North Carolina Division of Medical Assistance
HIV Case Management Provider
Recertification Application Checklist

Instructions: Mark an X in the Y column to indicate the item listed is present in the corresponding section of the Application. Mark an X in the N column to indicate the item is not present. If not included, explain reason in Comment section. If not applicable, type N/A with related comment in the Comments section.

	RECERTIFICATION APPLICATION CHECKLIST			
	General Instructions	**Y**	**N**	**Comments**
1.	Is this application for only one physical location?			
2.	Does submission include title page and signed *Recertification Application Checklist*?			
2.	If mailing, is submission bound?			
2.	If electronic, is application and all related documents scanned as one file?			
	Section 1: Agency Demographics	**Y**	**N**	**Comments**
1.	Is Agency Name, and all other fields completed for *Provider Contact Information*?			
3.	Is *Point of Contact (POC) Information* complete?			
4.	Is the *Owner/Director Contact Information* Complete? If same, type "same as POC" on application.			
5.	Is the *Preparer Contact Information* complete? If same, type "same as POC" or "same as Owner/Director" on application.			
	Section 2: General Requirements	**Y**	**N**	**Comments**
1.	Are all Case Managers listed with dates of employment?			
2.	Are all Case Management supervisors listed with dates of employment?			
3.	Are all counties listed where HIV CM Services are provided?			
4.	Are all services provided by your agency listed?			
5.	Are your operating hours and emergency after hours' plan entered?			
6.	Is the accrediting agency name and dates listed or an explanation entered?			
7.	Is the frequency of satisfaction survey completed including a description of how the results are used?			
8.	Are the numbers of Medicaid and Ryan White clients listed?			

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	Section 3:1 Attached Documents	Y	N	Comments
a.	Confidentiality	☐	☐	
b.	Beneficiary Grievance Policy	☐	☐	
c.	Beneficiary Rights Policy	☐	☐	
d.	Non-Discrimination Policy	☐	☐	
e.	Code of Ethics	☐	☐	
f.	Conflict of Interest Policy	☐	☐	
g.	Electronic Records Policy	☐	☐	
h.	Medicaid Records, including retention	☐	☐	
i.	Freedom of Choice	☐	☐	
j.	Transfer and Discharge Policy	☐	☐	
k.	Identification of Abuse, Neglect, and Exploitation Policy	☐	☐	
	Section 3:2 Attached Documents	**Y**	**N**	**Comments**
a.	Quality Assurance Policy	☐	☐	
b.	Quality Assurance Chart	☐	☐	
c.	Organizational Chart	☐	☐	
d.	Community Resources	☐	☐	
e.	Agency Ownership	☐	☐	
f.	Staff Credentials	☐	☐	
g.	CCNC and PCP Networking	☐	☐	
h.	HR Policies, Procedures, and Plans	☐	☐	
	Section 4: Compliance	**Y**	**N**	**Comments**
	Did preparer print name, sign and date attesting to agreement of statements?	☐	☐	
	Did Owner/Director print name, sign, and date attesting to agreement of statements?	☐	☐	

Note: Policy References in this document are in regard to Clinical Coverage Policy No: 12B HIV Case Management.

_____ Preparer Signature / Date