



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES

*ECONOMIC SERVICES ADMINISTRATION
COMMUNITY SERVICES DIVISION – CONTRACTS UNIT
PO BOX 45470, OLYMPIA WA 98504-5710*

RE: Your CSD Aged, Blind, or Disabled (ABD) Program Medical Evidence Review Contract
For the period of _____ to _____

Dear Contractor,

In place of an on-site visit by staff from the Department of Social and Health Services (DSHS) to monitor your Community Services Division (CSD) contract, DSHS/CSD is using this Contractor Self-Assessment Monitoring Tool. Our goal in using this Contractor Self-Assessment Monitoring Tool is to support your understanding of and compliance with your CSD contract while reducing DSHS travel and administrative costs.

You are required by contract to complete and return this form by the due date below. Your performance as a DSHS contractor is measured and recorded by your compliance with these requirements.

Failure to complete and return this form by the due date below will result in the suspension of referrals.

This tool is designed to be completed using Microsoft Word or compatible program and consists of a series of yes/no questions. Please answer all of the questions by double clicking and selecting the appropriate answer box. You may use the tab key on your keyboard to move from question to question and to the text fields. If an explanation is requested, please add a narrative response in the Contractor Explanation section which will expand to allow unlimited text. You may go back to a prior question by using the shift-tab keys on your keyboard or clicking once within the gray box.

Return the completed tool to me no later than _____.

In addition, you and your staff must read and sign the attached DSHS Notice of Nondisclosure form. You must retain the original signed form(s) and make the forms(s) available to DSHS upon request.

Sincerely,

Daisha N. Gomillion
DSHS CSD Program Manager
(360) 725-4781
Mail to: Daisha.Gomillion@dshs.wa.gov
PO Box 45470
Olympia WA 98504-5470

CONTRACTOR'S NAME	CONTRACTOR NUMBER -
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COMMUNITY SERVICES DIVISION (CSD)
**CSD ABD Program Medical Evidence Review
 Contractor Self-Assessment Monitoring Tool**

This form is formatted to be completed electronically using Microsoft Word. All Contractor Explanation text fields will expand to accommodate unlimited text.

Review Period: to

General Contractor Contact Information / Business and Professional Licensing	
1. Do you have a current Washington State License to practice as a psychologist or a psychiatrist? CONTRACTOR EXPLANATION	<input type="checkbox"/> Yes <input type="checkbox"/> No (explain)
2. Do you have any pending or current restrictions or disciplinary actions on your license? If your answer is yes, please describe the restriction or disciplinary action. CONTRACTOR EXPLANATION	<input type="checkbox"/> Yes (explain) <input type="checkbox"/> No
3. Does your business have a current Washington State Business License? CONTRACTOR EXPLANATION	<input type="checkbox"/> Yes <input type="checkbox"/> No (explain)
4. Is your business information (address, telephone, email) the same as when you entered into this contract? If your answer is no, please provide your current contact information below. NEW CONTACT INFORMATION	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are you currently employed with the State of Washington and performing services under this contract as outside employment? CONTRACTOR EXPLANATION	<input type="checkbox"/> Yes (explain) <input type="checkbox"/> No
6. If you answered yes to Question 5 above, are you in compliance with RCW 42.52.120 Compensation for outside activities? CONTRACTOR EXPLANATION	<input type="checkbox"/> Yes <input type="checkbox"/> No (explain)

CONTRACTOR'S NAME

CONTRACTOR NUMBER

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Subcontractor / Vendor Information

1. Do you understand that services provided under the ABD Program Medical Evidence Review contract cannot be subcontracted? Yes No (explain)

CONTRACTOR EXPLANATION

Insurance

The DSHS Insurance requirements have been waived for this contract.

Data Security

1. Are you keeping DSHS client data separate from non-DSHS data? Yes No (explain)
Please refer to your contract, Exhibit A, Data Security Requirements.

CONTRACTOR EXPLANATION

2. List all the names of your employees / vendors and their job title that have access to DSHS client personal information under this contract.

