** Must clearly indicate that their written or spoken comments, on behalf of any candidate for elective office, are their personal comments and they are not intended to represent the views of the agency. May make personal contributions to candidates for public office. The decision as to whether or not to contribute is at the sole discretion of the individual and any decision not to participate shall have no impact on any personnel actions regarding such individual. Under no circumstances will personal campaign contributions be reimbursed by Ontario ARC or otherwise identified as a business expense by the individual making the contribution.

1.13 Political Contributions and Lobbying, cont.

Person(s)	Responsibility
	Personal Involvement in Political Campaign Activities
All Staff, Board Members and Agency Representatives	When supporting or opposing any candidate for elective office in a publication, they may indicate their job title and affiliation with the agency, so long as any such publication includes an appropriate disclaimer indicating that the individual's affiliation is provided for identification purposes only and the individual's endorsement, participation or other involvement reflects the individual's views only and not the views of Ontario ARC.
LOBBYING	
	Prohibition Against Engaging in a "Substantial" Amount of Lobbying.
All Staff, Board Members and Agency Representatives	Must consult with the Corporate Compliance Officer before any lobbying activities are performed. Then, must receive prior approval from the Board of Directors**.** Must report all time and expenditures devoted by Ontario ARC to lobbying activities to the Corporate Compliance Officer for tracking purposes.
Corporate Compliance Officer	Tracks all time and expenditures devoted to lobbying activities to ensure that the agency does not engage in a "substantial" amount of lobbying. Consults with legal counsel, as necessary, to assess the agency's lobbying activities and to determine whether lobbying activities may jeopardize Ontario ARC's tax exempt status.
	Registration/Reporting
Corporate Compliance Officer	Maintains the agency's lobbying registration with appropriate state and federal agencies, as required, if engaged in lobbying. Provides any periodic reports required by such agencies.

1.13 Political Contributions and Lobbying, cont.

Person(s)	Responsibility
	New York Procurement Law
All Staff, Board Members and Agency Representatives	Will adhere to all requirements of New York procurement law, when seeking State of New York government contracts. Directs any questions regarding compliance with these requirements should be directed to the Corporate Compliance Officer.
Corporate Compliance Officer	Consults with the NYSARC attorney and/or agency attorney, as necessary, to ensure compliance with the procurement law.

DATE: 9/14/09
REVIEW/REVISION: 10/27/11, 8/16/12, 11/1/12, 8/22/13, 9/10/14, 7/9/15, 10/13/16

SECTION: 1.14

SUBJECT: Corporate Compliance

TOPIC: IRS Form 990 Review and Submission

POLICY
Ontario ARC complies with the Internal Revenue Service requirement for submission of Federal Form 990. We also comply with the New York State Department of Law, Charities Bureau requirement to file the 990 as an attachment to the New York State Form CHAR 500. The Board of Director's Audit Committee reviews and approves the Federal Form 990, prior to annual submission.

VALUES
Integrity, Quality

PROCEDURE

Person(s)	Responsibility
Associate Executive Director/ Chief Financial Officer	Communicates directly with the audit firm to ensure timely completion of the 990 form, including applicable attachments. Prior to the end of the calendar year, or as soon thereafter when available, reports to the Board of Directors' Audit Committee regarding any changes in 990 reporting requirements. Forwards a draft of the completed forms to the Board of Directors' Audit Committee at least 5-10 business days prior to the filing of the required tax forms with the IRS and New York State Department of Law, Charities Bureau. Following committee review, discusses any questions with the tax preparer. Revises the 990, if necessary, prior to filing.
Executive Assistant	At least 24 hours before the 990 and CHAR 500 are filed, posts the draft Form 990 on the agency SharePoint site. Sends an email to all agency Board members, informing them that these items are now available for their information and review.
Associate Executive Director/ Chief Financial Officer	Files the 990 and CHAR 500 within the allowable timeframe, as determined by the Federal Government and New York State, respectively.

DATE: 11/25/08
REVIEWED: 11/17/11, 09/20/12, 9/12/13, 10/09/14, 11/12/15, 10/13/16

SECTION: 1.15a

SUBJECT: Corporate Compliance

TOPIC: Record Retention

POLICY
Ontario ARC retains all service and business function documentation in compliance with the regulatory requirements. We adhere to the Records Retention guidelines distributed by the NYSARC Record Retention task group in March 2009 (See attached). The Single Personal Record for each individual supported, reflects these record retention guidelines. Record storage access is limited to those positions which have a critical need for immediate retrieval of stored records.

Our electronic service records are maintained in Therap, a cloud based platform. These records are available indefinitely.

Purged Single Personal Records, attendance records, Incident Reports, Board meeting minutes and personnel files are secured in our secure Records Room, located in our Main Facility. Business and Transportation records are maintained within their departments, until they are no longer needed for immediate access. These records are then transferred to our secure off site storage provider.

VALUES
Quality, Integrity

PROCEDURE

Person(s)	**Responsibility**
Corporate Compliance Officer	As updates occur, distributes a revised record retention schedule and related regulation guidelines to appropriate Program Director(s).
Single Personal Record (SPR) Committee Chairperson	Ensures that record retention guidelines/regulations are incorporated into the Single Personal Record indexes, which include a record retention/destruction guide for each document. Reviews adherence to the record retention schedule during quarterly SPR peer review of program records.
Program Directors	Ensures that staff within their service area are adhering to the approved Record Retention schedule, as applicable within the service area.
Habilitation Coordinators, MSCs, Residence Managers and Employment Specialists	Completes Single Personal Record purge at least annually. Files purged records by individual and year, in the sequence listed in the Single Personal Record index. Attaches Purge Authorization Transfer Form to top of purged records for each individual.

Accounting Specialist Supervisor or Designee	Purges Account Receivable and Payable records after receipt of the final year end audit and submits the Purge Authorization Transfer Form, to the Records Specialist.
Records Specialist	Maintains tickler of Purge Schedule to include annual purges by programs. Sends emails to Site Supervisors and Program Managers reminding of scheduled purge and records transfer, by the 15th of the prior month. Includes date purged records are due to arrive in Records Room. Prepares shelves by labeling for scheduled records transfer. Forwards Purge Authorization Form to the Maintenance Specialist, authorizing transport of the specified files to the Main Facility.
Maintenance Specialist	Only transfers documents for storage to the Main Facility upon receipt of the signed Purge Authorization Form, completed by a member of the Quality Assurance team.
Records Specialist	Upon receipt of purged records, sorts by Individual and years. Files records under individual's name labeled with the year. Retains most recent up to 3 years of documents in filing cabinets in secured Records Room. Retains 5 years prior in boxes by year, in secured Records Room. Purges oldest records at beginning of year to shred documents older than 7 years.
Compliance and Records Coordinator	On an annual basis, contacts Transportation and Finance for records no longer needed for Immediate access. Contacts offsite storage provider for pick up records for storage after transmittal forms are completed. May determine the need for more pick-ups during the year if necessary. Will request record retrieval from offsite storage provider in absence of the Records Specialist.
Records Specialist	In coordination with the Compliance and Records Coordinator completes transmittal sheets for offsite storage for all records being sent. Will request record retrieval from offsite storage provider if needed by Finance or Transportation Departments.

DATE: 9/14/09
REVIEWED/REVISED: 11/17/11, 9/20/12, 11/14/13, 10/9/14, 10/8/15

ONTARIO ARC
RECORDS RETENTION SCHEDULE
12/10/13

ADMINISTRATIVE/LEGAL	Retention Timeframe (Location- Permanent Records Only)
Articles of Incorp., Bylaws, Minutes of Board and Committee Meetings, Reports, Goals	Permanent
DBA- Qualifications To Do Business, Certificates of Assumed Names	Permanent
Contracts, Leases, Mortgages, Agreements Still in Effect	While in Effect
Insurance Policies, Reports, Claims Still in Effect	While in Effect
Insurance Policies, reports, Claims No Longer in Effect (See Human Resource Record:W/C)	7 Years
Leases, Contracts ,Mortgages, Agreements No Longer in Effect	7 Years
Letters Denying Liability	Permanent
Legal Correspondence	Permanent
Litigation Files	Preserved by Counsel
Loan Documents	Permanent
Policies and Procedures Still in Effect	While in Effect
Policies and Procedures No Longer in Effect	Originating Dept.; Permanent All Other Depts.-Discard Permanent
Requests for Departure from Document Destruction Guidelines/Opinions	Permanent- Corporate Compliance Officer X Drive Compliance Folder
Routine Correspondence, Memoranda	
Trademark Copyright Documents	Permanent
Letter Supporting a Principal Document	Permanent

ONTARIO ARC
RECORDS RETENTION SCHEDULE
12/10/13

FINANCE RECORDS	
Tax Exempt Certification	Permanent
990 Forms	7 Years
Accident Reports/Settled Claims	7 Years after disposal
Accounts Payable Ledgers/Schedules	7 Years
Audit Reports	Permanent
Bank Reconciliations	7 Years
Bank Statements/Deposit Slips	7 Years
Benefit Accruals	7 Years
Bids	7 Years
Billings	
Medicaid	7 Years
State Aid and Standard Voucher & Payments	7 Years
Transportation Billings (Children w/Special Needs, Brighter Days, Medicaid, etc.)	7 Years
Budgets – Back up information	7 Years
Canceled Checks (A/P, Staff/Client Payroll)	7 Years
Capital Funds	7 Years
Cash Disbursements Journals	Permanent on Great Plains Accounting Software
Cash Receipts Journal – Paper Journal Computerized as of 07/2009 Excel Format	Permanent
CFR – Actual Report	Permanent
CFR – Back up information	7 Years

ONTARIO ARC
RECORDS RETENTION SCHEDULE
12/10/13

Charitable Contribution Reports	5 Years
FINANCE RECORDS, cont.	
Chart of Accounts	Permanent
COLA Increase (back up)	7 Years
Collection Letters	5 Years After Payment
Credit Card Records	7 Years
Grant and Award Documents	6 Years, but not before completion of project
Depreciation Schedules	Permanent
Disability Benefits	7 Years
Electronic Payment Records	7 Years
Expense Reports	7 Years
Financial Correspondence	7 Years
Financial Statements – Year End (December)	Permanent
Fixed Assets Record	Permanent While Asset in Place; 3 Years after disposal of asset.
General Ledgers – Year End Trial Balance	Permanent
General Ledger Monthly Back up Folders	7 Years
HRA/HCE Applications and Back Up	7 Years
Internal Audit Reports	7 Years
Inventories of Products, Materials, and Supplies	7 Years
Investment Statements	7 Years
Invoices to Customers	7 Years

ONTARIO ARC
RECORDS RETENTION SCHEDULE
12/10/13

Invoices from Vendors	7 Years
FINANCE RECORDS, cont.	
Monthly Trial Balances	7 Years
OJT – Finger Lakes Works/Workforce Development	7 Years
Payroll:	
Staff/Client Timesheets	7 Years
Reports: Staff/Client	7 Years
Staff P/R Register with YTD (S109)	Permanent
Personal Allowance Ledgers	7 Years
Petty Cash Vouchers	7 Years
Purchase Orders	7 Years
Purchasing Records	7 Years
Quotation Letters, No Contract Awarded	7 Years
Rate Sheets/Appeals/Setting Data	7 Years
RFP's-VESID, Banking, Investments, Etc.	7 Years
Representative Payee Information (Letters from SS/SSI and Rent Worksheets	7 Years
Receivable Records	7 Years
Tax Reports	Permanent
Wage Records – Located in Personnel File	Permanent- Personnel Files in Main Facility Storage Room

