SECTION 1915(c) HOME AND COMMUNITY-BASED SERVICES WAIVER APPLICATION

1. The State of **California** requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

   This is a request for a model waiver.

   a.____ Yes b.__X__No

   If Yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

   This waiver is requested for a period of (check one):

   a.____ 3 years (initial waiver)

   b.__X__ 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following levels (s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

   a.__X__ Nursing facility (NF)

   b.____ Intermediate care facility for mentally retarded persons (ICF/MR)

   c.____ Hospital

   d.____ NF (served in hospital)

   e.____ ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

   a.__X__ aged (age 65 and older)

   b.____ disabled

   c.____ aged and/or disabled

   d.____ mentally retarded

   e.____ developmentally disabled

f.____ mentally retarded and/or developmentally disabled

g.____ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

a._____ Waiver services are limited to the following age groups (specify):

b._____ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):

c.____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

d.__X__ Other criteria. (Specify): **Individuals shall only be enrolled in one HCBS waiver at any one time.**

e.____ Not applicable.

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.

6. This waiver program includes individuals who are eligible under medically needy groups.

a.__X__ Yes b.____ No

7. A waiver of 1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.

a.__X__ Yes b.____ No c.____ N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

a.__X__ Yes b.____ No

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

a.__X__ Yes b.____ No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

Multipurpose Senior Services Program Sites			
Site #	**County**	**Contractor**	**Catchment Area**
01	Alameda	City of Oakland	City
02	Santa Cruz	County of Santa Cruz	Entire County
03	Los Angeles #1	AltaMed	East Los Angeles
04	Los Angeles #2	Jewish Family Service	West Los Angeles, San Fernando Valley
05	Los Angeles #3	SCAN Health Plan	Long Beach area of Los Angeles
06	San Francisco	Institute on Aging	Entire City/County
07	San Diego	County of San Diego	Central, South County
08	Mendocino, Lake	Community Care Management Corporation	Ukiah, Willits, Fort Bragg, Clearlake
09	Humboldt	Humboldt Senior Resource Center	Entire County
10	Butte, Glenn	California State University, Chico Research Foundation	Entire Counties
11	Sonoma	Sonoma County Area Agency on Aging	Entire County
12	Sacramento, Placer, Yolo	Regents of the University of California, Davis	All of Sacramento, parts of Placer and Yolo Counties
13	San Mateo	County of San Mateo	Entire County
14	Stanislaus	Stanislaus County, Community Services Agency	Entire County
15	Santa Barbara	County of Santa Barbara, Public Health Department	Entire County
16	Los Angeles #4	Pasadena Hospital Association, Ltd.	Pasadena, San Gabriel Valley
17	San Bernardino	San Bernardino County Department of Aging and Adult Services	San Bernardino urban, East and West Valleys
18	Orange	County of Orange, Social Services	Entire County

Multipurpose Senior Services Program Sites			
Site #	**County**	**Contractor**	**Catchment Area**
		Agency	
19	(site reassigned)		
20	Santa Clara	Council on Aging of Silicon Valley, Inc.	San Jose, Campbell, Santa Clara
21	Fresno	Fresno-Madera Area Agency on Aging	Entire County
22	San Joaquin	County of San Joaquin	Entire County
23	Imperial	Work Training Center	Entire County
24	Riverside	Riverside County Office on Aging	Entire County
25	Lassen, Modoc, Shasta, Siskiyou, Trinity	Golden Umbrella	Entire Counties
26	Marin	Jewish Family and Children's Services	Entire County
27	Contra Costa	Contra Costa Office on Aging	Entire County
28	Merced	Merced County Human Services Agency	Entire County
29	Kern	Kern County Aging and Adult Services	Entire County
30	Monterey	Monterey County Department of Social Services	Entire County
31	Napa, Solano	Area Agency on Aging Serving Napa-Solano Counties	Entire Counties
32	Tuolumne, Calaveras, Alpine, Amador, Mariposa	Area 12 Agency on Aging	Entire Tuolumne and Calaveras; parts of Alpine, Amador and Mariposa Counties
33	Kings, Tulare	Kings/Tulare Agency on Aging	Entire Counties
34	Ventura	County of Ventura Area Agency on Aging	Entire County
35	El Dorado	El Dorado County Department of Community Services	Entire County
36	Yuba	Yuba County Health Services	Entire County

37	Alameda	City of Fremont	Cities of Fremont, Hayward and Union City
38	Inyo and Mono	Inyo/Mono Area Agency on Aging	Inyo and Mono Counties
39	Los Angeles #5	Human Services Association	South Central Los Angeles
40	Los Angeles #6	Partners in Care Foundation	San Fernando Valley
41	Orange	CalOptima	Entire County
42	(site reassigned)		
43	Los Angeles #7	Partners in Care/South Central	South Central Los Angeles

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

Requested services are all listed under item "t, Other Services."

a._____Case management

b._____Homemaker

c_____Home health aide services

d._____Personal care services

e._____Respite care

f._____Adult day health

g._____Habilitation

____ Residential habilitation

____ Day habilitation

____ Prevocational services

____ Supported employment services

____ Educational services

h._____Environmental accessibility adaptations

i._____Skilled nursing

j._____Transportation

k._____Specialized medical equipment and supplies

l._____Chore services

m.____Personal Emergency Response Systems

n._____Companion services

o._____Private duty nursing

p.____ Family training

q.____ Attendant care

r.____ Adult Residential Care

____ Adult foster care

____ Assisted living

s._____Extended State plan services (Check all that apply):

____ Physician services

_____Home health care services

_____Physical therapy services

_____Occupational therapy services

_____Speech, hearing and language services

_____Prescribed drugs

_____Other (specify):

t. **X** Other services (specify):

Adult Day Support Center 1.0

Adult Day Care 1.1

Housing Assistance:

- **Minor Home Repairs and Adaptive Equipment (2.2)**
- **Nonmedical Home Equipment and Supplies (2.3)**
- **Emergency Move (2.4)**
- **Utility Service (2.5)**
- **Temporary Lodging (2.6)**

Chore (3.1)

Personal Care (3.2)

Health Care (3.3)

Protective Supervision (3.7)

Professional Care Assistance (3.9)

Care Management:

- **Site-Provided Care Management (50)**
- **Purchased Care Management (4.3)**
- **Transitional Care Management (4.6)**

Respite:

- **In-Home (5.1)**
- **Out-of-Home (5.2)**

Transportation:

- **Hour (6.3)**
- **One-Way Trip (6.4)**

Meal Services:

- **Congregate Meals (7.1)**
- **Home-Delivered Meals (7.2)**
- **Food (7.3)**

Protective Services:

- **Social Reassurance (8.3)**
- **Therapeutic Counseling (8.4)**
- **Money Management (8.5)**

Communication Services:

Communication/Translation (9.1)

Communication/Device (9.2)

u.____ The following services will be provided to individuals with chronic mental illness:

____ Day treatment/Partial hospitalization

____ Psychosocial rehabilitation

____ Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services that are not included in the individual written plan of care.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):

a. **X** When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, ~~foster home~~, or community residential facility).

b.____ Meals furnished as part of a program of adult day health services.

c.____ When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to CMS:

a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:

1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);

2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and

3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

b. The ~~agency~~ **MSSP sites** will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.

c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:

1. Informed of any feasible alternatives under the waiver; and

2. Given the choice of either institutional or home and community-based services.

d. The ~~agency~~ **MSSP sites** will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.

e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the

services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.

g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.

h. The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by CMS.

i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a. **X** Yes b.____ No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to CMS at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a.____ Yes b. **X** No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

19. An effective date of **July 1, 2004** is requested.

20. The State contact person for this request is **California Department of Health Services,**

Brigitte Baul, Chief, Demonstration Project Unit, who can be reached by telephone at **(916) 552-9631.**

21. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by CMS, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: _____

Print Name: _____

Title: _____

Date: _____

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449. The time required to complete this information collection is estimated to average 160 hours for each new and renewed waiver request and an average of 30 hours for each amendment, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

____ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

X The waiver will be operated by **the California Department of Aging (CDA),** a separate agency of the State, under the supervision of **the Department of Health Services (DHS),** the Medicaid agency. ~~The Medicaid agency exercises~~ **DHS will exercise** administrative discretion in the administration and supervision of the waiver and ~~issues policies, rules and regulations related to the waiver~~ **shall review all CDA waiver-related policies, procedures, rules or regulations for consistency with the waiver, Medicaid statutes and regulations.** A copy of the interagency agreement **(IA)** setting forth the authority and arrangements for this policy is on file at the Medicaid agency. **The description of roles and responsibilities of the parties to the IA is summarized in the Scope of Work, which is attached to this Appendix.**

A standardized MSSP Site Manual is in place to provide local site staff with current requirements relevant to this waiver. The Site Manual is a compendium of policies and procedures, designed to provide information in a usable, accessible format to assist staff in carrying out local program operations on behalf of waiver clients.

____ The waiver will be operated by _____, a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

APPENDIX A ATTACHMENT

Interagency Agreement
Scope of Work
07/01/01 – 06/30/04

Project Title: CDA Home and Community-Based Services Waiver

GOALS

Goal No. 1 The Department of Health Services (DHS), the Medicaid single State agency, will exercise administrative discretion in providing and ensuring proper administration of the Medicaid Home and Community-Based Services (HCBS) Waiver under the authority of Section 1915 (c) of the Social Security Act for purposes of providing services under the Multipurpose Senior Services Program (MSSP) to frail elderly persons who are at risk of institutionalization. The Waiver will be implemented by the California Department of Aging (CDA) under the supervision of DHS through an Interagency Agreement (IA). DHS will exercise administrative discretion in the administration and supervision of the Waiver and shall review any CDA Waiver-related policies, procedures, rules or regulations for consistency with the Waiver, Medicaid statutes and regulations. DHS may issue its own policies, procedures, rules and regulations related to the Waiver.

Goal No. 2 DHS and CDA will provide accurate reports as required to the Centers for Medicare & Medicaid Services (CMS) regarding this Medicaid Waiver.

OBJECTIVES

Objective No. 1 DHS Rate Development Branch (RDB) will ensure technical/programmatic compliance and correctness of the IA; DHS-RDB will serve as central point of contact for Centers for Medicare & Medicaid Services (CMS); CDA will serve as central point of contact for MSSP Sites and service vendors.

Objective No. 2 CDA shall provide fiscal oversight of MSSP Sites and service vendors.

Objective No. 3 Medi-Cal Operations Division (MCOD) will develop and maintain the DHS Monitoring and Oversight protocol for DHS monitoring and oversight reviews, to include, but not be limited to, Independent Reviews. CDA will maintain and manage the CDA Monitoring and Oversight Protocol (MSSP Site Manual) for its Utilization Reviews (URs) of local Sites and will provide reports to DHS-RDB for its utilization review of local MSSP Sites. MCOD will work collaboratively and/or independently with CDA to ensure the Waiver program and services are implemented in accordance with Medicaid statute, regulations, Waiver and IA requirements.

Objective No. 4 CDA will work with MSSP Sites to ensure that home and community-based services reimbursable under Section 1915(c) of the Social Security Act are available only to eligible Medicaid beneficiaries under the Waiver who are in need of such services. This is to be accomplished by ensuring, through monitoring, that MSSP Sites and equipment are meeting this objective

through proper use of the Electronic Data System (EDS).

Objective No. 5 CDA and RDB will jointly prepare the required CMS 372 report for submission. In the event that additional information is requested by DHS-RDB or CMS, CDA and RDB will meet and discuss. If necessary, they will confer with DHS-Information Technology Services Division (ITSD) to determine the type of data needed, the time-frames of data needed, and the availability of the data needed.

