EAR/CCHS REQUIREMENTS for Substitute Care & Respite Personnel ONLY

AGENCY/REGION: | | **DATE OF SURVEY:** | |

SURVEYOR: | |

Surveyor Instructions:

NMAC - 7.1.9 CCHS Requirement: CCHS letter must be addressed to the Agency, not an Individual staff member. Additionally, if Agency Personnel has documentation indicating CCHS Application has been submitted, verify with CCHS. If verified it is not a deficiency. 100% of Direct Support Personnel, Service Coordinators, Managers/Supervisors, Substitute Care & Respite must be reviewed. If personnel are found to have a disqualifying conviction and they are currently employed, the Surveyor is to notify the Agency immediately, as personnel must be terminated until resolved. For CCHS to be "MET" agency personnel must have a CCHS letter that is specific to the agency and the term of employment. CCHS will result in a potential CoP if there is no evidence of CCHS completed or if disqualifying conviction(s) are found and personnel are still employed.

NMAC - 7.1.12 - Employee Abuse Registry: If Employee Abuse Registry is not required as determined by NMAC 7.1.9 & 7.1.12 please document the licensure held by the staff and note if it is current. EAR is a one-time deficiency, once a staff member is cited it cannot be cited again if that staff has remained an employee of the agency. Team will look at EAR from last routine survey to determine personnel who have previously been cited. This is a potential CoP if there is no evidence of EAR being completed or if an employee is found on the registry and employed.

				MET	NOT MET
Substitute Care/Respite Personnel Name	**DOH**	**EAR** *1A26 / 1A26.1*	**CCHS** *1A25 / 1A25.1*	*Surveyors: Document met or not met and any additional notes specific to staff reviewed after reconciliation is complete. Any area deficient must be circled*	
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Original copy to Survey Team Lead & Copy to Provider Representative:

Agency Representative Name/Signature, Title & Date Received: _____

Training Evidence Must be provided to Survey Team by: **DATE:** _____ **TIME:** _____

				MET	NOT MET
Substitute Care/Respite Personnel Name	**DOH**	**COR** *1A26 / 1A26.1*	**CCHS** *1A25 / 1A25.1*	*Surveyors: Document met or not met and any additional notes specific to staff reviewed after reconciliation is complete. Any area deficient must be circled*	
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Substitute Care/Respite Personnel Name	**DOH**	**COR** *1A26 / 1A26.1*	**CCHS** *1A25 / 1A25.1*	*Surveyors: Document met or not met and any additional notes specific to staff reviewed.*	
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