Maryland
DEPARTMENT OF HEALTH
DEVELOPMENTAL DISABILITIES ADMINISTRATION

CCS Support Go-Live Checklist to Track PCP Review

CCS Agency: ______________________________

CCS Contact: ____________________ Phone: ____________________

CCS Email Address: ______________________________

Provider Agency: ______________________________

Provider Contact: ____________________ Phone: ____________________

Provider Email Address: ______________________________

Readiness Category	Pg #	Readiness Task	Completion Date
Medical Assistance Number (Base and Site)	12	Verified Base Number and associated services with the Provider	
	12	Verified Site Numbers and associated services (i.e., locations for Day Habilitation, CLGH, etc.)	
Person Centered Plan Review	15	Verified spelling of participant's name	
	15	Verified participant's home address	
	15	Verified participant's date of birth	
	15	Verified start/effective plan date, no gaps	
	15	Verified language in outcomes and goals is consistent with Service Implementation Plans	
	15	Verified that all needed/requested services are included for approval and that all service hours (as applicable) are entered correctly to capture the correct monthly units.	
	15	Verified that the participant is enrolled in the correct Waiver	

- Issue date: **2.10.22**
- Effective date: **2.10.22**
- Version number: **1**

CCS Support Go-Live Checklist to Track PCP Review

Readiness Category	Pg #	Readiness Task	Completion Date
Dedicated Hours	16	Reviewed and understand differences between dedicated hours and residential PCIS2 add-on hours	
	16	Verified shared hours in each residential setting	
	16	Reviewed and understand DDA policies and guidance for requesting Dedicated Support Hours	
	16	Verified that participants with this need have assessments that support the Dedicated Hours requested	
	16	Verified that Dedicated Hours are approved for a participant with this need	
Community Living-Group Home Configuration	17	Verified the MA site number for the location and ensured that it is captured accurately in the Detailed Service Authorization section of the PCP	
	17	Verified that home address is correct in LTSS*Maryland* (Client profile, PCP, and the Detailed Service Authorization section)	
	17	Verified Overnight Supports function is correctly set to "On" or "Off" for each home (if needed, check with the Regional Office)	
	17	Verified that each site has the participant in your caseload correctly assigned	
Service Referral	18	Completed the calculations for each service	
	18	Provided a screenshot or shared screen with provider	
	18	Provider reviewed, understood, and agreed to service referral	
	18	Followed up to ensure provider accepted service referral within 5 days	
Uploaded all support documentation	18	HRST	
	7	DSAT	
	7	Service Implementation Plan	

- Issue date: **2.10.22**
- Effective date: **2.10.22**
- Version number: **1**

CCS Support Go-Live Checklist to Track PCP Review

Readiness Category	Pg #	Readiness Task	Completion Date
Uploaded all support documentation	-	Supports Intensity Scale	
	-	All required signatures	
	-	Additional required documents	

CCS Name: ____ certifies by the signature below that the CCS has successfully completed the full checklist.

Signature: _________________________ Printed Name: ____________________ Date: ____________

Issue date: **2.10.22**
Effective date: **2.10.22**
Version number: **1**