Objective No. 6 CDA and DHS will assure that a formal system will be in place to ensure the health and welfare of the individuals served on the Waiver; CDA and DHS will monitor the quality control measures described in the Waiver and MSSP Site Manual in order to ensure that the quality of services provided under the Waiver and the State Plan, to persons served under the Waiver, are based upon the monitoring activities of both departments pursuant to the CDA and DHS Monitoring and Oversight Protocol(s).

Objective No. 7 CDA will ensure that necessary safeguards are taken to protect the health and welfare of persons receiving services under the Waiver, including the assurance that: a) adequate standards exist for each type of provider furnishing services under the Waiver, and that those standards are met, b) local MSSP Sites are ensuring their vendors meet State licensure or certification requirements for services furnished under the waiver and that this requirement is met on the date services are furnished.

Objective No. 8 CDA will provide training and technical assistance covering the entire Waiver program.

APPENDIX B - SERVICES AND PROVIDER STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

All services defined for use under the waiver will be provided only pursuant to an approved care plan. In providing services to MSSP clients, care managers must first fully utilize any and all other funding sources (e.g., State Medicaid Plan, Older Americans Act) before authorizing expenditure of waiver funds.

The MSSP care manager is responsible for monitoring the health, safety and welfare of the client. However, when the client makes their own arrangements for hiring or otherwise receiving any in-home services, including personal care, MSSP care management staff are not responsible for the monitoring or supervision of the service provider. In such situations, the care manager will be responsible for discussing with the client or their representative, the client's health status and the care or services being provided. The care manager is required to report to the appropriate authority (e.g., depending on the situation, Adult Protective Services or the client's physician), any areas of concern regarding a client, including any sign or symptom requiring professional evaluation or care.

The services listed below are those identified on page 7 of the Application.

a. **X** ~~Case~~ **Care** Management

X Services that will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

~~Case~~ **Care** managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1. **X** Yes 2.___No

~~Case~~ **Care** managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1. **X** Yes 2.___No

X Other Service Definition (Specify):

MSSP Site Care Management (50)
This service assists clients in gaining access to needed Waiver and other State Plan services, as well as needed medical, social, and other services, regardless of the funding source. Care Managers are responsible for ongoing monitoring of the provision of services included in the client's care plan. Additionally, care managers initiate and oversee the process of assessment and reassessment of client level of care and the monthly review of care plans.

The MSSP care management system vests responsibility for assessing, care planning, locating, authorizing, coordinating, and monitoring a package of long-term care services for clients with a local MSSP site contractor and specifically with the site care management team. The care management teams at each of the local sites are trained professionals working under the job titles of nurse care manager (NCM, i.e., public health nurse), and social work care manager (SWCM, i.e., social worker). These professionals may be assisted by care manager aides. The teams are responsible for care management services including: the assessment; care plan development; service authorization and delivery; monitoring and follow up components of the program. Although the Primary care manager (PCM) will be either a SWCM or NCM, both professionals will be fully utilized in carrying out the various care management functions. Case records must document all client contact activity each month.

Purchased Care Management (4.3)
For the vast majority of MSSP clients, care management services are provided solely by site care management staff. However, clients have the right to request care management by qualified outside vendors and, additional case-specific resources may be purchased from social and legal/paralegal specialists in the community in order to augment the resources and skills of site-staffed care managers. Fees necessary to procure birth certificates or other legal documents required for establishment of public health benefits or assistance are also covered.

Transitional/Deinstitutional Care Management(4.6)
(The term Transitional Case Management [TCM] is used by CMS to describe this service; however, in practice in California, this terminology is consistently confused with Targeted Case Management [also TCM]. To avoid this confusion, MSSP has adapted the federal terminology, changing the term to Deinstitutional Care Management.) Care management and the provision of other Waiver services may begin up to 180 days prior to discharge from an institution. All services provided will be billed against the Waiver on the date of discharge. If the beneficiary should die before discharge, all services provided may be charged to the Waiver under Administrative Case Management. If the individual is not discharged, or is ineligible for MSSP upon discharge to the community, all services provided will be billed against the waiver under Administrative Case Management.

b.___ Homemaker:

___ Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

___ Other Service Definition (Specify):

c.___ Home Health Aide services:

___ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

___ Other Service Definition (Specify):

d. **X** Personal care services:

___ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This services may include assistance with preparation of meals, but does not include the cost of the meals themselves. when specified in the plan of care, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

Personal Care (3.2)
This service is provided to individuals who are not eligible to receive it under the State Plan. It provides assistance to maintain bodily hygiene, personal safety, and activities of daily living. These tasks are limited to nonmedical personal services: feeding, bathing, oral hygiene, grooming, dressing, care of and assistance with prosthetic devices, rubbing skin to promote circulation, turning in bed and other types of repositioning, assisting the individual with walking, and moving the individual from place to place (e.g., transferring). Client instruction in self care may also be provided; may also include assistance with preparation of meals, but does not include the cost of the meals themselves.

Purchase of toiletries and other personal care supplies may be covered where there are no other resources and the purchase would create a financial hardship. These items include: shampoo, soap, lotion, tooth brush and paste, toothettes, shavers, medication assistive devices (e.g., medi-sets, pill crushers), incontinence

supplies not covered under the State Plan, disposable gloves and wipes.

When specified in the care plan, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are essential to the health and welfare of the recipient. The household chores that are performed by the worker are essentially ancillary to the provision of the client-centered care. Thus, if food is spoiled, it may be cleaned up, and when bed linen is soiled it may be changed, washed, and put away. However, at no time would household chores become the central activity furnished by a personal care worker.

When a personal care service is to be performed by an unlicensed health care worker (e.g., Home Health Aide), permissible duties will be limited to those allowed by the worker's employer, or permissible according to the Board of Registered Nursing policy on unlicensed assistive personnel, or as permitted by the worker's certification (if applicable).

Personal care service providers may be paid while the beneficiary is institutionalized. This payment is made to retain the services of the care provider and is limited to seven (7) calendar days per institutionalization.

1. Services provided by family members (Check one):

   X Payment will not be made for personal care services furnished by a member of the individual's family.

   ___ Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

   Justification attached. (Check one):

   ___ Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

   ___ Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

   X A registered nurse, licensed to practice nursing in the State **who is an employee of the agency employing the personal care worker.**

   ___ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

___ ~~Case~~ **Care** managers

_X_ Other (Specify): **If care quality issues are identified by the care manager, the care manager advocates for the client through referral to the client's own physician or to the appropriate oversight agency for any caretaker supervision or training that is necessary.**

3. Frequency or intensity of supervision (Check one):

___ As indicated in the plan of care

_X_ Other (Specify): **Care managers contact clients at least monthly to check on the client's condition, and verify the adequacy and effectiveness of the services. All purchased personal care is delivered by employees of contracted agencies. These agencies also provide a level of supervision in terms of assignments, training, disciplinary action, and education that is appropriate for them as employers.**

4. Relationship to State plan services (Check one):

___ Personal care services are not provided under the approved State plan.

___ Personal care services are included in the State plan, but with limitations. The waivered service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

_X_ Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

_X_ Other service definition (Specify):
Professional Care Assistance (PCA) (3.9)
This service is provided to those clients who are also receiving services under the Personal Care Services Program (PCSP). PCA is a comprehensive skilled service delivered by a home health aid (HHA). The HHA works under the supervision of a registered nurse employed by a home health agency. The specific tasks provided are the same as listed under Personal Care (3.2) above. However, the special needs and circumstances of Waiver clients require a provider who can make observations and exercise judgment regarding the execution of specific tasks and the overall provision of care. The training and expertise of a HHA is greater and more specialized than that of a provider working under the State Plan. This higher level of skill is required to meet the needs of the frail elderly clients served under the waiver.

When personal care assistance is performed by an unlicensed health care worker (e.g., Home Health Aide), permissible duties will be limited to those allowed by the worker's employer, or permissible according to the Board of Registered

Nursing policy on unlicensed assistive personnel, or as permitted by the individual's certification (if applicable).

Purchase of toiletries and other personal care supplies may be covered where there are no other resources and the purchase would create a financial hardship. These items include: shampoo, soap, lotion, tooth brush and paste, toothettes, shavers, medication assistive devices (e.g., medi-sets, pill crushers), incontinence supplies not covered under the State Plan, disposable gloves and wipes.

PCA service providers may be paid while the beneficiary is hospitalized up to seven (7) calendar days per each hospitalization. This payment is necessary to retain the care provider for services when the beneficiary returns home.

e. **X** Respite care:

___ Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

X Other service definition (Specify):
Respite Care (In-Home [5.1] and Out-of-Home [5.2])
The State Plan does not provide for respite care. By definition, the purpose of respite care is to relieve the client's caregiver and thereby prevent breakdown in the informal support system. Respite service will include the supervision and care of a client while the family or other individuals who normally provide full-time care take short-term relief or respite which allows them to continue as caregivers. Respite may also be needed in order to cover emergencies and extended absences of the caregiver.

As dictated by the client's circumstances, services will be provided In-Home (5.1) or Out-of-Home (5.2) through appropriate available resources. Federal Financial Participation (FFP) will not be claimed for the cost of room and board except when provided as part of respite care in a facility approved by the State that is not a private residence. Individuals providing services in the client's residence shall be trained and experienced in homemaker services, personal care, or home health services, depending on the requirements in the client's care plan.

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s) (Check all that apply):

X Individual's home or place of residence

___ Foster home

_X_ Medicaid certified Hospital

_X_ Medicaid certified NF

___ Medicaid certified ICF/MR

___ Group home

___ Licensed respite care facility

_X_ Other community care residential facility approved by the State that is not a private residence (Specify type): **Respite care may be provided in Residential Care Facilities for the Elderly (RCFE) if the RCFE has fully evaluated the individual client and has determined that the RCFE is an appropriate respite care setting for that particular individual. In making this evaluation, the RCFE must insure that all applicable licensing criteria are met and ensure the health and safety of the individual while under their care.**

___ Other service definition (Specify):

f.____ Adult day health:

___ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1.___Yes 2.___No

___ Other service definition (Specify):

Qualifications of the providers of adult day health services are in Appendix B-2.

g.____ Habilitation:

___ Services designed to assist individuals in acquiring, retaining and improving the self-

help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

___ Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation that shows that Medicaid payment does not cover these components is attached to Appendix G.

___ Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

___ Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). Prevocational services are available only to individuals who have previously been discharged from a SNF, ICF, NF or ICF/MR.

Check one:

___ Individuals will not be compensated for prevocational services.

___ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

___ Educational services, which consist of special education and related services as defined in section s (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

___ Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

   FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

   1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

   2. Payments that are passed through to users of supported employment programs; or

   3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1.___Yes 2.___No

___ Other service definition (Specify):

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h. **X** Environmental accessibility adaptations:

___ Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and

without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

X Other service definition (Specify):
Housing Assistance (2.2, 2.3, 2.4, 2.5, and 2.6). These services are necessary to ensure the health, welfare and safety of the client in their physical residence or home setting. As specified in the client's care plan, services may include provision of physical adaptations and assistive devices, emergency assistance in situations that demand relocation and assistance to obtain or restore utility service.

- **Minor Home Repairs and Maintenance (2.2):**
  These services do not involve major structural changes or major repairs to the dwelling. Maintenance is defined as those services necessary for accessibility (e.g., ramps, grab bars, handrails; items above what is covered by the State Plan and, installation), safety (e.g., electrical wiring, smoke alarms), or security (e.g., locks). Eligible clients are those whose health and/or safety or independence are jeopardized because of deficiencies in their place of residence. This service is limited to clients who are owners/occupiers of their own home, or those in rental housing where the owner refuses to make needed repairs or otherwise alter the residence to adapt to special client needs. Written permission from the landlord (including provision for removal of modifications, if necessary) is required before undertaking repairs or maintenance on leased premises. All services shall be provided in accordance with applicable State or local building codes.