ONTARIO ARC
RECORDS RETENTION SCHEDULE
12/10/13

HUMAN RESOURCES RECORDS	
Applications, Resumes, Related for Hired Staff	Permanent
Applications, Resumes, Related for Unhired Applicants	1 Year
Direct Deposit	Permanent
Employee Grievance Records	Permanent
Earnings Notices/Letters	Permanent
Employer's Copy of Federal Tax Return	Permanent
Employer's Copy of 1099, W2, W3	Permanent
Employee Releases/Termination Agreements	Permanent
ERISA Documents, Including Benefit Plan Descriptions, Filings, Claims, etc.	Permanent
FMLA Leave Information	Permanent
Garnishments	7 years
I-9	Permanent
IRS/DOL Correspondence	Permanent
Job Descriptions	Permanent
Job Opening Notices	1 Year
Labor Relations Files	Permanent
Medical Histories/Health Data	Permanent
Personnel Records	Permanent- Main Facility Storage Room
Unemployment Documents	Permanent

ONTARIO ARC
RECORDS RETENTION SCHEDULE
12/10/13

W-2's, W-4's, Annual Earning Records	Permanent
Worker's Comp. Records and Disability Claims	18 Years After Illness or Injury
HEALTH CARE DOCUMENTS – STAFF/CONSULTANTS	
HEP B (Sign-offs, Immunizations)	30 Years
Licenses, Permits, Physician Contracts	Permanent
Physician Agreement Documentation	5 Years After Termination
REAL ESTATE FILES	
Deeds, Contracts, Titles	6 Years After Disposition of Property
Financial Records Relating to Property	Permanent
Housing Notices, Inspections, Violations, etc.	3 Years After Property Disposed Of
Inventory of Assets	Permanent
Property Appraisals	3 Years After Determination Not to Purchase/ 3 Yr After Disposition
Records of Tangible Property	3 Years After Property Disposed Of
TRANSPORTATION	
Accident Reports/Settled Claims	7 Years
FLBS Driver Records/Maintenance on Vehicles	3 Years
Vehicle Information	7 Years after Disposition
SINGLE PERSONAL RECORD DOCUMENTS	
ISP's, Residential Habilitation Plans, and Daily Service Documentation	7 Years
HUD Resident Records (per HUD)	3 Years after tenancy
Liability Notices & Fee Schedules	Permanent
Representative Payee Information (Letters from SS/SSI and Rent Worksheets	7 Years

ONTARIO ARC
RECORDS RETENTION SCHEDULE
12/10/13

MEDICAL RECORDS- PARTICIPANTS	
Annual Physical	7 Years
Annual/Semi-Annual Nursing Review	7 Years
Informed Consent for Psychotropic Medications	7 Years
HIPAA Privacy Standards Documentation	7 Years
Lab Work	7 Years
Medication Administration Records (MARs)	7 Years
Physical Orders (Prescriptions and OTC Medications)	7 Years
PPD	7 Years
Self Medication Administration Evaluation	7 Years
STAFFING	
Staff Schedules	7 Years
STAFF DEVELOPMENT & QA	
Behavior Incident Reports (originals)	Permanent- High Priority Record Room
Hepatitis B Immunization/Declination (Per OSHA)	30 Years
Human Rights Related Records	Permanent- Iron Mountain
Incident Reports Related Records	Permanent- High Priority Record Room
Individual Trainings:	
Service Coordination	7 Years
Surveys- Family Support Services (FSS)	7 Years
Surveys- OPTS Contracts	7 Years after the end of

ONTARIO ARC
RECORDS RETENTION SCHEDULE
12/10/13

	Contract
STAFF DEVELOPMENT & QA, cont.	
Training Records: Class Sign-Ins Only CPR: Retain Tests SCIP: Retain Tests Med. Admin. Retain Tests Bloodborne Pathogens (3 yrs. Per OSHA)	7 Years " " " " " " " "
SAFETY	
Bloodborne Exposure Reports (Per OSHA)	30 Years
Fire Inspections/Safety Records	7 Years
Fire Drill/Evacuation Records	**OFPC:** 10 Yrs.
MSDS (Material Safety Data Sheets)	**NYSID**: 40 Yrs
Hazardous Substance Documents	Permanent
OSHA 300 & 301 Log, Privacy Case List & Annual Summary (Per OSHA)	5 Years

SECTION: 1. 16

SUBJECT: Corporate Compliance

TOPIC: Identity Theft Prevention

POLICY
It is the policy of the agency to prevent the intentional or inadvertent misuse of individuals' names, identities, identifying information, medical records and program records. The agency will report criminal activity relating to identity theft and theft of services to appropriate authorities and will take steps to correct and/or prevent further harm to any person whose name or other identifying information is used unlawfully or inappropriately.

VALUES
Integrity, Quality

I. Signs of Possible Identity Theft (Identification of Red Flags)

Agency staff will identify instances of possible identity theft by being alert to the following common red flags:

1. **Suspicious Documents**. Paperwork presented by the individual or family/advocate can have signs of identity theft. Examples of red flags involving documents include:

   A. Identification documents that look like they have been altered or forged.

   B. The individual or family/advocate present copies of official documents without the original document being available for review (e.g. copies of Medicaid cards or birth certificates).

   C. The person presenting the identification doesn't look like the photo or match the physical description on the documents; for example, the person's Medicaid card or other photo or description does not match the individual.

   D. Information on the identification document differs from what the person presenting the identification is telling you and doesn't match other information presented or on file with the Agency.

   E. An individual presents an application or other document that appears to have been altered, forged or torn up and reassembled.

2. **Suspicious Personal Identifying Information.** Identity thieves may use personally identifying information that appears to be false. Among the red flags involving identifying information are:

Identity Theft Prevention, cont.

2. Suspicious Personal Identifying Information, cont.

A. Inconsistencies with other information already on file regarding the individual (known false names / addresses / telephone number / social security numbers, etc.); or the same information provided by multiple individuals.

B. Inconsistencies in the information the individual or family/advocate has given you. For example, the name, social security number, Medicaid information, etc. differs from the information previously provided by the individual.

C. An individual or family/advocate who omits personally identifying information from a form he or she is asked to complete, and / or does not respond to notices that the forms are incomplete.

D. A person who cannot provide authenticating information beyond what is generally available in a wallet.

3. Suspicious Activity. Red Flags may arise in the course of the use of the personally identifying information. Some of the more common examples are:

A. A long-dormant account is suddenly reactivated with no reasonable explanation.

B. Mail sent to the individual is returned repeatedly as undeliverable although the account continues to be used.

C. Mail is received by the individual concerning accounts he/she did not open or would have no cause to open (e.g. individual receiving residential services receives a gas or electric bill).

D. The agency receives information that unauthorized users are using the account, there are unauthorized charges, documents are not being received by the individual, or the agency is notified by the individual or family/advocate that identity theft has occurred.

E. Family members / friends call the individual by a name different than that provided by the individual at intake.

Identity Theft Prevention, cont.

II. Procedures to Detect Red Flags

1. Individuals Requesting Services from the Agency.

A. During the intake process, the agency must make reasonable efforts to verify the identity of new individuals, including but not limited to confirming the name, address, telephone number, private insurance number, Social Security number, Medicaid identification number, etc.

B. Depending on the circumstances, the agency can confirm the individual's identity by examining original forms of identification documents such as the individual's birth certificate, drivers' license, passport, or other documents.

C. Information can be accessed from other sources, such as the Social Security Death Index, (http://ssdi.rootsweb.ancestry.com/) reports from law enforcement or credit agencies, etc., if necessary.

2. Individuals in Receipt of Agency Services.

During the course of providing services to individuals, the agency will make reasonable efforts to investigate suspicious accounts that are opened in the name of an individual served or unexplained activity on legitimate accounts.

III. Prevention and Mitigation of Identity Theft.

If Agency staff suspect or detect identity theft, staff will make reasonable efforts to respond. Some of the responses may include the following:

A. "Flagging" the account and monitoring the account for future use.
B. Contacting the individual or family/advocate.
C. Changing passwords, security codes, or other ways that the individual's account may be accessed.
D. Closing the account.
E. Reopening the account with the correct information.
F. Notifying law enforcement, and / or the Medicaid Inspector General.
G. Notifying the Developmental Disabilities Regional Office (DDRO).
H. Stopping the intake process and requiring the individual or family/advocate to provide additional satisfactory information to verify identity.
I. Correcting inaccurate information contained in an individual's record, and notifying other area MR/DD and other service providers, only after receipt of the completed FTC Identity Theft Affidavit.
J. If the agency has determined that they have suffered a financial loss, due to the identity theft, the agency may consider appropriate legal action.

Identity Theft Prevention, cont.

IV. Procedures.

1. When Identity Theft is Alleged

A. Flag the account as suspected identity theft-related, so that staff know that the record may contain inaccurate information.

B. Advise and assist the victim to report identify theft to law enforcement.

C. Complete and send the victim the FTC Identity Theft Letter (Attachment B) and assist the victim in completing the FTC Identity Theft Affidavit (Attachment C).

2. When Identity Theft is Reasonably Suspected or Known to have Occurred.

A. Complete the Identity Theft Reporting Form (Attachment D); provide copies to the Corporate Compliance Officer.

B. Place the individual's account on hold pending the outcome of an investigation.

C. The Compliance Officer will determine the nature and extent of investigation and reporting based upon the facts and circumstances of the matter.

D. The agency may notify an unknowing victim of identity theft and provide them with a copy of the FTC Identity Theft Affidavit.

E. Correct the individual's entire record and billing records as appropriate after receipt of the completed FTC Identity Theft Affidavit.

F. The HIPAA Privacy Officer must determine whether, as a result of identity theft, protected health information (PHI) was inappropriately disclosed. If PHI was improperly disclosed, the Privacy Officer must account for such disclosure in accordance with our policy for Accounting for Disclosures.

G. If the identity theft incident involves unauthorized access of unencrypted computerized data containing an individual's name (or other identifier) and (1) a social security number, (2) driver's license number, or (3) financial account number (including a credit or debit card number) in combination with any required security code, access code or password that would permit access to an individual's financial account, the Compliance Officer will direct a report to be made to the appropriate State Agencies and provide notification to any individuals affected in accordance with NY State's Security Breach Notification Act (General Business Law §899-aa).

Identity Theft Prevention, cont.

V. **Program Administration**.

1. The Agency will provide training on the Identity Theft Prevention Program to appropriate staff, volunteers, vendors and business associates.

2. The Corporate Compliance Officer will monitor, oversee and evaluate the Identity Theft Prevention Program. He/she will also inform the Corporate Compliance Committee of any situations of suspected identity theft.

3. The agency will follow the same protocol for investigation of suspected identity theft as outlined in the Internal Investigations Policy and Procedure.

DATE: 2/8/10
REVIEWED/REVISED: 11/17/11, 9/20/12, 11/14/13. 10/9/14
REGULATORY REFERENCE: 625.2 (2) (h) for community: for certified sites 624.4(c)(5)

SECTION: 1.17

SUBJECT: Corporate Compliance

TOPIC: Overpayments & Self-Disclosure

POLICY
Ontario ARC works to continuously support our reputation as a reliable and trustworthy organization. The agency actively seeks to identify situations in which the agency may have received overpayment for services delivered. Ontario ARC will report and repay any confirmed case of overpayment to the appropriate authorities, as required by law.

An overpayment is defined under PPACA as "any funds that a person receives or retains under title XVIII (Medicare) or title XIX (Medicaid) to which the person, after applicable reconciliation, is not entitled under such title". Overpayments include, but are not limited to findings of incorrect coding, insufficient or lack of documentation to support billed services; lack of medical necessity, or duplicate payment.

