Computer Readiness Survey Attachment 2 LDSS Name: County: Contact Phone: **Contact Name:** Contact E-mail: If you have any questions regarding this survey please contact us by e-mail at UASNY@health.state.ny.us or phone at 518-408-1600. 1. Does your office environment include ALL of the following: Computers Computer Network (server where files are stored) High Speed Internet Access 2. Do you provide computers to your office staff? 3. Do you have staff who conduct Medicaid LTC assessments? 3a. If Yes, do you provide assessor staff with laptops or desktops? 4. Do you retain Medicaid LTC assessment data electronically? 5. Please characterize your office staff (NON-ASSESSOR) according to one of the following brackets:

NON-ASSESSOR Computer Capability Scale	Percentage of Staff
Have extensive computer experience: whether at home, work, or both, they routinely install software, configure applications, or conduct more complex computer activities.	
Have moderate computer experience as a user: whether at home, work, or both, they use computer applications, are able to open files, create files, save files, organize files, etc. * NOTE: Exclude those who have extensive experience.	
Have ONLY basic computer experience as a user: they can use e-mail and browse the internet, or they otherwise have no or limited computer experience. (This value will calculate automatically based on previous values.)	100
	100

6. Please characterize your ASSESSORS according to the following brackets:

ASSESSOR Computer Capability Scale	Percentage of Staff
Have extensive computer experience: whether at home, work, or both, they routinely install software, configure applications, or conduct more complex computer activities.	
Have moderate computer experience as a user: whether at home, work, or both, they use computer applications, are able to open files, create files, save files, organize files, etc. * NOTE: Exclude those who have extensive experience.	
Have ONLY basic computer experience as a user: they can use e-mail and browse the internet, or they otherwise have no or limited computer experience. (This value will calculate automatically based on previous values.)	100
	100

7. Please list the Corporate name of all entities that your LDSS contracts with to conduct assessments for Medicaid LTC programs. Indicate the entity type and the programs for which they conduct assessment. If you as a Local District office conduct assessments, please include your LDSS name in the list.

* if you have more than 30 providers you may continue to fill out the cells below the colored area

				Entity Type			Provider conducts assessments for the following programs		
Provider (Corporate) Name	Provider Contact Name	Contact e-mail	Contract Term Date	Certified Home Health Agency	Licensed Agency	Other *please list	Assisted Living Program	Personal Care Program/ Consumer Directed	Care at Home Waiver Program