- **Nonmedical Home Equipment (2.3)**
  This service includes those assistive devices, appliances and supplies that are necessary to assure the client's health, safety and independence. It includes the purchase or repair of nonmedical home equipment and appliances such as refrigerators, stoves, microwave ovens, blenders, kitchenware, heaters, air conditioners, fans, washers, dryers, vacuum cleaners, furniture (i.e., couches, lamps, tables, chairs [including recliners and lift chairs]), mattresses and bedding under the following circumstances:

  1. **The client is receiving Deinstitutional Care Management services, and the items are required to facilitate discharge from the institution to a community residence.**

2. **The client's assessment identifies the need for this service including how it is a necessary support if the client is to remain in the community , and the care plan specifies the required item(s).**

In either circumstance, the following criteria must be met and documented in the case record:

1. **The items are unobtainable through other resources, and their purchase would be a financial hardship for the client.**

2. **The items are necessary to preserve the client's health, improve functional ability and assure maximum independence thereby preventing elevation to a higher level of care and avoiding more costly institutionalization.**

- **Emergency Move (2.4): This service involves facilitating a smooth transition from one living situation to another. Eligible clients are those who, due to loss of residence or the need for a change in residence, require assistance with relocation. Services may be provided by moving companies or other individuals who can guarantee the safe transfer of the client's possessions. Activities may include materials and labor necessary for such moves.**

- **Emergency Utility Service (2.5): This service allows for payment of utilities only when the client has no other resources to meet this need. Additionally, the client must be at risk to receive a shut-off notice, and the potential shut-off of utility services would place the health and safety of the client in jeopardy. Elderly individuals are more vulnerable to extremes in environmental changes because of decreased physiologic reserves, less flexible homeostatic processes, and decreased resistance to stress. These extremes affect organ systems that already are vulnerable because of physiologic and pathologic changes.**

- **Temporary Lodging (2.6): As specified in the individual's care plan, this service allows for payment of hotel or motel lodging for those clients, usually from rural areas, who must travel long distances and stay overnight for medical treatments not available in their home area. Lodging rates shall not exceed State per diem limits; these limits vary depending on geographic area.**

i.___ Skilled nursing:

___ Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

___ Other service definition (Specify):

j. **X** Transportation: **6.3 (Hour) and 6.4 (One-Way Trip)**

X Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care **and shall include transportation escort, if necessary, to assure the safe transport of the recipient. Escort services may be authorized for those clients who cannot manage to travel alone, and require assistance beyond what is normally offered by the transportation provider**. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.

___ Other service definition (Specify):

k.____ Specialized Medical Equipment and Supplies:

___ Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with he environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items that are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

___ Other service definition (Specify):

l. **X** Chore services:

___ Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

_X_ Other service definition (Specify):
Chore (3.1)
This service applies to the performance of household tasks rather than to the care of the client. Chore activities are limited to: household cleaning, laundry (including the services of a commercial laundry or dry cleaner), shopping, food preparation, and household maintenance, as long as the client does not live in a Residential Care Facility for the Elderly (RCFE). Client instruction in performing household tasks and meal preparation may also be provided.

This service is for purposes of household support for those services above and beyond those available through the residual In-Home Supportive Services (IHSS) program. Examples include:

1. **The MSSP client has not yet been assessed for IHSS, and needs services in the interim until IHSS services can be arranged.**

2. **The regular IHSS provider is not available, and IHSS cannot provide a substitute.**

3. **IHSS services are in place; however, MSSP has assessed a greater need. In these cases, every effort will be made to negotiate with IHSS towards an increase in those services before authorizing expenditure of waiver funds.**

m._X_ Personal Emergency Response Systems (PERS)

___ PERS is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

_X_ Other service definition (Specify):
Communication Device (9.2):
This service allows the rental/purchase of 24-hour emergency communication and assistance services, or installation of a telephone, to assist in communication for clients who are at risk of institutionalization due to physical conditions likely to result in a medical emergency. Purchase of emergency communication and assistance services is limited to those clients who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. Emergency communication and assistance services enable the recipient to secure immediate assistance in the event of an emotional, physical, or environmental emergency; training, installation, repair, maintenance, and response are

included. Hearing aids and appliances, and monthly telephone charges are excluded. The following are allowable:

1. **24-hour answering/paging**
2. **Beepers**
3. **Medic-alert type bracelets/pendants**
4. **Intercoms**
5. **Life-lines**
6. **Monitoring services**
7. **Light fixture adaptations (blinking lights, etc.)**
8. **Telephone adaptive devices not available from the telephone company**
9. **Other electronic devices/services designed for emergency assistance**

Telephone installation will only be authorized to enable the use of telephone-based electronic response systems where the client has no telephone, or for the isolated client who has no telephone and who resides where the telephone is the only means of communicating health needs. This service will only be authorized when the client has a medical/health condition that makes him/her vulnerable to medical emergency (e.g., congestive heart failure or emphysema).

All types of personal emergency response devices shall meet applicable standards of manufacture, design, and installation. Repairs to and maintenance of such equipment shall be performed by the manufacturer's authorized dealers where possible.

n.____ Adult companion services:

___ Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

___ Other service definition (Specify):

o.____ Private duty nursing:

___ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

___ Other service definition (Specify):

p.____ Family training:

___ Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

___ Other service definition (Specify):

q.____ Attendant care services:

___ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those that substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. this service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities that are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

___ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

___ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

___ Other supervisory arrangements (Specify):

___ Other service definition (Specify):

r.____ Adult Residential Care (Check all that apply):

___ Adult foster care: Personal care and services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. The total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed__). Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

___ Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way that fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

___ Home health care

___ Physical therapy
___ Occupational therapy

___ Speech therapy

___ Medication administration

___ Intermittent skilled nursing services

___ Transportation specified in the plan of care

___ Periodic nursing evaluations

___ Other (Specify)

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

___Other service definition (Specify):

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

s. **X** Other waiver services that are cost-effective and necessary to prevent institutionalization (Specify):

Adult Day Support Center (1.0):

These centers are community-based programs that provide nonmedical care to meet the needs of adults with functional impairments. Services are provided according to an individual plan of care in a structured comprehensive program that provides a variety of social, psychosocial, and related support services in a protective setting on less than a 24-hour basis. Eligible clients are those who: need but do not have a caregiver available during the day; are isolated and need stimulation; need a protective setting for social interaction; and/or need psychological supports to prevent institutionalization. This service will be provided when specific therapeutic goals are specified in the client's care plan. Adult day support center care is not meant to be merely diversional or recreational in nature. The State Department of Social Services (DSS) licenses Adult Day Support centers as community care facilities. Alzheimer's Day Care Resource Centers (ADCRC) are also allowable providers of this service.

Adult Day Care (1.1):
This service will be provided to clients whose care plan indicates they will benefit from being in a social setting with less intense supervision and fewer professional services than that offered in an adult day support center. The care plan should provide specific therapeutic goals that are not merely diversional or recreational in nature. Adult day care centers are community-based programs that provide nonmedical care to persons 18 years of age or older in need of personal care services, supervision or assistance essential for sustaining the activities of daily living or for the protection of the individual on less than a 24-hour basis. The DSS licenses Adult Day Care centers as community care facilities. Alzheimer's Day Care Resource Centers (ADCRC) are also allowable providers of this service.

Health Care (3.3):
This service addresses the care of health problems by appropriately licensed or certified persons when such care is not otherwise available under the State Plan. These services will be provided based on the following criteria:

- **The client assessment identifies need for this support and the care plan reflects the required item(s).**

- **MSSP utilizes all of the health care services available under the State Medicaid Plan prior to purchasing these services as waived services. MSSP's clients are extremely frail and, on occasion, in need of health-related services that cannot be provided under Medi-Cal, e.g., no Medi-Cal provider in that local area. Such services are especially critical for persons recently discharged from acute hospitals or who are otherwise recovering at home from an acute illness or injury. This MSSP service supplements benefits provided by the existing Medi-Cal program, using providers who meet standards under Provider Qualifications (Appendix B-2). Factor D includes the cost of waivered skilled nursing services; Factor D' includes the cost of State Plan skilled nursing services.**

- **The service is provided by authorized individuals when such care is prescribed or approved by a physician.**

- **Services may include the following professionals/services:**

  1. **Pharmacists: pharmacy consultations.**

  2. **Registered nurses or licensed vocational nurses: skilled nursing services.**

  3. **Nutritionists/Registered Dietitians: nutritional assessment or counseling.**

  4. **Occupational, physical, or speech therapists: consultation, including client assessment, training, planning.**

  5. **Other health professionals specific to the identified need of the client: art, dance**

exercise, massage, music, and recreation therapists.

In addition to the provision of care, these professionals and paraprofessionals may train, demonstrate, and supervise clients in techniques which will enable them (or their caregivers) to carry out their own care whenever possible.

Protective Supervision (3.7):
This service insures provision of supervision in the absence of the usual care provider to persons in their own homes who are very frail or otherwise may suffer a medical emergency, to prevent immediate placement in an acute care hospital, nursing facility, or other 24-hour care facility, e.g., Residential Care Facility for the Elderly (RCFE). Such supervision does not require medical skills and can be performed by an individual trained to summon aid in the event of an emergency. May also provide a visit to the client's home to assess the situation during an emergency (e.g., natural disaster). Waived service funds may not be used to purchase this service until existing county Title XX Social Services and Title XIX Medi-Cal resources have been fully utilized and an unmet need remains.

Meal Services (7.1, 7.2, and 7.3): These services may be provided daily, but are not to constitute a full nutritional regimen (three meals a day).

- **Congregate Meals (7.1): Meals served in congregate meal settings for clients who are able to leave their homes or who require the social stimulation or a group environment in order to maintain a balanced diet. Congregate meals can be a preventive measure for the frail older person who has few (if any) informal supports, as well as a rehabilitative activity for people who have been physically ill or have suffered emotional stress due to losses associated with aging. This service should be available to MSSP clients through Title III of the Older Americans Act (OAA). MSSP funds shall only be used to supplement congregate meals when they are unavailable or inadequate through Title III or other public or private resources.**

- **Home-Delivered Meals) (7.2): For clients who are homebound, unable to prepare their own meals and have no caregiver at home to prepare meals for them. As with Congregate Meals, the primary provider of this service is Title III of the OAA. MSSP funds shall only be used to supplement home-delivered meals when they are unavailable or inadequate through Title III or other public or private resources.**

- **Food (7.3): Provision of food staples is limited to purchase of food to facilitate and support a client's return home following institutionalization, and to food purchases which are medically required.**

  If oral nutritional supplements (ONS) are to be included in the care plan, efforts must be made to obtain them through a Medi-Cal Treatment Authorization Request (TAR) when applicable. If this is not possible or appropriate, the rationale will be documented.

If ONS are to be purchased with waived services funds, the following must be recorded in the client record:

- **The nurse care manager has assessed the client's nutritional needs and concluded that an ONS is advised; AND**

- **The use of home-prepared drinks/supplements (e.g., instant breakfast, pureed food) has been explored and found not to meet the client's needs.**

Following the criteria described above, ONS may be purchased initially for a period of three months. When it is determined that it is desirable to continue beyond that time, the client's personal physician must be notified, and additional supporting documentation must be obtained by either:

1. **A nutritional screening recommending this alternative (preferably a consultation or assessment obtained from a nutritionist or dietitian, but if these resources are not available, a screen conducted by the primary care manager in consultation with the nurse care manager); or**

2. **A prescription obtained from the physician; or**

3. **Approval (verbal or in writing) for this service from the physician noted in the record.**

If the service is to be continued beyond six months, the following criteria will be documented in the client record, and repeated every six months thereafter for as long as an ONS is being purchased with waived services funds:

1. **A prescription obtained from the physician, AND**

2. **A review of the client's nutritional status will be conducted by the nurse care manager. The purpose of the review is to assure the appropriateness of continuing to provide an ONS for an individual client. It is preferred that the review be conducted by obtaining an assessment from a nutritionist or dietitian. If these resources are not available, a member of the care management staff will complete a nutritional screen.**

When the client or family is purchasing the ONS, the care manager should advise them to notify the client's physician.