An overpayment must be reported and returned within 60 days after the date on which the overpayment was identified or the date any corresponding cost report is due, whichever is later. Overpayments retained beyond the applicable 60 day period can result in the imposition of triple damages and monetary penalties under the False Claims Act if there is a knowing and improper failure to return the overpayment**.**

VALUES
Integrity, Commitment

PROCEDURE

Person(s)	**Responsibility**
Corporate Compliance Officer (CCO)	Reviews all reported compliance concerns received directly by the CCO, via the Compliance Hotline, internal audits, external audits, voluntary disclosures by employees or vendors, investigations by certifying or governmental authorities and by any other means. Refer to Policy 1.10, Internal Investigations. <u>Medicaid</u>. In the case of a Medicaid overpayment, evaluates the appropriate course of action, considering any self disclosure guidance issued by the OMIG including the following factors: the exact issue, the amount of money involved, whether the error resulted from a systemic issue and whether the overpayment is attributable to intentional misconduct.

PROCEDURE **Person(s)**	**Responsibility**
Corporate Compliance Officer (CCO)	Consults with NYSARC and/or outside counsel regarding the sampling method for an internal "look back" audit of comparable and/or related claims for a period of time. Seeks OMIG approval of the statistical sampling for the "look back" audit. Self disclosure. If it is determined that a self disclosure is necessary, compiles the claim information and drafts an explanation of self-disclosure> Forwards both to NYSARC state office compliance staff . Determines if the agency or legal counsel will submit the final self disclosure to OMIG. Upon recommendation of outside counsel and NYSARC counsel, determines if self-disclosure to state or federal regulatory agencies (i.e. Office of Medicaid Inspector General, Office of Inspector General, Medicaid Fraud Control Unit) is warranted. Submits written report and explanation of overpayment to the appropriate state and/or federal regulatory or prosecutorial agencies, after review and approval by outside counsel and NYSARC counsel. Ensures corrective action identified in the internal investigation process is completed and reported to the Corporate Compliance Committee and Board of Directors. Coordinates method of repayment of the overpayment with the appropriate state and/or federal regulatory or prosecutorial agencies. Ensures report is made by the later of the date which is 60 calendar days after the date in which the overpayment was identified or the date any corresponding cost report is due, whichever is later.

SECTION: 1.18.

SUBJECT: Corporate Compliance

TOPIC: Missing Money

POLICY
Ontario ARC is responsible to safeguard the funds of the individuals we serve and the agency's resources. We will thoroughly investigate any report of missing money, in which agency staff were responsible for securement of cash or equivalent (gift cards, checks). In each situation, the individual will be reimbursed for the total amount of missing money.

VALUES
Respect, Integrity

PROCEDURE

Person(s)	Responsibility
	<u>$15.00 & Under</u>
All Staff	Reports missing money to direct supervisor.
Direct Supervisor	Reports to the Program Director.
Program Director	Reports to the Compliance and Records Coordinator.
Compliance and Records Coordinator	Maintains a log of missing money, to identify trends. Directs program staff to submit for agency reimbursement of missing funds. Informs the Quality Assurance Director within the next business day. Note: In the event that there are multiple incidents of missing money of $15.00 or less at the same site, the account investigation process outlined below will be implemented.
Compliance and Records Coordinator or Designee	<u>$15.01-$100.00</u> In addition to procedure above, informs the Corporate Compliance Officer, within the next business day. Reviews the account ledger and circumstances with the responsible program staff. Determines possible cause for missing money. Makes recommendations regarding additional money safeguards or staff re-training. Conducts internal account investigation and provides a written summary to the Quality Assurance Director and Corporate Compliance Officer.

1.18 Missing Money, cont.

PROCEDURE

Person(s)	Responsibility
Program Director	Instructs site staff to complete a Minor Notable Occurrence Report regarding the missing money.
Quality Assurance Director and Corporate Compliance Officer	<u>$15.01-$100.00</u> Inform the Executive Director. Determine who will contact local law enforcement to report missing funds.
	<u>$100.01 and Over</u> Same procedure as above, except the Compliance and Records Coordinator immediately informs the Quality Assurance Director and Corporate Compliance Officer.
Program Director	Instructs site staff to complete a Serious Notable Occurrence Report regarding the missing money.

REFERENCE: ADM 6/13/12, Reporting Suspected Theft of Personal Property and/or Financial Exploitation

DATE: 6/13/11
REVIEW/REVISION: 12/20/12, 12/12/13, 1/9/14, 11/13/14, 10/8/15

SECTION: 1.19

SUBJECT: Corporate Compliance

TOPIC: Suspected Theft of Personal Property

POLICY
Ontario ARC is responsible to safeguard the funds of the individuals we support and their resources. We will thoroughly investigate any report of missing items, in which agency staff were responsible for securement of the individual's personal items. In each situation, the individual will be reimbursed for the total value of the missing item(s).

VALUES
Respect, Integrity

PROCEDURE

Person(s)	Responsibility
All Staff	Report suspected theft to supervisor.
Direct Supervisor	Reports to the Program Director.
Program Director	Reports to the Director, Quality Assurance.
Director, Quality Assurance	Items Estimated Value: Less Than $15.00, requests an email describing the item and summarizing how the item was identified as missing and any other relevant information. Maintains of log of missing items under $15.00. Instructs site staff to complete an Incident Report (OPWDD 147) regarding the suspected theft: Items Estimated Value: $15.00-$100.00, complete a Minor Notable Incident Report. Items Estimated Value: Over-$100.00, complete a Serious Notable Incident Report.
Director, Quality Assurance	Notifies Sr. Associate Executive Director and Executive Director. Assigns agency investigator to thoroughly examine situation.
Corporate Compliance Officer (Sr. Associate Executive Director)	Determines who will contact local law enforcement to report suspicion of theft. (Does not initiate internal investigation if law enforcement indicates they will be investigating).
Agency Investigator	Conducts internal investigation, if law enforcement not investigating, and provides a written summary to the Quality Assurance Director and Corporate Compliance Officer.

REFERENCE: ADM 6/13/12, Reporting Suspected Theft of Personal Property and/or Financial Exploitation

DATE: 12/20/12
REVIEW/REVISION: 12/12/13, 11/5/14, 11/12/15

SECTION: 1.20

SUBJECT: Corporate Compliance

TOPIC: Grievances

POLICY
It is the policy of Ontario ARC to not discriminate on the basis of race, color, national origin, sex, age or disability. Ontario ARC has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by the Affordable Care Act.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for Ontario ARC to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

VALUES
Integrity, Commitment, Quality

PROCEDURE

Person(s)	Responsibility
Individual Supported, their Family/Advocate or Staff	Must submit to the agency Grievance Coordinator within 60 days of the date the person filing the grievance becomes aware of the alleged discriminatory action. Submits the complaint in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought. If the person is unable to submit the complaint in writing, he/she requests assistance from the Grievance Coordinator, to write their complaint.
Grievance Coordinator (Senior Associate Executive Director)	Conducts an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. Maintains files and records relating to such grievances. To the extent possible, and in accordance with applicable law, takes appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.

Person(s)	Responsibility
	Issues a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.
Person filing the Grievance	May appeal the decision of the Grievance Coordinator by writing to the Ontario ARC Executive Director and Board of Directors within 15 days of receiving the Grievance Coordinator's decision.
Executive Director/Board of Directors	Issues a written decision in response to the appeal no later than 30 days after its filing.

Other Grievance Options

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights.

A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination.

Translation Requirements

Ontario ARC will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. Ontario ARC is registered to use the OPWDD translation services. The Grievance Coordinator is responsible for such arrangements.

DATE: 10/13/16

REVISION/REVIEW:

APPENDIXES

Service Audit Tools

1. Behavioral Support Plan/Functional Behavioral Assessment (BSP/FBA)
2. Broker
3. Community Habilitation
4. Day Habilitation Kaleidoscope
5. Day Hab
6. Family Care
7. Medicaid Service Coordination
8. Nursing Audit Tool – Day Services
9. Nursing Audit Tool – Residential
10. Pathway to Employment
11. Plan of Care Support Services (PCSS)
12. Pre-Vocational
13. Quality
14. Residential Habilitation
15. Respite
16. SEMP ACCES-VR
17. SEMP Waiver
18. Transportation

Financial Audit Tools

16. Grocery Fund
17. Personal Allowance- Day Services
18. Personal Allowance- Residential
19. Personal Allowance with Special Personal Allowance
20. Personal Allowance – Supervised Apartments
22. Petty Cash – Day Services
23. Petty Cash – Residential
24. Recreation Program

Behavior Support Plans Mental Health Montioring Plan		Functional Behavior Analysis	
1. Completed/Reviewed every 6 months		1. Identifies the challenging behavior in observable, measurable terms	
2. All sections complete		2. Identifies antecedents for behavior	
3. Developed on the basis of the FBA target behaviors		3. Factors that may create or contribute to the behavior ie: cognitive, environ, social, physical, med, psychiatric	
4. Concrete description of challenging behaviors		4. Identifies the purpose or reason for the behavior	
5. includes least restrictive methods possible (meds used for behavior are considered restrictive/intrusive)		5. Identifies why the behavior continues	
6. Include a hierarchy of interventions, strategies and supports- preferred method positive approaches		6. Incl an eval about envir or social changes that may reduce/elim behavior	
5. Teaching alternate skills/replacement beh		7. Include an eval of preferred reinforcers.	
6. Data collection/tracking system		8. Multiple sources of data; ie direct observ, discussion, review records	
7. Tracking frequency met		9. Based on current actions and not just history of behaviors	
8. Tracked Data Reviewed		10. Baseline behaviors with details ie: freq, duration, intensity, setting, activities, people, time of day etc	
9. Observable/ measurable goals			
10. Informed Consent for med/signed by guardian/self when applicable			
11. HRC approval if rights limitations			
12. Residential consent to be done annually			
13. Fading plan in place if indicated			
13. Justification for services to be delivered			
14. Rev effect of interventions- semi annual			
15. Reviewed and acknowledged by staff			
16. Staff trained on usage of plan			
17. Signed consent for BSP			

Key: y- yes n- no x- not applicable

Comments:

BROKER ISP/SPR		LCED		Case Notes		MSC OMIG		Broker Documentation		required elements for team planning meetings	
1. Individual's Legal Name		1. Individual's name		1. Individual's Legal Name		1. Individual's Legal Name		Name & Medicaid number		Individual's name	
2. MSC Listed in ISP- State Plan Section		2. Medicaid #		2. Provider Agency		2. LCED annual redetermination present in file.		Name of Support broker		Name of Support Broker	
3. Medicaid #		3. Identification Developmental Disability		3. Type of Service Specified= MSC		3. Documentation of Service in the file.		category of waiver service		Category of waiver service	
4. ISP Review Date Listed		4. Annual Re-determination, may be signed by QIDP		4. Description of Activities Provided		4. Service performed by qualified MSC staff.		description of service		Identificatoin of Attendees	
5. ISP Effective Date Listed, Broker effective date		5. No lapses in LCED Effective Dates-Authorizing Signature Date		5. Specify Face-to-Face or Other Contact		5. Medicaid Service Coordination Agreement in file.		start and stop time		Description of discussion and results	
6. Individual's Signature Or "Unable to Sign"		6. LCED Signed w/in 365 Days		6. Specify Location, if Face-to Face		6. Initial ISP Completed in 60 day timeframe.		date the service was provided		meeting date	
7. MSC Name, Title & Signature on ISP		7. Initial LCED w/ physician sign & Physical, Psych eval & Soc Work history		7. Health & Safety Issues- Must specify, Yes or No, explain if Yes		7. Individualized Service Plan in file.		signature of broker		signature of the Support Broker	
8. MSC Signature w/in 45 Days of Review		**Best Practices**		8. Satisfaction with service		8. Caseload does not exceed caseload requirements.		Date the doc was signed by the Support Broker		Date the doc was signed by the Support Broker	
9. ISP Distribution Confirmation		1. Most recent Table of contents		9. Follow up taken		9. MSC note contains all required elements.		**Required elements for the Support Broker Agreement**			
10. ISP Distributed w/in 60 Days of Review		2.. SPR filed per the Table of Contents		10. Life changes noted		10. MSC note contemporaneous.		Individual's name			
11. ISP Reviewed 2x in 365 days		3.SPR has been purged		11. Contacts w/ Collaterals is 2-Way Communication		11. ISP contains all required elements.		Name of Support Broker			
12. Hab Plans & Safeguard/IPOP attached		**ISP (continued)**		12. Minimum- 1 List A Service/Month		12.ISP review present twice annually.		Name of the agency the Broker works for or if independent			
13. Liability for services notice		18. frequency (hourly)		13. Minimum- 2 List B Services/Month		13.ISP distributed in 45 day timeframe.		Description of expected responsibilities			
14. Privacy Practices notice (only if MSC is the only OARC service)		19. Duration (ongoing)		14. Name/Title & Signature of MSC		14. Meet minimum requirements for service meetings annually.		signature of the Support Broker			
15. MSC agreement is in the file				15. Date Note Written		15. Deliver and Document required service activity for billing.		Date the doc was signed by the Support Broker			
16. Billing for meetings, form, times billed				**Trainings (checked once annually)**		16. Face to face planning meetings x4 annually		Individual or designee's signature & date signed			
17. Identification of the Fiscal Intermediary or Broker agency		**Credentials (check once annually)**		1. 12 hours annually							
Broker		1. Minimum Bachelors & 1 year experience as MSC or relevant Masters		2. Broker trainings							

Key: y- yes n- no x- not applicable

PCP- Person Centered Planning

Comments:

updated 3/24/16

Comm Hab ISP/SPR & Hab Plan				Comm Hab Checklist		Comm Hab OMIG	
	ISP/SPR		Hab Plan				
1. Individual's name		1. Individual's name		1. Individual's name		1. Individual's Record is present.	
2. Medicaid #		2. Medicaid #		2. Medicaid #		2. Documentation of Service in the file.	
3. Provider Agency		3. Provider Agency		3. Identification of category of waiver serivce provided		3. Diagnosis of Developmental Disability in file.	
4. Type of Habilitation Service		4. Type of Habilitation Service		4. A description of the individualized service provided		4. Individualized Service Plan in file.	
5. Frequency correctly documented		5. Date the Habilitation Plan was reviewed		5. Documentation of start and stop times		5.Authorized Hab Service Provider identified in the ISP	
6. Duration correctly documented		6. Valued outcomes clearly linked		6. Documentation of staff to individual ratio		6. Habilitation Plan present in record.	
7. Effective date		7. Safeguards		7. Individual's response to service		7. Hab Plan contains all required elements	
8. Signature of the ISP author		8. Signature and title of Author		8. The date the service was provided.		8. Hab Plan reviewed twice annually.	
9. MSC supervisor signature		9. Supervisor signature OARC		9.Primary service location included.		9. Initial Hab Plan written within 60 days.	
10. Reviewed twice annually		10. Reviewed annually and semi-annually		10. Verification of sservices by staff person delivering the service.		10. Hab Service Documentation contains all required elements.	
11. Liability for Services letter				11. Services documented contemporaneously. Check 10 per sheet minimum.		11. Monthly summary present.	
12. LCED				12. Daily Activity Sheets saved in 5 days - printed by months end OARC		12. Proper number of CH Service increments billed (time)	
13. Privacy Notice Letter				13. Monthly Summary completed 30 days after month end OARC		13. Correct staff to individual ratio	
		Best Practices		14. Monthly summary reviewed by QIDP		14. Services delivered by authorized CH provider.	
		Family/individual signed for date of service.				15. Billing by CH elgible provider	
		Handwritten billing entries verified with Therap					

Key: y- yes n- no x- not applicable

Comments:

updated 3/24/16

Day Hab Kaleidoscope ISP/SPR & Hab Plan				Day Hab Checklist		Day Hab OMIG	
ISP/SPR		**Hab Plan**					
1. Individual's name		1. Individual's name		1. Individual's name		1.Individual's Record is present.	
2. Medicaid #		2. Medicaid #		2. Medicaid #		2. Documentation of Service in the file.	
3. Provider Agency		3. Provider Agency		3. Identification of category of waiver serivce provided		3. Diagnosis of Developmental Disability in file.	
4. Type of Habilitation Service		4. Type of Habilitation Service		4. A description of the individualized service provided		4. Authorized Hab Services Provider identified in the ISP	
5. Frequency correctly documented		5. Date the Habilitation Plan was reviewed		5. Service duration requirement met.		5. Individualized Service Plan on file	
6. Duration correctly documented		6. Valued outcomes clearly linked		6. Individual's response to the service		6. Day Habilitation Plan on file	
7. Effective date		7. Description of Services and Supports		7. Date the service was provided		7. Habilitation Plan written within 60 days of start of service	
8. Signature of the ISP author		8. Safeguards		8. Service Location		8. Hab Plan reviewed twice annually	
9. MSC supervisor signature		9. Signature and title of Author		9. Verification of service by staff person delivering and documenting service		9. Hab Plan contains all required elements	
10. Reviewed twice annually		10. Supervisor signature OARC		10. Services documented contemporaneously. Check 10 per sheet minimum.		10. Day Habilitation Service Present	
11. Liability of Service		11. Reviewed annually and semi-annually		11. Daily Activity Sheets saved in 5 days		11. Hab Service Documentation in record	
12. LCED		12. Sent to MSC within 30 days of review or significant change		12. Monthly Summary completed 30 days after month end OARC		12.Hab Service Documentation contains all required elements. Individual	
13. Privacy Notice Letter		13. Frequency Met				13.Hab Service Documentation contains all required elements.Group	
Kaleidoscope				**Best Practices continued**		14. Service Times checked on Therap - at least 10	
		Best Practices		7. SPR purged		15. Hab Monthly Summary by the end of the next month	
		1. Correct number of weekly notes		8. Waiver service plans document required fire safety safeguards as applicable.		16. Billing only for reimbursable time Individual	
		2. Diet order matches related documents		9. Hard copies of current plan and Therap checklists are available for emergency purposes.		17. Billing only for reimbursable time Group	
		3. Important information in Tlogs is noted in the monthly summary.		10. Meeting sign in sheet stored in Therap Document Warehouse		18. Proper billing incremements Individual	
		4. Dining Card matches the orders		11. Handwritten entries verified in Therap		19. Correct Rate Code Group N//A	
		5. Adaptive equipment in place				20. Billing by Eligible Provider/Employee	
		6. Table of contents current and documents filed accordingly.				21. Met duration requirements for services	

Key: y- yes n- no x- not applicable

Comments:

updated 3/24/16

Day Hab ISP/SPR & Hab Plan				Day Hab Checklist		Day Hab OMIG	
ISP/SPR		**Hab Plan**					
1. Individual's name		1. Individual's name		1. Individual's name		1.Individual's Record is present.	
2. Medicaid #		2. Medicaid #		2. Medicaid #		2. Documentation of Service in the file.	
3. Provider Agency		3. Provider Agency		3. Identification of category of waiver serivce provided		3. Diagnosis of Developmental Disability in file.	
4. Type of Habilitation Service		4. Type of Habilitation Service		4. A description of the individualized service provided		4. Authorized Hab Services Provider identified in the ISP	
5. Frequency correctly documented		5. Date the Habilitation Plan was reviewed		5. Service duration requirement met.		5. Individualized Service Plan on file	
6. Duration correctly documented		6. Valued outcomes clearly linked		6. Individual's response to the service		6. Day Habilitation Plan on file	
7. Effective date		7. Description of Services and Supports		7. Date the service was provided		7. Habilitation Plan written within 60 days of start of service	
8. Signature of the ISP author		8. Safeguards		8. Service Location		8. Hab Plan reviewed twice annually	
9. MSC supervisor signature		9. Signature and title of Author		9. Verification of service by staff person delivering and documenting service		9. Hab Plan contains all required elements	
10. Reviewed twice annually		10. Supervisor signature OARC		10. Services documented contemporaneously. Check 10 per sheet minimum.		10. Day Habilitation Service Present	
11. Liability of Service		11. Reviewed annually and semi-annually		11. Daily Activity Sheets saved in 5 days		11. Hab Service Documentation in record	
12. LCED		12. Sent to MSC within 30 days of review or significant change		12. Monthly Summary completed 30 days after month end OARC		12.Hab Service Documentation contains all required elements. Individual	
13. Privacy Notice Letter		13. Frequency Met				13.Hab Service Documentation contains all required elements.Group	
				Best Practices continued		14. Service Times checked on Therap - at least 10	
Site Review		**Best Practices**		7. SPR purged		15. Hab Monthly Summary by the end of the next month	
1. OPWDD cutting board		1. Correct number of weekly notes		8. Waiver service plans document required fire safety safeguards as applicable.		16. Billing only for reimbursable time Individual	
2. Right food, right consistency		2. Diet order matches related documents		9. Hard copies of current plan and Therap checklists are available for emergency purposes.		17. Billing only for reimbursable time Group	
3. Fire Drill records up to date		3. Important information in Tlogs is noted in the monthly summary.		10. Meeting sign in sheet stored in Therap Document Warehouse		18. Proper billing incremements Individual	
4. Fire evac plan matches the safeguards		4. Dining Card matches the orders		11. Handwritten entries verified in Therap		19. Correct Rate Code Group N//A	
5. Fire Drill times vary		5. Adaptive equipment in place				20. Billing by Eligible Provider/Employee	
Site Visit:		6. Table of contents current and documents filed accordingly.				21. Met duration requirements for services	

Key: y- yes n- no x- not applicable

Comments:

Family Care Res Hab ISP/SPR & Hab Plan				Res Hab Checklist		Res Hab OMIG	
	ISP/SPR		Hab Plan				
1. Individual's name		1. Individual's name		1. Individual's name		1. Individual's Record is present.	
2. Medicaid #		2. Medicaid #		2. Medicaid #		2. Documentation of Service in the file.	
3. Provider Agency		3. Provider Agency		3. Identification of category of waiver serivce provided		3. Diagnosis of Developmental Disability in file.	
4. Type of Habilitation Service		4. Type of Habilitation Service		4. A description of the individualized service provided		4. Individualized Service Plan in file.	
5. Frequency correctly documented		5. Date the Habilitation Plan was reviewed		5. Primary service location		5.Authorized Hab Service Provider identified in the ISP	
6. Duration correctly documented		6. Valued outcomes clearly linked		6. Date the service was provided		6. Habilitation Plan present in record.	
7. Effective date		7. IPOP/Health & Safety needs form		7. Verification of service by the FCP delivering and documenting the service		7. Hab Plan contains all required elements	
8. Signature of the ISP author		8. Signature and title of Author		8. Monthly summary by the end of the next month		8. Hab Service Documentation present	
9. MSC supervisor signature		9. Supervisor signature OARC		9.Month and year summary date		9. Hab Service Documentation contains all required elements.	
10. Reviewed twice annually		10. Reviewed annually and semi-annually		10 Summary includes person's response, issues and/or concerns		10. Billing for authorized Family Care Res Hab services	
11. Liability for Services letter		11. Frequency met		11. Signature, date & year		11. Hab Monthly Summary by the end of the next month	
12. LCED						12. Residential Hab Plan review present and reviewed twice annually	
13. Privacy Notice Letter							

