UTAH MEDICAID ICF/ID NURSING FACILITY
Quality Improvement Incentive (2)(i)(D) APPLICATION
Rule R414-504-5

This form and all supporting documentation must be emailed according to State Plan Requirements.

Facility Name: _____

National Provider ID _____ Administrator: _____

To qualify, facilities must complete 2 of the 5 programs. Select the programs your facility completed for the SFY.

Program D: Employment, vocational, or life skills training opportunity program

Please mark all that are complete:

☐ This facility executed an employment, vocational, or life skills training opportunity program

☐ The facility executed the following element(s) (Mark all that apply).

- ☐ Employment opportunity (unless the individual is in school or retirement age).
- ☐ Vocational opportunity as required through the state vocational rehabilitation office (unless the individual is of retirement age).
- ☐ Life skills training (for individuals of retirement age, retirement activities and outings).

☐ All of the following documentation is attached:

- ☐ A detailed description of the implementation and execution of the programs.
- ☐ A list of each individual who participated in the program during the period, the program(s) they specifically participated in, and how the resident benefited from participation in the program.

Program E: Work assessment program

Please mark all that are complete:

☐ This facility executed a work assessment program.

☐ The facility executed the following elements as part of the work assessment for each resident (all are required).

- Cognitive,
- Physical,
- Social,
- Behavioral appropriateness, and
- Communication abilities

☐ All of the following documentation is attached:

- ☐ A detailed description of the implementation and execution of the program.
- ☐ A list of each individual who participated in the program during the period and how the resident benefited from participation in the work assessment program.

Program F: Community integration program

Please mark all that are complete:

☐ This facility executed a community integration program

☐ The facility executed the community integration program included the following required elements (all are required):

- Membership,
- Community opportunity,
- Normalized errands,
- Housing,
- Adaptive equipment,
- Financial services,
- Healthcare services,
- Individualized interests, and
- Transportation services

☐ All of the following documentation is attached:

- ☐ A detailed description of the implementation and execution of the programs.
- ☐ A list of each individual who participated in the program during the period, the element(s) they specifically participated in, and how the resident benefited from participation in the program.

Program G: Staff education program

Please mark all that are complete:

☐ This facility executed a staff education program.

☐ The facility executed the following element(s) (all are required):

- Resident rights and
- Community opportunity and integration resources

☐ All of the following documentation is attached:

- ☐ A detailed description of the implementation and execution of the programs.
- ☐ A list of each employee who participated in the program during the period and how the employee benefited from participation in the program.

Program H: COVID-19 vaccination

program Please mark all that are complete:

☐ This facility executed a COVID-19 staff vaccination program.

☐ The facility executed the following required element(s):

- List of employees who received the full vaccination regimen (includes those who were fully vaccinated prior to the start of SFY 2023),
- Verification the employee received the incentive, and
- Employee signatures attesting to each employee having met the parameters.

☐ All of the following documentation is attached:

- ☐ A list of employees who have met the full vaccination regimen.
- ☐ Verification the employees received the incentive (pay stubs, receipts, etc.).
- ☐ A signature list attesting to each employee having met the parameters

Qualifying facilities may, overall, receive up to the amount on the website per Medicaid Certified bed (count as of 7/1) under this incentive (ii). This incentive is part of incentive (2)(i) which requires completion of two programs D, E, F, G, or H. ***Each quarterly execution application may qualify for 25% of the facility's base maximum allowable incentive payment (amount x Medicaid Certified bed count as of 7/1). ***

Amount Requested: $_____

Please ensure that all the supporting documentation is included. Failure to include <u>all</u> of the above detailed information will prevent the facility from qualifying.

By submitting this application, I certify that all of the above criteria have been met.

Administrator Signature: _____ Date: _____

Email to: qii@utah.gov