Protective Services (8.3, 8.4, and 8.5): These services include protection for clients who are isolated and homebound due to health conditions; who suffer from depression and other psychological problems; individuals who have been harmed, or threatened with harm (physical or mental) by other persons or by their own actions; or those whose cognitive functioning is impaired to the extent they require assistance and support in making and carrying out decisions regarding personal finances.

- **Social Reassurance (8.3):**
  This service includes periodic telephone contact, visiting or other social and reassurance services specified in the care plan, to verify that the individual is not in medical, psychological, or social crisis; or to offset isolation. Expenses for activities and supplies required for client participation in rehabilitation programs, therapeutic classes and exercise classes are also covered. Such services shall be provided based on need, as designated in the client's care plan. MSSP has found that isolation and lack of social interaction can seriously impact some clients' capacity to remain independent. Lack of motivation or incentive, or the lack of any meaningful relationships can contribute to diminishing functional capacity and premature institutionalization. These services are often provided by volunteers or through Title III of the OAA; however, alternate funding sources may not be available in a particular community. These services may be purchased under the Waiver only if otherwise unavailable in the community, or are inadequate as provided under other public or private programs.

- **Therapeutic Counseling (8.4):**
  This service includes individual or group counseling to assist with social, psychological, or medical problems identified on the care plan. MSSP has found that therapeutic counseling is essential for preventing some clients from being placed in a nursing facility (NF). This service may be utilized in situations where clients or their caregivers may face crises, severe anxiety, emotional exhaustion, personal loss/grief, confusion, and related problems. Counseling by licensed or certified counselors in conjunction with other services (e.g., respite, In-Home Supportive Services, meals) may reverse some states of confusion and greatly enhance the ability of a family to care for the client in the community; or allow the client to cope with increasing impairment or loss.

- **Money Management (8.5):**
  This service assists the client with activities related to managing money and the effective handling of personal finances. Services may be either periodic or as full-time substitute payee. Services may be provided by organizations or individuals specializing in financial management or performing substitute payee functions. MSSP has found that assistance with managing day-to-day household finances is often required by frail elderly. These clients may be isolated by geography or by not having a trustworthy other person to rely upon. Failure to meet personal financial obligations frequently results in eviction, disconnection of utilities, or jeopardizes eligibility for maintenance programs such as Supplemental Security Income (SSI) and Medicaid. Money management services ensure a stable living environment and thereby avoid institutionalization.

Communication: Translation/Interpretation (9.1):
The provision of translation and interpretive services for purposes of instruction, linkage with social or medical services, and conduct of business is essential to maintaining independence and carrying out the Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) functions. For non-English speaking

clients, this service is the link to the entire home- and community-based service delivery system. MSSP resources shall be used to support this service only where family and community resources are unable to meet the need as described in the care plan.

t.____ Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

___ Physician services

___ Home health care services

___ Physical therapy services

___ Occupational therapy services

___ Speech, hearing and language services

___ Prescribed drugs

___ Other State plan services (Specify):

u.____ Services for individuals with chronic mental illness, consisting of (Check one):

___ Day treatment or other partial hospitalization services (Check one):

___ Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

b. occupational therapy, requiring the skills of a qualified occupational therapist,

c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,

d. drugs and biologicals furnished for therapeutic purposes,

e. individual activity therapies that are not primarily recreational or diversionary,

f. family counseling (the primary purpose of which is treatment of the individual's condition),

g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and

h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

___ Other service definition (Specify):

___ Psychosocial rehabilitation services (Check one):

___ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);

b. social skills training in appropriate use of community services;

c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and

d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

a. vocational services,

b. prevocational services,
c. supported employment services, and

d. room and board.

___ Other service definition (Specify):

___ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

___ This service is furnished only on the premises of a clinic.

___ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):

APPENDIX B-2

PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

Any requirement for Licensure/Certification means that the document (e.g., license, certificate) is active and current. All providers must complete a Vendor Application form, and sites must follow selection and monitoring processes specified in the Site Manual.

Service	Provider	License	Certification	Other Standard
1.0 Adult Day Support Center	Community Care Facility **or** Alzheimer's Day Care Resource Center	CCR Title 22, Div., 6, Ch. 3.5. None		
1.1 Adult Day Care	Community Care Facility **or** Alzheimer's Day Care Resource Center	CCR Title 22, Div., 6, Ch. 3. None		
2.2 Minor Repair/ Maintenance	Building Contractor **or** Handyman	State of Calif. Local business license		See below
Other Standard: Sites must assure that the vendor for repair jobs that cost more than $500 (total for materials and labor) is a licensed contractor; is bonded, insured, and has a local business license. Hourly handymen must have a local business license. The need for building inspection is governed by local ordinance: if an inspection is required, a copy of the inspection clearance shall be attached to the invoice for services.				
2.3 Nonmedical Home Equipment	Private nonprofit or proprietary agency	Local business license		
2.4 Emergency Move	Private nonprofit or proprietary agency	Local business license		
2.5 Emergency Utility Service	Public or private utility company	Public Utilities Commission		
2.6 Temporary Lodging	Hotel or motel establishment	Local business license		

3.1 Chore, and 3.2 Personal Care	Home health agency **or** Private nonprofit or proprietary agency	State of Calif. Local business license	Medicare N/A	See below See below
Other Standard: Tasks authorized under Chore (3.1) and Personal Care (3.2) are specified in the California DSS Manual, Division 30, Chapter 30-757. All individuals performing these services must: ▪ Be a US citizen or legal alien; ▪ Be at least 18 years of age; ▪ Have a Social Security card; ▪ Be able to read, write, carry out directions, and maintain simple records; ▪ Have transportation available; ▪ Be able to communicate changes in the status of the client and/or family; and ▪ Be physically capable of performing the work required.				
3.3 Health Care	Home health agency **or** Registered Nurse **or** Specified health professionals	State of Calif. State of Calif, R.N. See below	Medicare N/A N/A	See below See below See below
Other Standards: Registered nurses, occupational, physical and speech therapists must be employed by an agency licensed/certified by DHS as Medicare Home Health Agency (HHA) provider or licensed by DHS as a HHA unless any one of the following conditions apply: ▪ No licensed or certified HHA exists within the site's local service catchment area; or ▪ The licensed of certified HHA cannot meet the need of the MSSP client; or ▪ The client is not satisfied with the service provider from the licensed/certified HHA. Then the site may choose to contract with the following providers: 1. Local county Department of Public Health personnel who are professionally licensed; 2. Independent health professionals licensed by the California Department of Consumer Affairs in their appropriate profession (e.g., registered nurse), and who are qualified to provide the care of service contracted for. A client home visit must be made by the site's NCM to assess and document the quality of service provided by the independent contractor, or a written report submitted to the NCM by the contractor. Licensure standards for independent contractors are the same as those for professionals working for HHAs. These standards are contained in CCR, Title 22, Division 5, Chapter 6, Article 1. Nutritionists and Registered Dieticians (RD) must have completed a Bachelor's degree in food/nutrition; RDs must have passed the examination offered by the Commission on Dietetic Registration. Pharmacists must be licensed by the California Department of Consumer Affairs, Board of Pharmacy as a licensed pharmacist, pharmacy intern, technician or certified exemptee. Art, dance, exercise, massage, music and recreation therapists must be registered/certified by the appropriate professional organization.				

3.7 Protective Supervision, and 3.9 Professional Care Assistance	Private nonprofit or proprietary agency **or** Home Health Agency	Local business license State of Calif.	N/A Medicare	See below See below
Other Standard: Tasks authorized under Protective Supervision (3.7) and (3.9) Professional Care Assistance are specified in the California DSS Manual, Division 30, Chapter 30-757. All individuals performing these services must: ▪ Be a US citizen or legal alien; ▪ Be at least 18 years of age; ▪ Have a Social Security card; ▪ Be able to read, write, carry out directions, and maintain simple records; ▪ Have transportation available; ▪ Be able to communicate changes in the status of the client and/or family; and ▪ Be physically capable of performing the work required. For Professional Care Assistance (3.9) services, the provider must also be a certified home health aide, employed by a licensed home health agency.				
4.3 and 50 Care Management	Nurse Care Manager Social Work Care Manager Care Manager Aide Social, legal, and health specialists	State of Calif, R.N. See below	Public Health Nurse	See below See below See below See below
Other Standards: Nurse Care Manager (NCM): Must have a bachelor's degree in nursing (public health, health education, health administration, gerontology, or equivalent), plus two years experience, two of which is in public health, geriatrics preferred; hold a valid current license to practice nursing in the State of California; and have a public health certificate issued by the State of California.* Social Work Care Manager (SWCM): Must have a masters degree in social work, psychology, counseling, rehabilitation, gerontology, or sociology, plus one year working with the elderly; or a bachelor's degree in one of the above fields and two years experience with the elderly.* Care Manager Aide: Must have a bachelor's degree in a human services discipline; or two years of direct service experience with the elderly. Knowledge of community service delivery resources for the elderly preferred.* Social, legal and health specialists: Vendors of care management services other than site staff shall be licensed/certified in their appropriate professional field (e.g., a lawyer must be licensed to practice law in this state), and be qualified to provide the service contracted for. *Sites may request from CDA an exemption to minimum qualifications stated (see attachment to this Appendix for process).				

4.6 Deinstitutional (Transitional) Care Management	Nurse Care Manager Social Work Care Manager Care Manager Aide	State of Calif, R.N.	Public Health Nurse	See below See below See below
Other Standards: Nurse Care Manager (NCM): Must have a bachelor's degree in nursing (public health, health education, health administration, gerontology, or equivalent), plus two years experience, two of which is in public health, geriatrics preferred; hold a valid current license to practice nursing in the State of California; and have a public health certificate issued by the State of California.* Social Work Care Manager (SWCM): Must have a masters degree in social work, psychology, counseling, rehabilitation, gerontology, or sociology, plus one year working with the elderly; or a bachelor's degree in one of the above fields and two years experience with the elderly.* Care Manager Aide: Must have a bachelor's degree in a human services discipline; or two years of direct service experience with the elderly. Knowledge of community service delivery resources for the elderly preferred.* *Sites may request from CDA an exemption to minimum qualifications stated (see attachment to this Appendix for process).				
5.1 Respite, In-Home	Home Health Agency **or** Private nonprofit or proprietary agency	State of Calif. Local business license	Medicare	See below See below
Other Standards: Tasks authorized under Respite, In-Home (5.1) are specified in the California DSS Manual, Division 30, Chapter 30-757. All individuals performing these services must: ▪ Be a US citizen or legal alien; ▪ Be at least 18 years of age; ▪ Have a Social Security card; ▪ Be able to read, write, carry out directions, and maintain simple records; ▪ Have transportation available; ▪ Be able to communicate changes in the status of the client and/or family; and ▪ Be physically capable of performing the work required.				
5.2 Respite, Out-of-Home	Residential Care Facilities Intermediate Care Facilities Skilled Nursing Facilities Hospitals	CCR, Title 22, Div. 6, Ch.8 CCR, Title 22, Div. 6, Ch.4 CCR, Title 22, Div. 6, Ch.3 CCR, Title 22, Div. 5, Ch. 1		

6.3 Transportation (hour) and 6.4 Transportation (one-way trip)	Private nonprofit or proprietary agency Ambulance or wheelchair van/paratransit Escort: See below	See below See below See below		
License and Certification: Providers of regular transportation services must be either a properly registered private nonprofit or a licensed proprietary agency. Drivers must possess a valid class II or III drivers license issued by the California State Department of Motor Vehicles. The provider must furnish documentation that adequate vehicle insurance will be in effect during the term of the service contract. Providers of ambulance services must have a California Highway Patrol (CHP) vehicle inspection certificate; drivers must have successfully completed ambulance attendant training. The provider must furnish documentation that adequate vehicle insurance will be in effect during the term of the service contract. Providers of wheelchair van/paratransit services must provide evidence of CHP inspection and driver training. The provider must furnish documentation that adequate vehicle insurance will be in effect during the term of the service contract. Providers of escort services must be experienced in serving the needs and conditions of the frail elderly. In communities where the need for this service cannot be met through agency providers of 3.1 Chore described above, individuals may be used, provided they have documented on the MSSP Service Vendor Application an appropriate degree of experience and insurance, and reference checks verified by MSSP staff confirm a history of satisfactory performance.				
7.1 Congregate Meals	Title III (OAA) nutrition sites or private providers	Local business license; and any others as required by local governments.		
7.2 Home-Delivered Meals	Title III (OAA) or other nonprofit or proprietary agency	Local business license and health department inspection.		
7.2 Food	Private nonprofit, proprietary agency, or business	Local business license, and any others as required by local governments.		
8.3 Social Reassurance	Private nonprofit or proprietary agency	Local business license		See below
Other Standards: All individuals performing these services must: ▪ Be a US citizen or legal alien; ▪ Be at least 18 years of age; ▪ Have a Social Security card; ▪ Be able to read, write, carry out directions, and maintain simple records; ▪ Have transportation available; ▪ Be able to communicate changes in the status of the client and/or family; and ▪ Be physically capable of performing the work required.				