Key: y- yes n- no x- not applicable

Comments:

updated 3/24/16

Medicaid Service Coordination ISP/SPR		LCED		Case Notes		MSC OMIG	
1. Individual's Legal Name		1. Individual's name		1. Individual's Legal Name		1. Individual's Legal Name	
2. MSC Listed in ISP- State Plan Section		2. Medicaid #		2. Provider Agency		2. LCED annual redetermination present in file.	
3. Medicaid #		3. Identification Developmental Disability		3. Type of Service Specified= MSC		3. Documentation of Service in the file.	
4. ISP Review Date Listed		4. Annual Re-determination, may be signed by QIDP		4. Description of Activities Provided		4. Service performed by qualified MSC staff.	
5. ISP Effective Date Listed		5. No lapses in LCED Effective Dates- Authorizing Signature Date		5. Specify Face-to-Face or Other Contact		5. Medicaid Service Coordination Agreement in file.	
6. Individual's Signature Or "Unable to Sign"		6. LCED Signed w/in 365 Days		6. Specify Location, if Face-to Face		6. Initial ISP Completed in 60 day timeframe.	
7. MSC Name, Title & Signature on ISP		7. Initial LCED w/ physician sign & Physical, Psych eval & Soc Work history		7. Health & Safety Issues- Must specify, Yes or No, explain if Yes		7. Individualized Service Plan in file.	
8. MSC Signature w/in 45 Days of Review		**Best Practices**		8. Satisfaction with service		8. Caseload does not exceed caseload requirements.	
9. ISP Distribution Confirmation		1. Most recent Table of contents		9. Follow up taken		9. MSC note contains all required elements.	
10. ISP Distributed w/in 60 Days of Review		2.. SPR filed per the Table of Contents		10. Life changes noted		10. MSC note contemporaneous.	
11. ISP Reviewed 2x in 365 days		3.SPR has been purged		11. Contacts w/ Collaterals is 2-Way Communication		11. ISP contains all required elements.	
12. Hab Plans & Safeguard/IPOP attached		**Trainings (checked once annually)**		12. Minimum- 1 List A Service/Month		12.ISP review present twice annually.	
13. Liability for services notice		1. 15 hrs- 1st 3 years		13. Minimum- 2 List B Services/Month		13.ISP distributed in 45 day timeframe.	
14. Privacy Practices notice (only if MSC is the only OARC service)		2. 10 hrs after 3 years unless Willowbrook class members on caseload		14. Name/Title & Signature of MSC		14. Meet minimum requirements for service meetings annually.	
15. MSC agreement is in the file		3. Core training within the 1st 6 months		15. Date Note Written		15. Deliver and Document required service activity for billing.	
16. Billing for meetings, form, times billed		**Credentials (check once annually)**		16. Signed by MSC by 15th, Following Month		16. Met required face to face meeting for in-home visit.	
17. Signature page for Face to face visits		1. Minimum Bachelors & 1 year experience as MSC or relevant Masters		17. Met Annual Visit Requirement: 3 Face to Face and 1 Home Visit		**Medicaid Service Coordination**	

Key: y- yes n- no x- not applicable

Comments:

updated 3/24/16

Nursing Services Day program					
Medication		**Medication (continued)**		**Policies & Protocols**	
1. Keys, med room, cupboard secured		1. PRN med effectiveness documented		1. Annual med admin certifications up to date	
2. Control sub & syringes double locked		2. Med error/discrepancies documented.		2. Annual injection admin certs current when applicable	
3. Meds available for use in original cont.		3. Med disposal sheets complete		3. G tube certs if applicable	
4. Clear, legible labels		4. RN checks control meds monthly		4. Helmet protocol	
5. Expiration dates current		**Best Practices**		5. Seizure protocols in place per MD orders	
6. No DC'd meds unless for future use		1. Signature/Initials key in the MAR		6. Diabetic protocols in place per MD orders	
7. Change of direction labels		2. Allergies on the MAR match related documents		7. Dx Hypertension- protocol in place	
8. Internal and external meds separate		3. AED checklist		8. Head Injury Protocol baseline form present	
9. Fridge meds secured separately				9. Annual physical	
10. Complete MAR for each person				10. Self- medication administration annually	
11. Complete med info sheet for each med				11. Diet order current	
12. Meds have current scripts/orders in the MAR book				12. Syringes in a tamper resistant container	
13. Med orders are clear and easy to understand					
14. PRN meds are on hand		**Visit Date:**			
15. Med order matches MAR					

Key: y- yes n- no x- not applicable

Comments:

Nursing Services- Residential					
Medication Standards		**Med Standards continued**		**Policies and Protocols**	
1. Meds have prescriptions		22. PRN bowel meds given per orders		1. Syringes in a tamper resistant container	
2. Meds are available for use		23. PRN/tracking sheets clear & complete		2. Annual med admin recertifications current & readily available	
3. Complete med information sheet for each		24. Bowel regime reviewed by the RN weekly		3. Annual injection admin certifications current	
4.Medications is stored in original containers		24. MARs stored for 7 years	x	4.Float policy med rev forms when indicated	
5. All meds have clear and legible labels		**Consults**		5. Helmet protocol	
6. Meds are current with expirations dates		1. Medication regime reviewed bi-annually		6. Bedrails safety checked by RN & PT	
7.No dc'd meds unless for future use		2. Self- medication administration annually		7.Monitors checked	
8. Meds secured; control &syringes double locked		3. annual physical		8. Nursing plans of service in place	
9. refrigerated meds secured separately		4. Tardive Dyskinesia assess bi-annually		9. Protocols complete	
10. change of direction labels when applicable		5.PPD evaluation- intake within one year		10. Dx Hypertension- BP monitored monthly by RN	
11. OTC meds iniitialed		6. Lab work received and filed		11. Seizure protocols in place	
12. Complete MAR for each person		7. Tetanus up to date (T-dap)		12. Diabetic protocols in place	
13.internal and external meds separate		8. Diet order current		13. Head Injury Protocol baseline form present	
14. Med orders clear and easy to understand		9. Special Cares in place		14. Aging screening	
15. current med orders in MAR book		10. Instructions from consults in Special Cares		15. Medical immob/protective stabilization	
16. PRN med effectiveness documented		**Best Practices**		16. MIPS needed in PONS	
17.med error/discrepancies documented		1. Signature/Initials key in the MAR		17. G tube certs if applicable	
18. Controlled substances accounted for		2. Allergies on the MAR match related documents		18. Keys secured	
19. Med disposal sheets complete				19. AED checklist up to date	
20. Med order matches MAR					
21. BM tracking sheets indicated		**Site Visit:**			

Key: y- yes n- no x- not applicable

Comments:

Consults

5. PPD evaluation is for persons newly entering the agency or if a person presents with symptoms

7. Lab work ordered on a consultation sheet needs to reviewed and filed.

Policies and Protocols

4. Float policy is a form available on the web site which should be used when float staff dispense meds.

15. MIPS- Medical immobilization protective stabilization. This included holding someone's arm for a blood draw and/or sedation that may be required to complete the procedure.

Pathway to Employment Career/ Vocational plan				Checklist		OMIG		
	ISP/SPR		Hab Plan					
1. Individual's name		1. Individual's name		1. Individual's name		1.Individual's Record is present.		Time studies -identify jobs
2. Medicaid #		2. Medicaid #		2. Medicaid #		2. Documentation of Service in the file.		
3. Provider Agency		3. Provider Agency		3. Identification of category of waiver serivce provided		3. Diagnosis of Developmental Disability in file.		direct services- Allowable activities
4. Type of Habilitation Service		4. Type of Habilitation Service		4. A description of the individualized service provided		4. Authorized Hab Services Provider identified in the ISP		Indirect services- Observations and assessment of interactions and
5. Frequency correctly documented		5. Date the Habilitation Plan was reviewed		5. Service duration requirement met.		5. Individualized Service Plan on file		routines that could translate into employable skills
6. Duration correctly documented		6. Valued outcomes clearly linked		6. Individual's response to the service		6. Hab Plan on file		development of community exp
7. Effective date		7. Description of Services and Supports		7. Date the service was provided		7. Habilitation Plan contains all required elements		Preparing the plan
8. Signature of the ISP author		8. Safeguards		8. Service Location		8. Hab Plan reviewed twice annually		Limited to 50 houirs per month
9. MSC supervisor signature		9. Signature and title of Author		9. Verification of service by staff person delivering and documenting service		9. Initial Hab Plan written within 60 days		hourly service
10. Reviewed twice annually		10. Supervisor signature OARC		10. Services documented contemporaneously.		10. Hab Plan submitted to MSC within 30 days of review		
11. Liability of Service		11. Reviewed annually and semi-annually		11. Daily Activity Sheets saved in 5 days		11. Hab Service Documentation contains all required elements.		
12. LCED		12. Sent to MSC within 30 days of review or significant change		12. Monthly Summary completed 30 days after month end OARC		12. Response, Implementation & concerns in Monthly Summary		
13. Privacy Notice Letter		13. Handwritten entries verified in Therap		**Best Practices**		13.Hab Service Documentation in record.		
14. Agreement letter- OPWDD &ACCES-VR for Path to Emp, ETP & Prevoc		14. plan development- a report with a summ of interviews, actions steps, career dev activities, vol exp, work exp and rec.		1. Important information in T logs is noted in the monthly summary. Implementation, response, issues, concerns		14.Billing only for reimbursable time (no clinic, etc)		
		15. Start & Stop times		2. Table of contents current and documents filed accordingly.				
		16. ratios						
		17. description for Indirect services- lists all provided						
Pathways to Employment		18. frequency (hourly)						
		19. Duration (time limited- 12 months or 278 hours						

Key: y- yes n- no x- not applicable

Comments:

updated 3/24/16

PLAN OF CARE SUPPORT SERVICES		LCED		Case Notes		MSC OMIG	
1. Individual's Legal Name		1. Individual's name		1. Individual's Legal Name		1. Individual's Legal Name	
2. MSC Listed in ISP- State Plan Section		2. Medicaid #		2. Provider Agency		2. LCED annual redetermination present in file.	
3. Medicaid #		3. Identification Developmental Disability		3. Type of Service Specified= MSC		3. Documentation of Service in the file.	
4. ISP Review Date Listed		4. Annual Re-determination, may be signed by QIDP		4. Description of Activities Provided		4. Service performed by qualified MSC staff.	
5. ISP Effective Date Listed		5. No lapses in LCED Effective Dates = Authorizing Signature Date		5. Specify Face-to-Face or Other Contact		5. Medicaid Service Coordination Agreement in file.	
6. Individual's Signature Or "Unable to Sign"		6. LCED Signed w/in 365 Days		6. Specify Location, if Face-to Face		6. Initial ISP Completed in 60 day timeframe.	
7. MSC Name, Title & Signature on ISP				7. Health & Safety Issues- Must specify, Yes or No, explain if Yes		7. Individualized Service Plan in file.	
8. MSC Signature w/in 45 Days of Review				8. Satisfaction with service		8. Caseload does not exceed caseload requirements.	
9. ISP Distribution Confirmation				9. Follow up taken		9. MSC note contains all required elements.	
10. ISP Distributed w/in 60 Days of Review				10. Life changes noted		10. MSC note contemporaneous.	
11. ISP Reviewed 2x in 365 days				11. Contacts w/ Collaterals is 2-Way Communication		11. ISP contains all required elements.	
12. Hab Plans & Safeguard/IPOP attached				12. Minimum- 1 List A Service/Month		12.ISP review present twice annually.	
13. Liability for services notice				13. Minimum- 2 List B Services/Month		13.ISP distributedin 45 day timeframe.	
14. Privacy Practices notice				14. Name/Title & Signature of MSC		14. Meet minimum requirements for service meetings annually.	
15. Medicaid Provider Agreement in the file				15. Date Note Written		15. Deliver and Document required service activity for billing.	
				16. Signed by MSC by 15th, Following Month		16. Met required face to face meeting for in-home visit.	
				17. Met Annual Visit Requirement: 2 Face to Face/ISP reviews, up to 4 billings per year			

