Lori Knapp CHOICE™
Part of the AssuranceSD Family

VERIFICATION OF INFORMATION

This form is used to document the verification of, or actions taken regarding the review of information in the Lori Knapp Choice™ system. Check the boxes that best represent the action taken and complete information as directed.

Date of Verification Contact: _____ Fiscal Agent: _____

Verification of Information For: _____ ☐ Participant ☐ Direct Care Worker

Information Verified By: ☐ Telephone ☐ Face-to-Face ☐ Written Correspondence

CONTACT INFORMATION:

Mailing Address on File: _____
Address City State Zip

☐ Correct ☐ Address Change: _____

Email on File: _____

☐ Correct ☐ Email Change: _____

Phone Number on File: _____ Cell Number on File: _____

☐ Correct ☐ Number Changes/Additions: _____

Forms Sent: _____ Forms Returned: _____ Date System Updated: _____

DIRECT CARE WORKER INFORMATION:

Relationship/Live-in Status: Review form on file.

☐ Reviewed ☐ New Form Sent

W4: Review forms on file.

☐ Reviewed ☐ New Form Sent

WT4: Review forms on file.

☐ Reviewed ☐ New Form Sent

Direct Deposit Authorization: Review form on file.

☐ Reviewed ☐ New Form Sent

Convictions since last BID:

☐ No ☐ Yes** ☐ New Form Sent

** If yes, a start date cannot be given and payroll cannot be processed until a new BID is ran, sent to Care Manager, and approved.

Forms Sent: _____ Forms Returned: _____ Date System Updated: _____

PARTICIPANT INFORMATION:

2678 Active: ☐ Yes ☐ No

Forms Sent: _____ Forms Returned: _____ Date System Updated: _____

Attestation Statement: Only one statement is to be signed and dated, dependent on the verifier of information.

FISCAL AGENT REPRESENTATIVE, PARTICIPANT, OR DIRECT CARE WORKER:

I attest that I have reviewed the above information myself or with the Participant or Direct Care Worker. If changes were necessary, I sent/completed the appropriate forms to be updated. Upon receipt of the forms, Lori Knapp Choice™ approved processes were followed to meet regulatory and company expectations.

Fiscal Agent Representative Signature: _____ Date: _____

Participant or Direct Care Worker Signature: _____ Date: _____