8.4 Therapeutic Counseling	Licensed/certified professionals listed below	Professional license/ certification and local business license		See below
Other Standards: Providers are professionals who are licensed or certified (as appropriate) to practice in the State of California. The licensing authority for clinical social workers, marriage and family counselors and therapists, psychologists and psychiatrists is the California Department of Consumer Affairs, Boards of Behavioral Science Examiners and Medical Quality Assurance. The certification authority for rehabilitation counselors is the Commission on Rehabilitation Counselor Certification.				
8.5 Money Management	Private nonprofit or proprietary agency, or individual	Local business license		Must be bonded and insured.
9.1 Communication: Translation/ Interpretation	Individual translators/ interpreters			See below
Other Standards: Providers shall have: ▪ Fluency in both English and a language other than English; and ▪ Ability to read and write accurately in both English and a language other than English; and ▪ Ability to maintain confidentiality.				
9.2 Communication: Device	Private nonprofit or proprietary agency, as appropriate for the service to be purchased.	Local business license		See below
Other Standards: Any electronic communication/response device obtained for client use must be of a type already in general use; product warranties and servicing for the unit must be available. Providers must be competent to meet applicable standards of installation, repair and maintenance of these systems and devices. Passive communication devices (e.g., identification bracelets or cards for emergency use or identification) and other devices designed for emergency assistance may also be purchased.				

ATTACHMENT TO APPENDIX B-2

Description of the process for requesting and processing an exemption to the minimum qualifications for MSSP care management staff.

Related forms:

- Criteria Rating Sheets:

  Nurse Care Manager

  Social Work Care Manager

  Supervising Care Manager

- Training and Development Pathways

  Nurse Care Manager

  Social Work

  Social Work/Nurse Care Manager Training and Development Plan

  Supervising Care Manager

  Supervising Care Manager Training and Development Plan

- Orientation Checklist

  Supervising Care Manager

  Social Work/Nurse Care Manager

Process For Requesting An Exemption To
Minimum Qualifications For
MSSP Care Management Staff

If efforts to recruit fully qualified applicants for a care management staff vacancy have been unsuccessful, the site may request an exemption to hire a candidate who does not meet the stated minimum qualifications for education and experience. This request must be made in writing and approved by CDA prior to making a commitment to hire. The process is as follows:

1. Prerequisites For An Exemption
All of the following expectations must be met in order for CDA to consider the request for exemption:

- The site must have a history of compliance with program standards in identifying, addressing and monitoring the psychosocial, health and safety issues of clients as identified in past UR findings. For Nurse Care Manager (NCM) exemptions, there must also be a history of appropriate level of care determinations at the site.

- Documentation and timeliness of program and casework processes must demonstrate compliance with Federal waiver requirements and MSSP guidelines.

- The site effectively utilizes an acceptable care management staffing model. For example, at a 200 client site, there are two NCMs and three Social Work Care Managers (SWCMs) as case carriers, or one NCM in a "consulting" role and four SWCMs as case carriers.

A site must first demonstrate and submit evidence of:

- Continuous advertisement for at least thirty (30) days. Advertisements may be in a variety of media, e.g., local and surrounding area newspapers; if rural, a major newspaper of closest proximity; internet listings and websites; appropriate professional journals; and

- Outreach to appropriate institutions of higher education and professional organizations (e.g., nursing, social work).

2. Procedure For Requesting An Exemption
A written request to CDA for exemption of the educational, experience or certification requirement will be submitted by the site prior to hiring an individual who does not meet the minimum qualifications. The request will include all of the following:

- The candidate's resume.

- The appropriate Criteria Rating Sheet (for either the SWCM, the Supervising Care Manager [SCM], or the NCM). (Criteria Rating Sheets attached.)

- Documentation demonstrating an appropriate recruitment process, e.g., advertisements,

mailings, organizational contacts, etc., covering at least a 30-day period.

- A written plan that addresses mentoring, supervision and oversight of the employee for whom the exemption is being requested. The plan must address all of the following:

  1. The candidate's ability to perform all duties outlined in the Site Manual.

  2. Plans for training and development activities that address the core competencies listed on the appropriate Training and Development Pathway (for either the SWCM, the SCM, or the NCM). (Pathway forms attached.) As a supplement to site-developed orientation materials, sites may also use the appropriate Orientation Checklist (blank form attached), as a guide to ensure that the SCM, SWCM or NCM is oriented to all care management duties.

  3. Goals and time frames for accomplishing any required training and development activities.

3. CDA Process
CDA will provide a verbal response to the exemption request within 48 hours of acknowledged receipt by CDA, followed by a written response within 10 working days.

4. Duration Of Exemption
Once granted, the exemption will remain in effect as long as the site assures, and CDA utilization reviews confirm, the candidate's competency in performing all care management activities/ duties.

If at any time the exempted employee does not demonstrate competency in performing their duties as determined by the applicable supervisor or utilization review (UR) findings, the site must immediately develop and implement a plan of corrective action.

CDA retains the right to rescind an exemption at any time a UR or other program review findings demonstrate that the exempted employee has not provided care management services in compliance with minimum program standards.

NURSE CARE MANAGER CRITERIA RATING SHEET

Name of Candidate _____

The following criteria will be assessed for the candidate who does not meet the requirements for Nurse Care Manager. A rating in each category is required in order to qualify for employment; i.e., Educational Background (A), Work Experience (B), and Care Management Experience (C). A total of 40 points is required for employment.

Rating Factor	Assigned Points	Achieved Points	Comments
A. **Educational Background**			
1. Graduate of CA BSN program (PHN certificate pending)	40		Must possess a CA RN license.
2. CA RN enrolled in CA BSN program (PHN certificate pending)	35		Must possess a CA RN license.
3. BSN graduate from out of state program	30		Must possess a CA RN license and obtain PHN certificate within 6 months of hire.
4. BS in field other than nursing (BS in Public Health, Health Education, Health Adm., or equivalent, focused on geriatric assessment)	25		Must possess a CA RN license. Education must include ADN degree or graduate from a Diploma nursing program.
5. RN from an accredited school of nursing (ADN) RN	15		Must possess a CA RN license.
6. Graduate of a Diploma nursing program	15		Must possess a CA RN license.
B. **Work Experience**			
1. >3 years experience performing geriatric assessments and care	20		
2. 1-3 years experience performing geriatric assessments and care	15		
3. 0-1 year experience performing geriatric assessments and care	10		
4. >5 years experience as RN in any nursing specialty other than geriatrics	10		
C. **Care Management Experience**			
1. 1-2 years care management experience as RN in community health	15		
2. 1-2 years experience as Home Health RN	10		
3. > 2 years experience as Discharge Planning RN in acute care setting	10		
4. Geriatric Care management experience as RN in other than community health (HMO, private corporation or agency, etc.)	10		

SOCIAL WORK CARE MANAGER CRITERIA RATING SHEET

Name of Social Work Care Manager Candidate _____

The following criteria will be assessed for the candidate who does not meet the requirements for Social Work Care Manager. A rating in each category is required in order to qualify for employment; i.e., Educational Background (A), Work Experience (B), and Case Management Experience (C). A total of 40 points is required for employment.

Rating Factor	Assigned Points	Achieved Points	Comments
A. **Educational Background**			
1. Masters degree in social work, psychology, counseling, rehabilitation, gerontology, or sociology.	**30**		
2. Bachelor of Science degree in social work, psychology, counseling, rehabilitation, gerontology or sociology.	**25**		
3. Masters degree in field other than those listed in numbers one and two.	**15**		
4. BS degree in field other than those listed in numbers 1 and 2 above.	**10**		
B. **Work Experience**			
1. Two or more years experience working with the elderly and performing psychosocial assessments.	**25**		
2. One year experience working with the elderly and performing psychosocial assessments.	**20**		
3. Less than one years experience performing psychosocial assessments and working with the elderly.	**15**		
C. **Care Management Experience**			
1. Two or more years geriatric care management experience as social worker in the community.	**20**		
2. One year care management experience as a social worker in the community.	**15**		
3. Less than one year care management experience as a social worker in the community.	**10**		
4. Less than six months geriatric care management experience as a social worker in other than community setting (HMO, private corporation or agency, etc.).	**10**		

SUPERVISING CARE MANAGER CRITERIA RATING SHEET

Name of Supervising Care Manager Candidate _____

The following criteria will be assessed for the candidate who does not meet the requirements for Supervising Care Manager. A rating in each category is required in order to qualify for employment; i.e., Educational Background (A), Work Experience (B), and Case Management Experience (C). A total of 35 points is required for employment.

Rating Factor	Assigned Points	Achieved Points	Comments
A. **Educational Background**			
1. Masters degree in social work, nursing, health care administration, psychology, counseling, rehabilitation, gerontology, or sociology.	**20**		
2. Bachelor of Science degree in social work, nursing, psychology, counseling, rehabilitation, gerontology, health care administration or sociology.	**15**		
3. Masters degree in field other than those listed in numbers 1 and 2 above.	**10**		
4. BS degree in field other than those listed in numbers 1 and 2 above.	**5**		
B. **Work Experience**			
1. Two or more years experience working directly with the elderly.	**10**		
2. One year or less experience working directly with the elderly.	**5**		
3. Two or more years administrative experience in health or human services.	**10**		
4. One year or less administrative experience in health or human services.	**5**		
C. **Care Management Experience**			
1. Two or more years geriatric care management experience in the community.	**15**		
2. One year care management experience in the community.	**10**		
3. Less than one year care management experience in the community.	**5**		
4. Less than six months geriatric care management experience in other than community setting (HMO, private corporation or agency, etc.).	**5**		

Training and Development Pathway
Nurse Care Manager

Core Competencies	Suggested Courses/ Workshops*	Suggested Time Frame for Completion After Employment
Ability to conduct in-depth assessments and reassessments covering medical, health, and rehabilitation.	• Geriatric assessment • Risk management	Six Months
Ability to evaluate the client as a total person and identify the functional limitations that impede independent living.	• Geriatric assessment • Risk management	Six Months
Ability to interpret clinical health findings and address them.	• Chronic disease management • Case management	Four Months
Good written and verbal communication skills.	• Written communication • Teaching strategies • Teamwork	Six Months
Negotiation skills with ability to advocate on behalf of client.	• Problem solving • Case management	Four Months
Collaboration skills including consultation with physicians other health professionals, team members, client, family, and community contacts.	• Conflict resolution	Four Months
Ability to analyze and interpret data and use for level of care determinations.	• Case management • Community health nursing • Applicable regulations	Four Months
Ability to develop care plans that address client needs.	• Case management • Community health nursing	Four Months
Ability to evaluate, monitor, and determine unmet needs of client.	• Case management • Community health nursing	Four Months
Ability to apply critical thinking/problem solving techniques.	• Problem solving • Project resolution	Four Months

Knowledge and skills in accessing and utilizing community health resources	• Community outreach and networking	Ongoing
Ability to identify and develop support systems for the client.	• Community outreach and networking	Ongoing

- Courses in appropriate subjects may be available on-line as well as through conferences, seminars, and traditional community resources.