Key: y- yes n- no x- not applicable

Comments:

updated 3/24/16

Pre Vocational Billing	
Type of service Name:	
Month/Year	
In/Out sheet match Therap for daily total	
Hand written In/Out sheets - 2 hours max in a certified setting	
Meets the criteria per the Maximum Day Services Combinations regs	
6 hrs per day max- lives in an IRA	
6 Hours per day max - lives in a non certified setting	
Lunch time is deducted when applicable	
No overlapping service times	
1 service minimum per billing increment	
No overlapping services- ie Ultrafab prevoc and SEMP	
Group Count indicated	
Data entered in Therap compliant	
Transportation included	
Lunch deducted	

Prevoc Site based- ongoing as authorized -day

Prevoc Community based- hour

Key: y- yes n- no x- not applicable

Comments:

Prevoc ISP/SPR & Hab Plan				Prevoc Checklist		Prevoc OMIG		
	ISP/SPR		Hab Plan					
1. Individual's name		1. Individual's name		1. Individual's name		1.Individual's Record is present.		Time studies -identify jobs
2. Medicaid #		2. Medicaid #		2. Medicaid #		2. Documentation of Service in the file.		
3. Provider Agency		3. Provider Agency		3. Identification of category of waiver serivce provided		3. Diagnosis of Developmental Disability in file.		
4. Type of Habilitation Service		4. Type of Habilitation Service		4. A description of the individualized service provided		4. Authorized Hab Services Provider identified in the ISP		
5. Frequency correctly documented		5. Date the Habilitation Plan was reviewed		5. Service duration requirement met.		5. Individualized Service Plan on file		
6. Duration correctly documented		6. Valued outcomes clearly linked		6. Individual's response to the service		6. Prevocational Plan on file		Site based prevoc is daily
7. Effective date		7. Description of Services and Supports		7. Date the service was provided		7. Habilitation Plan contains all required elements		
8. Signature of the ISP author		8. Safeguards		8. Service Location		8. Hab Plan reviewed twice annually		
9. MSC supervisor signature		9. Signature and title of Author		9. Verification of service by staff person delivering and documenting service		9. Initial Hab Plan written within 60 days		
10. Reviewed twice annually		10. Supervisor signature OARC		10. Services documented contemporaneously.		10. Hab Plan submitted to MSC within 30 days of review		
11. Liability of Service		11. Reviewed annually and semi-annually		11. Daily Activity Sheets saved in 5 days		11. Hab Service Documentation contains all required elements.		
12. LCED		12. Sent to MSC within 30 days of review or significant change		12. Monthly Summary completed 30 days after month end OARC		12. Response in Prevoc Monthly Summary		
13. Privacy Notice Letter		13. Frequency Met		**Best Practices**		13.Hab Service Documentation in record.		
14. Agreement letter- OPWDD &ACCES-VR for Path to Emp, ETP & Prevoc		14. Handwritten entries verified in Therap		1. Important information in T logs is noted in the monthly summary.		14. Correct Rate Code billed		
		15. Start & Stop times		2. Table of contents current and documents filed accordingly.		15.Billing only for reimbursable time (no clinic, etc)		
		16. ratios		3. SPR purged		16. Billing by Eligible Provider/Employee		
				4. Location specified for CBPV		17. Monthly summary present		

Key: y- yes n- no x- not applicable

Comments:

Updated 3/24/16

Quality			
Personal Information sheet is present and updated in SPR.		Only one skill focus is documented for each activity in the hab plan.	
SPR Table of Contents are present and updated.		Individuals and family members, guardians and correspondents have been notified of their rights and	
The SPR is filed by SPR Table of Contents		Individuals have been informed of what to do if they have an objection, problem or complaint	
DDP2 is present in SPR		Individuals are afforded their rights and live free from abuse or intimidation	
Hard copies of current plan and checklist are available for emergency purposes.		No rights limitations are occurring without a current clinical justification.	
The Habilitation Plan is based on the person's strengths, choices and needs.		No rights limitations are occurring without a time limit for the restriction or a plan to eliminate the restriction.	
Valued Outcomes show learning, maintaining and practicing skills that lessen their dependence upon others.		Recommendations from last BPC visit are checked and completed.	
Services are individualized and, unless contraindicated by an unreasonable risk of health or safety, based on the individual's interests and choices.		Personal Outcome Measure recommendations follow up	
Individuals spend time in activities which are meaningful to them and which contribute to their home, work and social environment.		Personal Outcome Measures part of the ISP or MSC notes	
Individuals have relationships with people of their choice		Assessments current	
Staff interact with participants in a respectful and supportive manner			
Assessments, evaluations and narrative info in the plan are consistent.			
Personal info sheet, IPOP, safeguards, ISP narrative and/or plans are consistent			
If individuals have assessed food, medication or environmental allergies, corresponding allergy safeguards are documented			
The plan includes or references an addendum that describes health and/or welfare safeguards			

Key: y- yes n- no x- not applicable

Comments:

RES HAB ISP/SPR		Res Hab Plan		Res Hab Checklist		Res Hab OMIG	
1. Individual's name		1. Individual's name		1. Individual's name		1.Individual's Record is present.	
2. Medicaid #		2. Medicaid #		2. Medicaid #		2. Documentation of Service in the file.	
3. Provider Agency		3. Provider Agency		3. Identification of category of waiver service provided		3. Diagnosis of Developmental Disability in file.	
4. Type of Habilitation Service		4. Type of Habilitation Service		4. A description of the individualized service provided		4. Individualized Service Plan in file.	
5. Frequency correctly documented		5. Date the Habilitation Plan was reviewed		5. Individual's response to the service		5.Authorized Hab Service Provider identified in the ISP	
6. Duration correctly documented		6. Valued outcomes clearly linked		6. Date the service was provided		6. Habilitation Plan present in record.	
7. Effective date		7. Description of Services and Supports		7. Service Location		7. Hab Plan contains all required elements	
8. Signature of the ISP author		8. Safeguards		8. Verification of service by staff person delivering and documenting service		8. Hab Service Documentation in record	
9. MSC supervisor signature		9. Signature and title of Author		9. Services documented contemporaneously. Check 10 per sheet minimum.		9. Hab Service Documentation contains all required elements.	
10. Reviewed twice annually		10. Supervisor signature OARC		10. Daily Activity Sheets saved in 5 days OARC		10. Proper number of countable service days for billing Supervised	
11. Liability of Service		11. Reviewed annually and semi-annually		11. Monthly Summary completed 30 days after month end OARC		11. Proper number of countable service days for billing Supportive	
12. LCED		12. Sent to MSC within 30 days of review or significant change		12. QIDP sign Monthly Summary prior to the end of the following month.		12. Not Absent from IRA on countable service day.	
13. Privacy Notice Letter		13. Includes Therapeutic Leave Days statement		**Best Practices**		13. Billing for authorized IRA res hab services	
		14. Frequency met		1. Diet order matches related documents		14. Hab Monthly Summary by the end of the next month	
		Site Review		2. Important information in Tlogs is noted in the monthly summary.		15. Residential Hab Plan review present twice annually	
Site Visit:		1. Fire Equipment up to date and initialed		3. Fire Drill records/information up to date			
Residential Habilitation		2. Diet orders being followed		4. Fire evac plan matches the IPOP		**Documentation**	
		3. Adaptive Equipment in place		5. The IPOP is present and is reviewed at least annually		1. Handwritten entries verified with Therap	
		4. Fire Drill times vary		6. The IPOP is being implemented as specified.		2. Frequencies met	
		5. Residential Key Choice form filed under Miscellaneous		7. Level of Supervision definitions attached to IPOP & safeguards		3. Hard copies of current plan and Therap checklists are available for emergency purposes.	
				8. If independent, protocol for return & what if they don't in the time frame			

Key: y- yes n- no x- not applicable

Comments:

updated 3/24/16

RESPITE - SPR								OMIG			
Initials				Initials				Initials			
1. Individual's name				19. NOD				1. Individual's Record is present.			
2. Medicaid #				20. Rights on file				2. Documentation of Service in the file.			
3. Provider Agency				21. Attendance timesheets signed				3. Diagnosis of Developmental Disability in file.			
4. Type of Habilitation Service				Best Practices				4. Authorized Hab Services Provider identified in the ISP			
5. Frequency correctly documented				1. If individuals have assessed food, medication or environmental allergies, corresponding allergy safeguards are documented				5. Individualized Service Plan on file			
6. Duration correctly documented				2. Diet order matches related documents				6.. Respite Service Present			
7. Effective date				3. Quarterly clinic visit				7. Hab Service Documentation in record			
8. Signature of the ISP author				4. Adaptive equipment in place				8.Hab Service Documentation contains all required elements.			
9. MSC supervisor signature				5. Recommendations from last BPC visit are checked and completed.				9. Service Times in record			
10. Reviewed twice annually								10. Billing by Eligible Provider/Employee			
11. Liability for Services letter								11. Met duration requirements for services			
12. LCED				Children's Recreation				12. Proper billing increments			
13. Privacy Notice Letter				1. Binder book				13. Correct billing code			
14. Respite Documentation record				2. Quarterly clinic visit during actual respite day							
15. Safeguards in place											
16. QIDP observation respite report provider											
17. BSP in SPR											
18. Profile sheet in SPR											

Active Academy **Children's Rec**

Key: y- yes n- no x- not applicable

Comments:

Updated 3/24/16

SEMP Plan/ISP ACCES Non waiver				SEMP - Notes		SEMP-OMIG	
Habilitation plan		**ISP**	**ISP**				
1. Individual's name		1. Individual's name		1. Individual's name		1. Individual's Record is present.	
2. Medicaid #		2. Medicaid #		2. Medicaid #		2. Documentation of Service in the file.	
3. Provider Agency		3. Provider Agency		3. Identification of category of waiver serivce provided		3. Diagnosis of Developmental Disability in file.	
4. Type of Habilitation Service		4. Type of Habilitation Service		4. A description of the individualized service provided		4. Individualized Service Plan in file.	
5. Date the Habilitation Plan was reviewed		5. Frequency correctly documented		5. Consumer's response to the service		5.Authorized Hab Service Provider identified in the ISP	
6. Valued outcomes clearly linked		6. Duration correctly documented		6. Date the service was provided		6. Habilitation Plan present in record.	
7. Description of services and supports		7. Effective date		7. Service Location		7. Hab Plan contains all required elements	
8. Signature of the Hab plan author		8. Signature of the ISP author		8. Verification of service by staff person delivering service		8. Hab Service Documentation in record	
9. Author title		9. MSC supervisor signature		9. Signature of the staff person documenting the service		9. Hab Service Documentation contains all required elements.	
10. Reviewed annually and semi-annually		10. Reviewed twice annually		10. Title of the staff person documenting the service		10. Proper number of countable service days for billing	
		11. Liability of Service		11. Date the note was written - contemporaneously		11. Present on countable service day.	
		12. LCED		12. Correct # of services for employ status{employed=2 face to face; unemployed 2 face to face and 2 add contacts- (not necessarily with the individual i.e. collaterol with potential employer or other provider)		12. Billing for authorized hab services	
		13. Privacy Notice Letter				13. Hab Plan review present twice annually	
		14 sign family/individual for date/time of service					
				Innovations training			