3. Have all of your employees / vendors with access to DSHS client personal information signed a Notice of Non-Disclosure? Yes No (explain)

CONTRACTOR EXPLANATION

4. Have you provided training to all of your employees with access to DSHS client data on compliance with DSHS data security requirements? Yes No (explain)

CONTRACTOR EXPLANATION

5. How are you documenting this training?

6. Are you storing DSHS records in a secure area that is accessible only by authorized personnel? Yes No (explain)

CONTRACTOR EXPLANATION

CONTRACTOR'S NAME		CONTRACTOR NUMBER
		-
7. When not in use, are DSHS records stored in a locked container, such as a file cabinet, locking drawer, or safe?		<input type="checkbox"/> Yes <input type="checkbox"/> No (explain)
CONTRACTOR EXPLANATION		
8. Are you using portable devices or media, such as a laptop, flash drive, or digital voice recorder to provide services under this contract? If your answer is yes, describe what devices or media you are using.		<input type="checkbox"/> Yes (explain) <input type="checkbox"/> No
CONTRACTOR EXPLANATION		
9. Have you received written permission from the CSD Program Manager to use portable devices or media?		<input type="checkbox"/> Yes <input type="checkbox"/> No
10. If you are using portable devices or media to provide services under this contract, are you protecting the data as required by Exhibit A, Data Security Requirements?		<input type="checkbox"/> Yes <input type="checkbox"/> No (explain)
CONTRACTOR EXPLANATION		
11. If you are using portable devices or media to provide services under this contract, are you keeping the following records about the use of portable devices:		
a. Type of portable devices or media <input type="checkbox"/> Yes <input type="checkbox"/> No		
b. Serial Numbers <input type="checkbox"/> Yes <input type="checkbox"/> No		
c. Proof of encryption of DSHS data <input type="checkbox"/> Yes <input type="checkbox"/> No		
d. Check-in and check-out system which identifies which of the Contractors staff is using the portable device or media that contains DSHS Data. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable		
12. If you are using a portable device, are you downloading client information at least weekly as required by your contract?		<input type="checkbox"/> Yes <input type="checkbox"/> No (explain)
CONTRACTOR EXPLANATION		
13. Are you keeping a record of the dates of the weekly storage download and the storage method?		<input type="checkbox"/> Yes <input type="checkbox"/> No (explain)
CONTRACTOR EXPLANATION		

CONTRACTOR'S NAME

CONTRACTOR NUMBER

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Program Specific Requirements

1. Do you notify the DSHS Contact when you receive a referral for a client that you have examined or are treating so that the referral can be reassigned? Yes No (explain)

CONTRACTOR EXPLANATION

2. Do you notify the DSHS Contact when you are unavailable to accept referrals at least seven (7) days in advance for planned absences or due to any unplanned absences? Yes No (explain)

CONTRACTOR EXPLANATION

3. Do you respond to accepted referrals as required by Special Terms and Conditions, Statement of Work, Section 4? Yes No (explain)

CONTRACTOR EXPLANATION

Contractor Input

1. What do you consider best practices that help you effectively perform services under this contract?

2. Do you have any suggestions for improving or enhancing services provided under this contract? Yes (explain) No

CONTRACTOR EXPLANATION

3. Are there items in the contract you don't understand or think could be improved? Yes (explain) No

CONTRACTOR EXPLANATION

CONTRACTOR'S NAME	CONTRACTOR NUMBER -
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I hereby declare that the information I have given on this form is true, correct and complete to the best of my knowledge.

SIGNATURE	DATE	PRINTED NAME	
		TITLE	TELEPHONE NUMBER (AREA CODE)

Please return the completed form to: Daisha N. Gomillion
 DSHS CSD Program Manager
Daisha.Gomillion@dshs.wa.gov
 Phone: (360) 725-4781
 Fax: (360) 725-4904
 PO Box 45470
 Olympia WA 98504-5470

DSHS will accept a mailed, faxed, or scanned copy. Please keep a copy for your records.