Training and Development Pathway
Social Work Care Manager

Core Competencies	Suggested Courses/Workshops*	Suggested Time Frames for Completion After Employment
Ability to conduct in-depth assessments and reassessments covering psychosocial issues and rehabilitation.	• Geriatric assessment • Risk management	Six Months
Ability to evaluate the client as a total person and identify the functional limitations that impede independent living.	• Geriatric assessment • Risk management	Six Months
Good written and verbal communication skills.	• Written communication • Teaching strategies • Teamwork	Six Months
Negotiation skills with ability to advocate on behalf of the client.	• Problem solving • Case management	Four Months
Collaboration skills including consultation with health professionals, team members, client, family, and community contacts.	• Conflict resolution	Four Months
Ability to develop care plans which address client's needs.	• Case management	Four Months
Ability to evaluate, monitor, and determine unmet needs of client.	• Case management • Risk management	Four Months
Ability to identify and develop support systems for the client.	• Community outreach and networking	Ongoing
Knowledge of community resources and services available to clients.	• Community outreach and networking	Ongoing
Ability to apply critical thinking/problem solving techniques.	• Problem solving • Project resolution	Four Months

* Courses in appropriate subjects may be available on-line as well as through conferences, seminars, and traditional community resources.

CALIFORNIA DEPARTMENT OF AGING
Multipurpose Senior Services Program

Social Work Care Manager/Nurse Care Manager Exemption Training and Development Plan

Goals/Objectives:
Plan for Meeting Goals/Objectives:
List Training/Courses with Times for Completion:
Plan for Monitoring Exempted Orientee:
Additional Requirements for Job Performance:

Orientee Signature: _____

Supervisor Signature: _____

Date Exempted Orientee Completed Checklist: _____

Training and Development Pathway
Supervising Care Manager

Core Competencies	Suggested Courses/ Workshops*	Suggested Time Frames for Completion After Employment
Personnel management and supervision	• Management certificate program	Six Months
Problem solving, decision making, conflict management	• Management certificate program	Six Months
Quality improvement	• Quality management	Four Months
Fiscal management, including oversight of waived services expenditures	• Management certificate program	Six Months
Basic understanding of geriatric assessment	• Geriatric assessment	Six Months
Social casework objectives, principles and methods	• Principles of social work	Six Months
Principles of human behavior and development of psychological defense mechanisms	• Social work supervision	Six Months
Interaction with community referrals and vendors	• Community outreach and networking	Ongoing
Supervision and training of new staff in the following: • Conducting in-depth assessments, reassessments. • Evaluation of the client as a total person and identification of the functional limitations that impede independent living and support level of care determinations, • Good written and verbal communication skills, • Negotiation skills with ability to advocate on behalf of the client. • Collaboration skills and ability to consult with health professionals, tem members, client, family and community contacts. • Development of care plans that address client's needs,	• Care management • HCBS Waiver and MSSP guidelines • Teaching strategies • Teamwork • Problem solving • Conflict resolution	Six Months

• Evaluation, monitoring and determining client's unmet needs, • Identification and development of support systems for the client, • Knowledge of community resources and services available to the client, • Ability to analyze complex situations and think critically.	• Project management	

*Courses in appropriate subjects may be available on-line as well as through conferences, seminars, and traditional community resources.

CALIFORNIA DEPARTMENT OF AGING **Multipurpose Senior Services Program** **Supervising Care Manager** **Training and Development Plan**
Goals/Objectives:
Plan for Meeting Goals/Objectives:
List Training/Courses with Times for Completion:
Plan for Monitoring Progress:
Additional Requirements for Job Performance:

SCM Signature:_____

Manager/Administrator Signature: _____

Date Completed:_____

CALIFORNIA DEPARTMENT OF AGING
Multipurpose Senior Services Program

Supervising Care Manager
Recommended Orientation Checklist

JOB FUNCTION	Cannot Perform/ Needs Training*	Performs with Minimal Supervision	Performs Independently
1. Plans, organizes, and develops the principles and techniques employed in community-based comprehensive care management for the frail elderly.			
a. Knowledgeable regarding the changes of aging, chronic disorders of the older individual, and issues inherent in providing services for elders and their caregivers.			
b. Knowledgeable regarding the basic principles of care management and social casework.			
c. Makes recommendations regarding the establishment and maintenance of an appropriate staffing model considering the number of client slots and caseload ratio.			
2. Supervises care management staff:			
a. Ensures that casework is completed according to program standards by utilizing appropriate tools for managing casework activities, e.g., tracking and oversight of casework processes, clinical supervision and consultation with care management staff			
b. Ensures that effective collaboration occurs between nursing and social work care management staff			
c. Ensures that the flow of information between the fiscal, data and care management staff is timely and accurate.			
d. Identifies needs for staff development and implements plans for provision of necessary training.			
e. Develops and oversees the site's quality assurance program, including peer review processes and soliciting input regarding client satisfaction with services.			
3. Manages waived services expenditures:			
a. Ensure that services available through informal sources and referred services are utilized to the maximum before waiver services are authorized and utilized.			
b. Ensure that individual client monthly costs are accurately verified for all tracked services, and that service data is entered and reported accurately.			
c. Ensure authorizations for service have appropriate approval (i.e., that care manager does not authorize service costs exceeding 95% of the Benchmark without SCM approval; SCM approval required for costs 95-120%; and Site Director approval required if > 120%), and that high cost situations are appropriately documented.			
d. Ensure that applicant costs exceeding 120% of Benchmark are reduced within three months of enrollment.			

4. Analyzes social service/health operations internal and external to the program and recommends changes to improve service accessibility for clients.			
a. Collaborate with peers and attend Site Supervisor meetings.			
b. Conduct outreach to community.			
c. Network with other community agencies to explore sources for necessary services.			
d. Maintain effective working relationships with agencies such as IHSS, APS, Public Guardian, Linkages, AAA, etc.			
5. Resolves provider/client problems.			
a. Establish and maintain good working relationship with vendors.			
b. Establish and oversee grievance procedure for clients who are dissatisfied with services.			
c. Monitor and oversee incident reporting process.			

CALIFORNIA DEPARTMENT OF AGING
Multipurpose Senior Services Program

Social Work Care Manager/Nurse Care Manager Waiver
Recommended Orientation Checklist

JOB FUNCTION	Cannot Perform/ Needs Training*	Performs with Minimal Supervision	Performs Independently
DEMONSTRATES THE ABILITY TO:			
1. Screen clients for eligibility and appropriateness for MSSP participation.			
2. **NCM only:** Certify level of care (LOC) determinations at SNF/ICF levels			
a. Complete the LOC certification form with rationale and justification to substantiate the LOC determination,			
b. Sign and date all entries on the LOC certification form,			
c. Check the appropriate blank to indicate either NF-A or NF-B LOC,			
d. Re-certify client's LOC at six- month intervals,			
e. Reestablish eligibility as it relates to LOC.			
3. Complete application form and inform clients of:			
a. Circumstances under which the he/she will lose services,			
b. The client grievance procedure,			
c. Termination procedures,			
d. Any other information deemed essential for the proper delivery of services.			
4. Confirm and document the client's perception of why he/she was referred to the program, how he/she characterizes his/her situation and needs, and verify client's choice to participate in MSSP.			
5. Complete the Release of Information form(s).			
6. Conduct in-depth assessments appropriate to the discipline, adequately addressing all appropriate elements, and within two weeks of enrollment. Conducting assessments involves:			
a. Face to face interview with the client,			
b. Contact with family and other informal supports, if appropriate,			
c. Contact with client's physician and other health providers, as appropriate.			
7. Assessment elements include, as appropriate to discipline:			
a. Medical history.			
b. Health history.			
c. Psychosocial history.			
d. Rehabilitation history/needs.			
e. Functional Grid.			
f. Mini-Mental Status Exam.			
g. Medications Sheet.			
h. Health Professional List.			
i. Summary.			
j. Complete client problem list.			

JOB FUNCTION	Cannot Perform/ Need Training*	Perform with Minimal Supervision	Perform Independently
8. Critically identify the assessment outcome to include:			
a. The client's functional capacity to live independently.			
b. The system, if any, that supports independent functioning.			
c. What more is needed to sustain as much independence as possible.			
d. Situations where the client is at risk.; e.g., safety, abuse, neglect, depression, other psychosocial and/or health factors.			
9. Conduct quarterly home visits and monthly contacts to include:			
a. Identification of changes in client's situation warranting care plan changes.			
b. Identification of safety risks.			
c. identification of physical, fiduciary, exploitative abuse.			
d. Identification of immediate health/medical risks, including those of a pharmacological nature.			
e. Identification and provision of education to client and family.			
10. Consult and work closely with others involved with the client, including collateral agencies, physician, pharmacists, consultants, IHSS, APS, and others.			
11. Make service arrangements.			
12. Provide justification, obtain authorization, and implement services.			
13. Monitor service delivery and client's use of service.			
14. Monitor client's situation to ensure that services continue to meet the client's needs.			
15. Appropriate consultations between Social Work Care Manager and Nurse Care Manager; client seen by both disciplines at least once/year..			
16. Review records pertaining to clients' situation, conditions, services.			
17. Perform case recording by:			
a. Documenting all case management activity.			
b. Including entries at least monthly.			
c. Including type of contact with client or other identified individual.			
d. Recording all events that affect the client.			
e. Including evaluative comments on services delivered.			
f. Including comments on the relationship between identified problems and services delivered or not delivered.			
g. Documenting all contacts with collateral agencies, physician, pharmacists, consultants, IHSS, APS, and others.			
h. Ensuring that notes are dated and signed.			
i. Ensuring that notes follow MSSP standards of documentation.			
j. Verifying applicant's choice to participate in MSSP.			

JOB FUNCTION	Cannot Perform/ Need Training*	Perform with Minimal Supervision	Perform Independently
k. Verifying the necessity and appropriateness of MSSP services, including the need for care management.			
l. Reflecting monitoring and follow-up of services.			
m. Verifying services delivered.			
n. Reflecting the timeliness and effectiveness of services.			
18. Report to other professionals/agencies as appropriate.			
19. Share information across disciplines and act as a consultant in the care manager's area of expertise.			
20. Conduct a complete reassessment at least annually in client's place of residence. Reassessment activities include:			
a. Completion of the Reassessment tool.			
b. Analysis of changes during the period since last assessment.			
c. Assurance that client's needs are being met.			
d. Assurance that increases, additions, augmentation, decreases, reductions or termination of services are addressed,			
21. Develop and write a care plan that is consistent with MSSP policies, reflects client's medical, physical and psychosocial needs. Elements include:			
a. Contains problem statements.			
b. Identifies the services needed.			
c. Specifies frequency of service.			
d. Specifies type of service (I-R-P-C).			
e. Specifies plan for intervention.			
f. Specifies goals/outcomes for client's problems.			
g. Includes the client rights to a fair hearing.			
h. Considers the client/caregiver's wishes.			
i. Includes the primary care manager's signature.			
j. Ensures that the client signs the care plan within 30 days.			
k. Ensures that services are listed on the SPUS.			
l. Revisions as necessary to reflect changes in the client's situation.			
22. As appropriate, develop and write a risk management plan which reflects:			
a. A description of the situation.			
b. An explanation of the cause(s) of concern.			
c. The possible negative consequences to the client and/or others.			
d. A description of the client's preference.			
e. Possible alternatives/interventions to minimize the potential risk(s) associated with the client's preference/action.			
f. A description of the services, if any, that will be provided to accommodate the client's choice or minimize the potential risk.			
g. The final agreement, if any, reached by all involved parties.			
23. Determine when a notice of action is required, and the process and time frames for the action.			
COMMENTS:			

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

APPENDIX B-3
KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

___ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

_X_ A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

APPENDIX C-Eligibility and Post-Eligibility

Appendix C-1--Eligibility

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1._____Low income families with children as described in section 1931 of the Social Security Act.

