DOH/DDSD SUPPORTS WAIVER REQUIREMENTS FOR COMMUNITY SUPPORT COORDINATORS (CSC)

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

SURVEYOR:

Surveyor Instructions: *100% of CSCs must be reviewed.*

NMAC - 7.1.9 CCHS Requirement: *CCHS letter must be addressed to Agency, not Individual consultant. Additionally, if Agency Personnel has documentation indicating CCHS Application has been submitted, verify w/CCHS. If verified it is not a deficiency. If personnel are found to have a disqualifying conviction and currently employed Surveyor is to notify agency immediately, as personnel must be terminated until resolved. For CCHS to be met agency personnel must have a CCHS letter which is specific to the agency and the term of employment.*

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 not met if there is no evidence of EAR being completed or if an employee is found on the registry and employed or if completed after hire.*

Credentials: *Be at least 21 years of age; Possess a minimum of a bachelor's degree in social work, psychology, human services, counseling, nursing, special education or a closely related field; or have a minimum of six (6) years of direct experience related to work with Individuals with IDD: Have one (1) year of supervised experience working with people living with disabilities. For this to be met the CSC must be 21 and meet the requirements outlined in standards.*

Community Support Coordinator (CSC) Name	DOH	EAR	CCHS	Credentials (degree or 6 yrs. experience)	*Surveyors: Document met or not met and any additional notes specific to staff reviewed after reconciliation is complete. Any area deficient must be circled*	
					MET	NOT MET
	DATE	DATE	DATE	TYPE / Years		
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	DATE	DATE	DATE	TYPE / Years		
Notes:						

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:** _____

Community Support Coordinator (CSC) Name	**DOH**	**EAR**	**CCHS**	**Credentials (degree or 6 yrs. experience)**	***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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NEW SW Effective: 7.2021; 8.2022;2/2024