Key: y- yes n- no x- not applicable

Comments:

Updated 3/24/16

SEMP Plan/ISP				SEMP - Notes		SEMP-OMIG		Checklist
Habilitation plan		**ISP**	**ISP**					
1. Individual's name		1. Individual's name		1. Individual's name		1. Individual's Record is present.		1. Individual's name /Medicaid number
2. Medicaid #		2. Medicaid #		2. Medicaid #		2. Documentation of Service in the file.		2. ratio of staff to individual
3. Provider Agency		3. Provider Agency		3. Identification of category of waiver serivce provided		3. Diagnosis of Developmental Disability in file.		3. Identification of category of waiver serivce provided
4. Type of Habilitation Service		4. Type of Habilitation Service		4. A description of the individualized service provided		4. Individualized Service Plan in file.		4. A description of the individualized service provided
5. Date the Habilitation Plan was reviewed		5. Frequency correctly documented		5. Consumer's response to the service		5.Authorized Hab Service Provider identified in the ISP		5. Start/stop times
6. Valued outcomes clearly linked		6. Duration correctly documented "ongoing as Authorized"		6. Date the service was provided		6. Habilitation Plan present in record.		6. Individual's response to the service
7. Description of services and supports		7. Effective date		7. Service Location		7. Hab Plan contains all required elements		7. Date the service was provided
8. Signature of the Hab plan author		8. Signature of the ISP author		8. Verification of service by staff person delivering service		8. Hab Service Documentation in record		8. Service Location
9. Author title		9. MSC supervisor signature		9. Signature of the staff person documenting the service		9. Hab Service Documentation contains all required elements.		9. Verification of service by staff person delivering and documenting service
10. Reviewed annually and semi-annually		10. Reviewed twice annually		10. Title of the staff person documenting the service		10. Hourly billing		10. Services documented contemporaneously. Check 10 per sheet minimum.
SPR		11. Liability of Service		11. Date the note was written - contemporaneously		11. Present on countable service day.		11. Daily Activity Sheets saved in 5 days
1. Earns above minimum wage when hired. (wage salary verification in SPR-Pay stub, payroll rcecord, hiring letter)		12. LCED		12. Monthly Summary completed 30 days after month end		12. Billing for authorized hab services		12. Monthly Summary completed 30 days after month end OARC
2. Documentation about when an individual is initially hired by an employer.		13. Privacy Notice Letter		13. Correct # of services for employ status{employed=2 face to face; unemployed 2 face to face and 2 add contacts- (not necessarily with the individual i.e. collaterol with potential employer or other provider)		13. Hab Monthly Summary by the end of the next month		13. Summary narrative must include implementation of the plan, description of progress, how challenges are being addressed, response & issues or concerns
3. Letter of eligibility for Intensive SEMP services.		Staff Training		14. Family/Individual sign for date/time of service		14. Hab Plan review present twice annually		14. Name of Agency
4. Documentation of OPWDD's approval to bill for Intensive SEMP services		1. 6 hours training annually after 24 hours of training completed.		**Billing**				**Best Practices**
		Innovations training		Extended- maximum 200 hours annually unless additional hours have been authorized.				1. Important information in T logs is noted in the monthly summary.
Transportation				Intensive- Maximum 250 hours annually				2. Table of contents current
1. GPS tracking aligns with documentation				ISP or plan reference group, mobile or enclave employment. Regular billing should be group.		Individual and Group billing not combined		3. SPR purged
				Documentation about approvals for extensions of intensive and Extensive SEMP hours in the file				

Key: y- yes n- no x- not applicable

Updated 3/24/16

Transportation	**Date:**
Driver's initials	
Procedures	**Physicals**
1 License	1 DOT physical prior to hire date
2 Application	2 Physical signed in blue ink
3 FBI & DCJS Fingerprints	3 Biennial physical
4 3 character references (2nd folder)	4 Annual physical
	5 6 month physical
1 Driver's abstract	6 3 month physical
1a Employee driving record- attached to abstract	7 Health History
1b must say "End of Record"	7a If yes, Medical examiner must comment
1c must be within 30 days of abstract	7b Required follow up/considerations
1d no lapses in annual abstracts	7c Related restrictions
2 Defensive Driving Performance	7d Diabetic follow up form
3 Road Test	8 Change in health status (compare previous physical)
4 Written/oral Examination	8a restrictions added
6 File in order by 19-A cover sheet	8b restrictions removed

Key: Y=Yes; N=No; X=N/A;

Comments:

Ontario ARC Grocery Fund Audit

The following houses have grocery fund accounts that need to be audited annually:

Site_____ **Amt.** _____

Does the ledger balance to the cash? **Yes** **No**

Do the ledger/cash balance and outstanding receipts total to this amount? **Yes** **No**
Any discrepancies please note (See Back):

If the ledger/cash and outstanding receipts do not balance to the above balance listed above, then you need to make an adjustment to get the house back on track. You need to ask the manager for a blank requisition and make the adjustment for their next reimbursement.

Supervised Apts. has a grocery fund specifically for the residents. Each resident receives $37.00 a week for grocery shopping. Each resident will have an individual grocery ledger that needs to be audited. When auditing you need to pick one person to verify receipts.

Any discrepancies found? If yes list the resident, date, and a description of error found?

Which resident receipts were verified? _____

Any discrepancies found?

Managers should have a copy of the requisition request for reimbursement that you can reference or you can check with Accounts Payable for any requests they recently received.

Signature of Auditor **Date**

1/30/15

Personal Allowance Audits – Day Services

Site _____

Name	Comments	Receipts Verified	OK to Cash

Are balance verifications being completed bi-monthly by the Hab Specialist or staff Yes No
Are balance verifications being completed at least once a month by Hab Supervisor Yes No
Are balance verifications being completed at least once a month by the Program Manager Yes No

Any math errors found Yes No If yes please list: _____

Were receipts verified Yes No Name and list any discrepancies of $5.00 or more: _____

Receipts are signed by staff Yes No

Are the handling limits on the ledgers Yes No _____

Copy of ledger sent home indicated Yes No

Follow-up indicated Yes No If yes, please specify: _____

Comments: _____

_____ _____

Signature of Auditor **Date**

Personal Allowance Audits – Day Services

If a math error is found in the ledger for less than $5.00, just note in the right hand column of the ledger +$.05 or -$.10 when the error occurred. If the error is $5.00 or more you need to do a little research and try to find a money receipt or a store receipt, it's possible the entry was never entered into the ledger. If you can not find any information to back up why the ledger was short $5.00 or more, you must reimburse the individual from petty cash. If the ledger is $5.00 or more in favor of the individual also research for receipts, if no information found accept the overage and continue on.

Per Ontario ARC guidelines a money receipt must be written for $5.00 or more if the money is handed to the individual. In the ledgers if there is a transaction under $5.00 and you cannot find a receipt, you can not write the staff up for that. (Ex. $1.00 for church you will not have a receipt, $2.00 for the vending matching at work you will not have a receipt)

Any discrepancies found for $5.00 or more, please list (List the staff's initials, date of transaction, and the discrepancy (ex. No money receipt found, no store receipt found, receipt was found but the change from the purchase was never noted if individual kept the change and it doesn't show change being returned to the ledger).

Ontario ARC Personal Allowance Audits

Name of Resident_____

Month/Year _____ _____

Manager's Safe Ledger _____ _____ _____ OK to cash Yes No

Weekend Safe Ledger _____ _____ _____ OK to cash Yes No

Gift Card Ledger _____ _____ ----------

Total _____ _____ _____ (Circle total over $213)

Are dates in the ledgers in sequence? Yes No

Ledgers sent home quarterly for Non-OARC Rep payee status? Yes No N/A

Personal allowance deposited monthly for Non-OARC Rep Payees? Yes No N/A

Paychecks deposited into their ledger? (See Back) DD Yes No N/A

Balance Verification:

Safe ledgers at least once a week by House Manager		Yes	No
Weekend ledgers two staff must initial once a day.		Yes	No
Weekends ledgers-House Manager balance verifying weekly		Yes	No
Program Manager verified quarterly?	Safe ledger	Yes	No
	Weekend Ledger	Yes	No

If no to any balance verifications, specify the date range(s) _____

Handling limit on ledger? Yes No

Any math errors found? Yes No

If yes please list below, be sure to specify if it's the safe ledger or weekend ledger (See back):

Were receipts verified (See Back)? Yes No

Were receipts signed by staff Yes No

Any discrepancies found for $5.00 or more, please list below:

Were Bank Statements verified? Date of Statement: _____ Yes No

Do they have personal allowance deposited monthly (Rep Payees)? Yes No

Were there any discrepancies? If so, explain below. Yes No

_____ _____

Signature of Auditor Date

Ontario ARC Personal Allowance Audits

PA AMOUNT: As of 2014, the PA checks are direct deposit for all Rep Payees accounts.

PAYCHECKS: Residents may not work and others may work at Abbeys, Wegmans, Tops, Ultrafab, etc. Check with the manager of the house regarding resident paycheck status (weekly, biweekly, etc.). Be sure to account for all paychecks during the quarter. If paychecks are not direct deposited into the resident's checking or savings account, then the paychecks must be ledgered in the safe ledger. Check with the manager for all unaccounted paychecks not ledgered in. If a paycheck was deposited into a resident's bank account but not recorded in the ledger, we must note in the ledger that the paycheck was deposited into the bank (make sure you find a deposit slip supporting the deposit)

MATH ERRORS: If a math error is found in the safe ledger an adjustment must be made to the ledger. For example if the math error is in the residents favor then you must note in the ledger a math error was found on 1/5/14(use the date the math error happened) for $.10 in the residents favor.

However if the math error creates a shortage in the safe ledger then the resident must be reimbursed from petty cash. For example if the math error shorted the resident you must note in the ledger that a math error was found on 1/5/14 (use the date the math error happened) for $.50, reimbursing resident from petty cash. Make a new line in the ledger to show the reimbursement from petty cash as a deposit of $.50. Then on the next line write OK to cash etc.

If a math error is found in the weekend ledger for less than $5.00, just note in the right hand column of the ledger +$.05 or -$.10 when the error occurred. If the error is $5.00 or more you need to do a little research and try to find a money receipt or a store receipt, it's possible the entry was never ledgered into the ledger. If you can not find any information to back up why the ledger was short $5.00 or more, you must reimburse the resident from petty cash. If the weekend ledger is $5.00 or more in favor of the resident also research for receipts, if no information found accept the overage and continue on.

RECEIPTING: Per Ontario ARC guidelines a money receipt must be written for $5.00 or more if the money is handed to the resident. In the ledgers if there is a transaction under $5.00 and you cannot find a receipt, you can not write the staff up for that. (ex. $1.00 for church you will not have a receipt, $2.00 for the vending matching at work you will not have a receipt)

Any discrepancies found for $5.00 or more, please list (List the staff's initials, date of transaction, safe ledger or weekend ledger, and the discrepancy (ex. No money receipt found, no store receipt found, receipt was found but the change from the purchase was never noted if resident kept the change and it doesn't show change being returned to the ledger).