2.__X__SSI recipients (SSI Criteria States and 1634 States).

3._____Aged, blind or disabled in 209(b) States who are eligible under 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).

4.__X__ Optional State supplement recipients

5.____ Optional categorically needy aged and disabled who have income at (Check one):

a.____ 100% of the Federal poverty level (FPL)

b.____% Percent of FPL that is lower than 100%.

6.__X__ The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

__X__A. Yes ___B. No

Check one:

a.__X__ The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b.____ Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1)___ A special income level equal to:

____ 300% of the SSI Federal benefit (FBR)

___%_ of FBR, which is lower than 300% (42 CFR 435.236)

$____ which is lower than 300%

(2)___ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3)___ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)

(4)___ Medically needy without spenddown in 209(b) States. (42 CFR 435.330)

(5)_X_ Aged and disabled who have income at:

a._X_ 100% of the FPL

b.___%, which is lower than 100%.

(6)___ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7._X_ Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8.____ Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

Appendix C-2--Post-Eligibility

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under 435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (435.217). For individuals whose eligibility is not determined under the spousal rules (1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR 435.726 and 435.735 just as it does for other individuals found eligible under 435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under 1924.

REGULAR POST-ELIGIBILITY RULES--435.726 and 435.735

- The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.

- If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.

- If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.

- If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the

appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of 1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The 1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in 1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as $30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The $30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the 1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

POST ELIGIBILITY

REGULAR POST ELIGIBILITY

1. X **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

A. § **435.726**--States that **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A.___ The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income level for the institutionalized

(4)___ The following percent of the Federal poverty level):__%

(5) X Other (specify): **An amount which represents the sum of (1) the income standard used to determine eligibility/share of cost and (2) any amounts of income disregarded during the Section 1902 (a) (10) (A) (ii) (VI) eligibility phase.**

B.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

C.___ The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1 is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2 and 3**. following.

2. spouse only (check one):

A.___ SSI standard

B.___ Optional State supplement standard

C.___ Medically needy income standard

D.___ The following dollar amount:$_____*

* If this amount changes, this item will be revised.

E.___ The following percentage of the following standard that is not greater than the standards above: ____% of ____standard.

F.___ The amount is determined using the following formula:

G.__X__ Not applicable (N/A)

3. Family (check one):

A.___ AFDC need standard

B.___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount: $____*

*If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: %___ of ____ standard.

E.___ The amount is determined using the following formula:

F.___ Other

G.__X__ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1.(b)____**209(b) State, a State that is using more restrictive eligibility requirements than SSI**. The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deduction the following amounts from the waiver recipient's income.

B. **42 CFR 435.735**--States **using more restrictive** requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A.___ The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income level for the institutionalized

(4)___ The following percentage of the Federal poverty level:_____%

(5)___ Other (specify):

B.___ The following dollar amount: $_____*

* If this amount changes, this item will be revised.

C.___ The following formula is used to determine the amount:

Note: If the amount protected for waiver recipients in 1 is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 435.217, **enter NA in items 2 and 3** following.

2. spouse only (check one):

A.___ The following standard under 42 CFR 435.121:
B.___ The medically needy income standard_____;

C.___ The following dollar amount: $_____*

* If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above:_____% of

E.___ The following formula is used to determine the amount:

F.___ Not applicable (N/A)

3. family (check one):

A.___ AFDC need standard

B.___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount: $_____*

* If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: ____% of _____standard.

E.___ The following formula is used to determine the amount:

F.___ Other

G.___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2. **X** The State uses the post-eligibility rules of 1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual: (check one)

(a)___ SSI Standard

(b)___ Medically Needy Standard

(c)___ The special income level for the institutionalized

(d)___ The following percent of the Federal poverty level: ____%

(e)___ The following dollar amount $___**

**If this amount changes, this item will be revised.

(f)___ The following formula is used to determine the needs allowance:

(g) **X** Other (specify): **An amount which represents the sum of (1) the income standard used to determine eligibility/share of cost and (2) any amounts of income disregarded during the Section 1902 (a) (10) (A) (ii) (VI) eligibility phase.**

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

Appendix C-3

WAIVER OF COMMUNITY INCOME AND RESOURCE POLICIES FOR THE MEDICALLY NEEDY (§ § 1915 (c) (3) and 1902 (a) (10) (C) (i) (III) of the Social Security Act).

A. A waiver of § 1902 (a) (10) (C) (i) (III) of the Social Security Act is requested for the medically needy, only as reflected in section C below.

B. Computation of income for purposes of FFP limits is not applicable (N/A).

C. The following is a description of the income and resource methods and standards that differ from those otherwise required for the medically needy under the State Plan (including approved § 1902 (r) (2) policies) and § 1902(a) (10) (C) (i) (III) for individuals living in the community.

SECOND VEHICLE EXEMPTION FOR WAIVER PROGRAM: A recipient may claim an exemption for a second, modified vehicle if it was modified to accommodate the physical handicap(s) for the medical needs of the individual. Verification shall be by physician's written statement of necessity.

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in the Executive Summary of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (check all that apply):

_____ Discharge planning team

_____ Physician (MD or DO)

_____ Registered nurse, licensed in the state

_____ Licensed social worker

_____ Qualified mental retardation professional, as defined in 42 CFR 483.430(a)

___X___ Other (specify):

All applicants for MSSP services will be screened for eligibility as to level of care (LOC), age, Medi-Cal status, need for care management, cost, and residence within the service catchment area prior to acceptance into the program. Individuals conducting the screening are nurse care managers (NCM), social work care managers (SWCM),and the supervising care manager (SCM). Final determination for LOC rests with the NCM, i.e., registered nurse, following the health assessment. The qualifications for these staff are the same as those stated above for care management services (Appendix B-2, Services 4.3, 50 and 4.6). The minimum academic and experience requirements for MSSP staff performing initial LOC evaluations are:

1. **Supervising Care Manager (SCM): Masters degree in social work, nursing, psychology, counseling, rehabilitation, gerontology or sociology, and two years experience working directly with the elderly. One year of supervisory experience preferred. Demonstrated expertise and ability as a care manager, as evidenced by experience successfully carrying out these job duties, is also preferred.**

2. **Nurse Care Manager (NCM): Bachelors degree in nursing (public health, health education, health administration, gerontology, or equivalent), plus three years experience, two of which are in public health, geriatrics preferred; hold a valid current license to practice nursing in the State of California; and have a public health certificate issued by the State of California.**

3. **Social Work Care Manager (SWCM): Masters degree in social work, psychology, counseling, rehabilitation, gerontology or sociology plus one year working with the elderly; or a bachelor's degree in one of the above fields, and two years experience with the elderly.**

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (specify):

_____ Every 3 months

__X__ Every 6 months

_____ Every 12 months

_____ Other (specify):

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

__X__ The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

____ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for all individuals performing reevaluations of level of care (specify):

_____ Physician (MD or DO)

_____ Registered nurse, licensed in the state

_____ Licensed social worker

_____ Qualified mental retardation professional, as defined in 42 CFR 483.430(a)

_____ Other (specify):

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The state will employ the following procedures to ensure timely reevaluations of level of care (check below):

__X__ "Tickler" file

__X__ Edits in computer system

__X__ Component part of ~~case~~ **care** management

____ Other (specify):

APPENDIX D-2 (a)

CRITERIA FOR DENIAL OR TERMINATION OF MSSP WAIVER SERVICES

a. **MSSP Waiver services may be denied or terminated when any one of the following circumstances occur:**

   1. **The client dies.**

   2. **The client moves from the geographical area within which MSSP waiver services were authorized for provision.**

   3. **The client elects to terminate services.**

   4. **The client's care needs are being met without MSSP services, or for any reason other than listed herein.**

   5. **The client is no longer certifiable at the nursing facility level of care.**

   6. **The client loses Medi-Cal eligibility.**

   7. **The client is institutionalized.**

   8. **The service costs are expected to exceed 120% of the site's benchmark for more than three consecutive months, without required justification.**

   9. **The client may still be eligible for Medi-Cal, but no longer with an aid code that qualifies for MSSP; including unable to meet the share of cost requirement through In-Home Supportive Services.**

   10. **The client is unable/unwilling to follow the care plan; unable/unwilling to effectively utilize care management services.**

b. **MSSP Waiver services may be modified when the client's condition changes such that s/he needs a level of service different from that identified in the previous MSSP Waiver services assessment.**

c. **When MSSP Waiver services are denied, changed, or terminated, a notice of action will be forwarded to the client in conformance with 42 CFR, Part 431, Subpart E, and CCR, Title 22, Division 3, Subdivision 1, Chapter 3, Article 1.3, Section 51014.1.**

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (check all that apply):

_____ By the Medicaid Agency in its central office

_____ By the Medicaid Agency in district/local offices

_____ By the agency designated in Appendix A as having primary authority for the daily operation of the waiver program

__X__ By the ~~case~~ **care** managers

__X__ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations

_____ By service providers

__X__ Other (specify):
Local program sites are required to maintain legible, accurate and current records on each eligible client, each care plan implemented, each assessment and reassessment performed, and each service authorized (Waived and tracked Referred services) and to verify monthly the costs of Waived services from the point of enrollment to termination.

Each site will also have within its contracted obligation the responsibility for maintenance and storage of all information collected on each of its clients. These records will be maintained at each site for a minimum of four years from the termination date of the contractual agreement. Case records will be secured in locked files and client data systems will have appropriate confidentiality safeguards. Responsibility for ensuring that these requirements are met rests with the individual site program administrator. Responsibility for setting standards for record maintenance and security is vested in CDA.

The names of persons receiving MSSP services are confidential and are protected from unauthorized disclosure in accordance with: the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191; Title 45, CFR, Section 205.50; California Welfare and Institutions Code, Section 10850; and the California Information Practices Act of 1977. All client-related information, records, and data elements shall be protected by all MSSP contractors from unauthorized disclosure.

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation and screening procedures for individuals need for a level of care indicated in the Executive Summary of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the state's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in the Executive Summary of this request.

Check one:

___ The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

_X_ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

ATTACHMENT TO APPENDIX D-3

For diverted individuals (regular waiver clients), a description of the screening and evaluation process and copies of:

- Initial assessment instruments (Health and Psychosocial Assessments), and
- Annual Reassessment

For deinstitutionalized individuals, a description of the screening and evaluation process and copies of:

- Initial Interview for Deinstitutionalization Services
- Deinstitutionalization Assessment

DIVERTED INDIVIDUALS

Screening Process:
Potential clients are screened to determine eligibility and appropriateness for participation in MSSP.

Forms: Screening forms or tools may vary from site to site, however, each site must be consistent in the form and process it employs. The screening form must be completed for each referral and retained either in the case record (if the individual is enrolled), or in a separate file maintained for all referrals that are screened out. Screening forms must be made available during Utilization Reviews and/or other types of monitoring and oversight visits.

Process: The initial screening can be performed by telephone, in an acute care hospital, nursing facility, or the person's place of residence.

Assessment Process:
Each person determined to be eligible through the MSSP initial screening process will receive face-to-face comprehensive health and psychosocial assessments to determine specific problems, resources, strengths, needs, LOC, and preferences.

These initial assessments are conducted by the nurse and the social work care managers, and must be completed within two weeks of the date of enrollment. If this time frame cannot be met, the reason for the delay must be documented in the client's progress notes.