Ontario ARC Personal Allowance Audits

Name of Resident_____ Site - Supervised Apts.

Month/Year _____ _____ _____

Manager's Safe Ledger _____ _____ _____ OK to cash Yes No

Weekend Safe Ledger _____ _____ _____ OK to cash Yes No

Gift Card Ledger _____ _____ _____

Grocery Ledger _____ _____ _____ OK to cash Yes No

Special PA _____ _____ _____ OK to cash Yes No

Total _____ _____ _____(Circle total over $213)

Are dates in the ledgers in sequence? Yes No

Ledgers sent home quarterly for Non-OARC Rep payee status? Yes No N/A

Personal allowance deposited monthly for Non-OARC Rep Payees? Yes No N/A

Paychecks deposited into their ledger? (See Back) DD Yes No N/A

Balance Verification:

Safe ledgers at least once a week by House Manager Yes No
Weekend ledgers two staff must initial once a day. Yes No
Weekends ledgers-House Manager balance verifying weekly Yes No
Program Manager verified quarterly? Safe ledger Yes No
Weekend Ledger Yes No
If no to any balance verifications, specify the date range(s) _____

Handling limit on ledger? Yes No
Any math errors found? Yes No
If yes please list below, be sure to specify if it's the safe ledger or weekend ledger (See back):

Were receipts verified (See Back)? Yes No
Were receipts signed by staff Yes No
Any discrepancies found for $5.00 or more, please list below:

Were Bank Statements verified? Yes No
Do they have personal allowance deposited monthly (Rep Payees)? Yes No
Were there any discrepancies? If so, explain below. Yes No

_____ _____
Signature of Auditor Date

Ontario ARC Personal Allowance Audits

PA AMOUNT: For 2014, the PA checks are direct deposit for all Rep Payees accounts.

PAYCHECKS: Residents may not work and others may work at Abbeys, Wegmans, Tops, Ultrafab, etc. Check with the manager of the house regarding resident paycheck status (weekly, biweekly, etc.). Be sure to account for all paychecks during the quarter. If paychecks are not direct deposited into the resident's checking or savings account, then the paychecks must be ledgered in the safe ledger. Check with the manager for all unaccounted paychecks not ledgered in. If a paycheck was deposited into a resident's bank account but not recorded in the ledger, we must note in the ledger that the paycheck was deposited into the bank (make sure you find a deposit slip supporting the deposit)

MATH ERRORS: If a math error is found in the safe ledger an adjustment must be made to the ledger. For example if the math error is in the residents favor then you must note in the ledger a math error was found on 1/5/14(use the date the math error happened) for $.10 in the residents favor.

However if the math error creates a shortage in the safe ledger then the resident must be reimbursed from petty cash. For example if the math error shorted the resident you must note in the ledger that a math error was found on 1/5/14 (use the date the math error happened) for $.50, reimbursing resident from petty cash. Make a new line in the ledger to show the reimbursement from petty cash as a deposit of $.50. Then on the next line write OK to cash etc.

If a math error is found in the weekend ledger for less than $5.00, just note in the right hand column of the ledger +$.05 or -$.10 when the error occurred. If the error is $5.00 or more you need to do a little research and try to find a money receipt or a store receipt, it's possible the entry was never ledgered into the ledger. If you can not find any information to back up why the ledger was short $5.00 or more, you must reimburse the resident from petty cash. If the weekend ledger is $5.00 or more in favor of the resident also research for receipts, if no information found accept the overage and continue on.

RECEIPTING: Per Ontario ARC guidelines a money receipt must be written for $5.00 or more if the money is handed to the resident. In the ledgers if there is a transaction under $5.00 and you cannot find a receipt, you can not write the staff up for that. (ex. $1.00 for church you will not have a receipt, $2.00 for the vending matching at work you will not have a receipt)

Any discrepancies found for $5.00 or more, please list (List the staff's initials, date of transaction, safe ledger or weekend ledger, and the discrepancy (ex. No money receipt found, no store receipt found, receipt was found but the change from the purchase was never noted if resident kept the change and it doesn't show change being returned to the ledger).

Ontario ARC Personal Allowance Audits

Name of Resident_____ Site - Supervised Apts.

Month/Year _____ _____ _____

Manager's Safe Ledger _____ _____ _____ OK to cash Yes No

Weekend Safe Ledger _____ _____ _____ OK to cash Yes No

Gift Card Ledger _____ _____ _____

Special PA _____ _____ _____ OK to cash Yes No

Total _____ _____ _____(Circle total over $213)

Are dates in the ledgers in sequence? Yes No

Ledgers sent home quarterly for Non-OARC Rep payee status? Yes No N/A

Personal allowance deposited monthly for Non-OARC Rep Payees? Yes No N/A

Paychecks deposited into their ledger? (See Back) DD Yes No N/A

Balance Verification:

Safe ledgers at least once a week by House Manager Yes No
Weekend ledgers two staff must initial once a day. Yes No
Weekends ledgers-House Manager balance verifying weekly Yes No
Program Manager verified quarterly? Safe ledger Yes No
Weekend Ledger Yes No
If no to any balance verifications, specify the date range(s) _____

Handling limit on ledger? Yes No

Any math errors found? Yes No
If yes please list below, be sure to specify if it's the safe ledger or weekend ledger (See back):

Were receipts verified (See Back)? Yes No
Were receipts signed by staff Yes No
Any discrepancies found for $5.00 or more, please list below:

Were Bank Statements verified? Yes No
Do they have personal allowance deposited monthly (Rep Payees)? Yes No
Were there any discrepancies? If so, explain below. Yes No

_____ _____
Signature of Auditor Date

Ontario ARC Personal Allowance Audits

PA AMOUNT: For 2014, the PA checks are direct deposit for all Rep Payees accounts.

PAYCHECKS: Residents may not work and others may work at Abbeys, Wegmans, Tops, Ultrafab, etc. Check with the manager of the house regarding resident paycheck status (weekly, biweekly, etc.). Be sure to account for all paychecks during the quarter. If paychecks are not direct deposited into the resident's checking or savings account, then the paychecks must be ledgered in the safe ledger. Check with the manager for all unaccounted paychecks not ledgered in. If a paycheck was deposited into a resident's bank account but not recorded in the ledger, we must note in the ledger that the paycheck was deposited into the bank (make sure you find a deposit slip supporting the deposit)

MATH ERRORS: If a math error is found in the safe ledger an adjustment must be made to the ledger. For example if the math error is in the residents favor then you must note in the ledger a math error was found on 1/5/14(use the date the math error happened) for $.10 in the residents favor.

However if the math error creates a shortage in the safe ledger then the resident must be reimbursed from petty cash. For example if the math error shorted the resident you must note in the ledger that a math error was found on 1/5/14 (use the date the math error happened) for $.50, reimbursing resident from petty cash. Make a new line in the ledger to show the reimbursement from petty cash as a deposit of $.50. Then on the next line write OK to cash etc.

If a math error is found in the weekend ledger for less than $5.00, just note in the right hand column of the ledger +$.05 or -$.10 when the error occurred. If the error is $5.00 or more you need to do a little research and try to find a money receipt or a store receipt, it's possible the entry was never ledgered into the ledger. If you can not find any information to back up why the ledger was short $5.00 or more, you must reimburse the resident from petty cash. If the weekend ledger is $5.00 or more in favor of the resident also research for receipts, if no information found accept the overage and continue on.

RECEIPTING: Per Ontario ARC guidelines a money receipt must be written for $5.00 or more if the money is handed to the resident. In the ledgers if there is a transaction under $5.00 and you cannot find a receipt, you can not write the staff up for that. (ex. $1.00 for church you will not have a receipt, $2.00 for the vending matching at work you will not have a receipt)

Any discrepancies found for $5.00 or more, please list (List the staff's initials, date of transaction, safe ledger or weekend ledger, and the discrepancy (ex. No money receipt found, no store receipt found, receipt was found but the change from the purchase was never noted if resident kept the change and it doesn't show change being returned to the ledger).

Ontario ARC Petty Cash Audits – Day Services

Site _____

Cash in petty cash pouch +_____

Outstanding receipts (have not been turned In for reimbursement) +_____

Outstanding Reimbursement request +_____

Total should balance to $100.00
Eberhardt should balance to $175.00 _____

If discrepancies, list below the correction made to balance to $100.00:

_____

_____

_____ _____

Signature of Auditor **Date**

Ontario ARC Petty Cash Audits – Day Services

The Petty cash balance for all day services is $100.00. All sites will have one ledger maintained by the supervisor and the staff.

If total does not balance to the $100.00, then you need to fill out a blank requisition making the adjustment to bring the ledger back to $100.00.

If cash is more than the ledger, you need to accept a new ledger balance that totals the cash balance. On a requisition you need to request less the difference to bring the ledger back to $100.00.

If cash is less than the ledger, you need to accept a new ledger balance that totals the cash balance. On a requisition you need to request more the difference to bring the ledger back to $100.00.

You need to always adjust the ledger balance to equal to the cash balance before you write OK to cash and then make the adjustment on the blank requisition that will be used by the supervisor on the next reimbursementrequest.

Supervisors should be copying their requisition and envelope reimbursement request, so you can reference that when auditing. You can always check with Ann Augustine before you go to audit a program to see if she has received any reimbursement requests recently.

Ontario ARC Petty Cash Audits

Site _____

1) Main ledger OK to cash? Y or N **Amount**_____

1A) Petty Cash on site _____
**safe + pouch should equal ledger balance

** Cash in managers safe_____weekend pouch _____

2) Outstanding receipts (have not been turned In for reimbursement) **+** _____

3) Outstanding Reimbursement request **+**_____

Total 1,2 & 3 (should equal $150) _____

If discrepancies, list below the correction made to balance to $150.00:

_____

_____

Indicate any adjustments made to the Main Ledger to balance to 150:

_____

_____

_____ _____

Signature of Auditor **Date**

Ontario ARC Petty Cash Audits

Petty cash balances for residential is $150.00. All houses will have a ledger maintained by the manager and also a ledger that staff has access to. Both ledgers need to be audited back to the time of the last audit.

If total does not balance to the $150.00, then you need to fill out a blank requisition making the adjustment to bring the ledger back to $150.00.

If cash is more than the ledger, you need to accept a new ledger balance that totals the cash balance. On a requisition you need to request less the difference to bring the ledger back to $150.00.

If cash is less than the ledger, you need to accept a new ledger balance that totals the cash balance. On a requisition you need to request more the difference to bring the ledger back to $150.00.

You need to always adjust the ledger balance to equal to the cash balance before you write OK to cash and then make the adjustment on the blank requisition that will be used by the manager on the next reimbursementrequest.

Managers should be copying their requisition and envelope reimbursement request, so you can reference that when auditing. You can always check with Ann Augustine before you go to audit a house to see if she has received any reimbursement requests recently.

Recreation Audit

Audit Period_____ **Date**_____

Selection of 10 receipts verified against the Receipts for Time Period Report:

Were there any discrepancies?_____Yes _____No If so, explain below:

_____

_____

Receipts per A/R –Recreation:
Go to file for copies of cash receipts. Pull the months being reviewed and look for recreation deposits. Use the recreation deposit slip for detail and verify with receipt books from the recreation for cash or checks.

Date Deposit Receipts

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Were there any discrepancies?_____Yes _____No If so, explain below:

_____

_____

_____

_____

_____ _____

Signature of Auditor Date