An initial assessment requires: a face-to-face interview with the client and, as appropriate, contact with the family and other informal supports; contact with the client's physician and other health providers (if any); as well as a review of the client's health/medical/psychosocial history. These contacts are made with the knowledge and consent of the client, or the client's significant support person who remains involved in the assessment/care planning process.

Assessments or reassessments will be conducted in the client's place of residence. Since it is the goal of the MSSP to support a client's ability to live as independently as possible in the community, it is important to have a clear understanding of the home environment and its impact on the client's functioning. Should it be necessary or advisable for the interview to be conducted in an alternate location, the rationale for this decision will be documented in the progress notes.

Assessments and reassessments will be reviewed by the Supervising Care Manager for completeness of functional information and pertinent medical/social information relating to present conditions or situations. All sections are to be completed. If information is unobtainable for some reason, the situation should be noted on the form. On occasion, completion of an item may be deferred. Deferring an entry means that it will be completed later; it does not mean eliminating or not attempting to get the information at all. If completion of an item is deferred, the reason will be noted along with plans for obtaining the information at a later time.

Explanatory comments should clearly indicate whether these are "subjective" (coming from the client) or "objective" (coming from the care manager's assessment). The client's participation in the process should be clear by documenting input regarding services or other information, as appropriate.

The health and psychosocial assessment should contain sufficient information to identify the following:

- **Current level of care**
- **Major problem areas**
- **Client's strengths and resources**
- **Client's functional level**
- **Client's preferences or choice**
- **Care Manager's assessment of the client's situation**
- **Congruity or lack of congruity between problems, functional level, choice, and needs**
- **Implications for service delivery and care management**

The outcome of the assessment is a determination of:

- **The client's functional capacity to live independently;**
- **The system, if any, that supports independent functioning; and**
- **What additional services or supports are needed to sustain the client with as much independence and self-determination as possible.**

Copies of the initial health and psychosocial assessments are attached.

Reassessment:
The reassessment is a formalized method of documenting and analyzing changes during the period since the previous assessment, re-establishing eligibility as it relates to level of care (LOC) and assuring that the client's needs are being met. Changes since the last assessment, as well as over a longer span of time, are particularly relevant. Elements of change to be considered include whether it is present or absent, planned or unanticipated, positive or negative. It is not acceptable to write in "No change."

Reassessments will be completed annually by either the nurse or the social work care manager.

The format of the reassessment document is the same regardless of the professional discipline of the care manager conducting the reassessment. All findings and documentation are to be recorded on a single document.

How the reassessment is conducted and carried out is to be based on the needs of the client; site staffing and administrative policies may also impact how this part of the workload is assigned. Some alternatives for staffing this responsibility include: each care manager performing the reassessment on their own client with the alternate discipline seeing the client at a point to be determined during the care planning process; care managers within a team exchanging reassessments for each other's clients; care managers jointly making the visit and completing the document together. In any event, sites will maintain a multi-disciplinary staffing model and ensure that each client is seen by both a nurse and a social work care manager at least once per year.

Reassessments must be done at least once a year, however they are to be conducted more frequently if changes in the client's condition (living condition, health, or functional status) warrant reassessment.

The reassessment document used is prescribed by CDA and consists of:

- **Functional Grid**
- **Mini-Mental Status Exam**
- **Health Professional List**
- **Medications Sheet**
- **Summary**
- **Problem List**

Sites may use additional documents, including interview guides or check lists, that they find helpful to collect the information for the reassessment. However, information collected in this manner must be incorporated into the recording on permanent case documents. Informal notes are not to be included in the client's file.

Care managers are encouraged to use collateral sources of information as reference points for the reassessment. Examples of these sources include: the current record; pertinent hospital discharge summaries and physical examination reports; home health agency records; other specialty reports such as occupational and physical therapy, nutrition consultation, etc.

A copy of the reassessment tool is attached.

MSSP

Initial Health Assessment

MSSP Initial Health Assessment

Client Name		**MSSP #**	
Assessment Date		**Staff Code**	
Staff Signature/Title			

Diagnosis/Medical History

What are the client's diagnoses?

What is the client's medical history?

What is the client's rating of his/her own health?

☐ Poor ☐ Fair ☐ Good ☐ Excellent

Has client been in a hospital, SNF or ER in past year? ☐ No ☐ Yes

If Yes, provide approximate date(s) and reason(s):

Medications

Pharmacy used:

☐ Allergies to medications ☐ Forgets medications ☐ Problem with cost

☐ Medications prescribed are covered by Medi-Cal ☐ Has prescription medications in stock which are no longer prescribed

☐ Primary physician knows about all of client's medications

☐ Does client have help with medications? ☐ No ☐ Yes

If yes, who helps?

What kind of help?

Medications continued

Is more help with medications needed? ☐ No ☐ Yes

If yes, describe:

Comments S/O

Nutritional Assessment

Y = Yes	N = No	D = Deferred

Include in your assessment:

- Usual eating
- Diet patterns
- Preparation of meals
- Shopping
- Finances
- Allergies

☐ Weight loss or gain in past year:

☐ Special diet/restricted foods:

☐ Client follows diet:

Client's appetite (subjective):

☐ Good	☐ Fair	☐ Poor

Meals per day:	☐ 1	☐ 2	☐ 3

Assessment of client's diet quality (objective):

☐ Good	☐ Fair	☐ Poor

Nutritional Supplements?

Approximate amount/type of fluid intake:

Comments S/O

Health Habits

Y = Yes	N = No	D = Deferred

Describe usual use patterns and significant changes:

☐ Tobacco	☐ Caffeine	☐ Alcohol

☐ HX of alcohol/drug abuse	Sleep pattern
Comments S/O	

Review of Systems

Instructions: Check each condition identified by client or observed during the assessment. Inquire about specfiic items only as appropriate. It is not necessary to indicate a response to each condition. Comments should include changes and impact of condition on function.

S=Subjective	O=Objective

Eyes/Ears/Mouth

Eyes

☐ Glasses or contact lens	☐ Trouble with vision
☐ Change in vision in last year	
Comments S/O	

Ears

☐ Trouble with hearing	☐ Wears a hearing aid
Comments S/O	

Mouth

☐ Problems with teeth/gums	☐ Dentures
☐ Problems with dentures	☐ Dentures fit well
Comments S/O	

Respiratory/Pulmonary

☐ Short of breath	☐ Uses oxygen
☐ Coughs frequently	☐ DX of tuberculosis
Comments S/O	

Cardiovascular

☐ Pain, tightness, or pressure in chest, neck, or arms		
☐ Swelling of feet or ankles		
☐ Prop pillows at night for shortness of breath		
☐ Fainting/blackouts		
☐ Rapid, irregular, or skipped heartbeats		
☐ High blood pressure		
☐ Cramps in leg muscles	☐When walking	☐When not walking
Comments S/O		

Breasts

☐ Lumps

☐ Mammogram | Approximate Date

☐ Performs breast self-exam

Comments S/O

Gastrointestinal

☐ Trouble swallowing	☐ Indigestion/heartburn	☐ Nausea/vomiting
☐ Constipation	☐ Change in bowel habits	☐ Loose stools or diarrhea
☐ Blood from rectum	☐ Bowel incontinence	☐ Black or tarry stools

Comments S/O

Genitourinary

☐ HX Bladder disease	☐ Catheter	☐ Incontinence
☐ Frequency at night	☐ Urgency	
☐ Trouble starting/stopping urine	☐ Pain/burning with urination	

Comments S/O

Vaginal Problems

☐ Bleeding	☐ Discharge	☐ Odor	☐ Bulging	☐ Itching

Comments S/O

Testicular/Prostate Problems

Comments S/O

Musculoskeletal

☐ Back pain	☐ Falls	☐ Osteoporosis	☐ Joint pain or stiffness

☐ Engages in physical activities	☐ Changes in activity level	☐ Foot problems

Comments S/O

Mobility

☐ Fully ambulatory	☐ Ambulatory with assistance	☐ Cane/walker

☐ Prosthesis/appliance	☐ Occasional Wheelchair use	☐ Bed Bound

Gait (if observed):

☐ Ataxia	☐ Unsteady	☐ Poor Balance	☐ Shuffling	☐ Wide Based

Describe need for foot care:

If bed bound describe ROM:

Joint deformity description:

Comments S/O

Neurological

☐ CVA	☐ Numbness in arm, leg or face	☐ Trouble finding words/slurred speech
☐ Paralysis	☐ Headaches	☐ Dizziness
☐ Tremors	☐ Weakness	☐ Seizures

Comments S/O

Psychiatric

☐ Confused	☐ Wanders	☐ Feelings of Depression

☐ Psychiatric HX

☐ Changes in memory

Comments S/O

Endocrine

☐ Diabetes	☐ Insulin Dependent	☐ Controlled Diet

☐ Oral Hypoglycemics	☐ Thyroid Problems

Comments S/O

Skin

☐ Rash	☐ Dry skin	☐ Itching	☐ Growths

☐ Changes in wart or mole	☐ Wounds/lesions

☐ Sores that will not heal

Skin characteristics:

☐ Warm	☐ Cool	☐ Dry	☐ Moist	☐ Color

Comments S/O

Vital Signs

Temperature (optional)	Respiration

Pulse	BP (indicate position)
Weight (history or taken)	Height (by history)
Comments S/O	
Who provided assessment information?	
☐ Client ☐ Caregiver ☐ Family	
☐ Other	
Comments S/O	
How reliable is provided information?	
Was this Assessment conducted in the client's home?	
☐ Yes	☐ No (if no, where?)

Client's Physicians and Other Health Professionals

Client's Last Name	First Name	MI	MSSP #

NAME: SPECIALTY: ADDRESS:	MSSP Assessment Date Last seen by HP?	1	2	3	4
PHONE: MEDI-CAL PAYS? ☐ Yes ☐ No	MSSP Assessment Date Last seen by HP?	5	6	7	8

NAME: SPECIALTY: ADDRESS:	MSSP Assessment Date Last seen by HP?	1	2	3	4
PHONE: MEDI-CAL PAYS? ☐ Yes ☐ No	MSSP Assessment Date Last seen by HP?	5	6	7	8

NAME: SPECIALTY: ADDRESS:	MSSP Assessment Date Last seen by HP?	1	2	3	4
PHONE: MEDI-CAL PAYS? ☐ Yes ☐ No	MSSP Assessment Date Last seen by HP?	5	6	7	8

MSSP Client's Medications Including: Nonprescription Medications, Vitamins and Minerals

Client's Last Name	First Name	MI	MSSP #

Date	Medication	Dosage	#/ Freq Taken	Doctor	Covered By Medi-Cal? Yes or No

MSSP Staff		Date:	
(Optional) Sent for Review to Doctor(s):		Date:	

MSSP Initial Health Assessment Summary

Client Name		**MSSP #**	
Assessment Date		**Staff Code**	
Summarize current circumstances and problem areas:			
Client Description			
Medical History • Review Of Systems • Vital Signs • Diagnoses			
Medical Care • Medications			
Nutrition • Health Habits			
Print Staff Name			
Staff Signature/Title			

MSSP

Initial Psychosocial Assessment

MSSP Initial Psychosocial Assessment

Client Name		**MSSP #**	
Assessment Date		**Staff Code**	
Staff Signature/Title			

Living Arrangements

What is the client's usual living situation?

☐ Apartment	☐ Board & Care	☐ House	☐ Mobile Home
☐ Other:			

Describe:

☐ Owned	☐ Rented	☐ Subsidized

Who lives with client?

General

Occupational history:

Significant current and past activities and/or interests (including religious and social activities, pets, etc.)

Financial

How is client managing financially?

☐ Problematic expenses		☐ Budget	
☐ Entitlements	☐ Medi-Cal	☐ Medicare	☐ IHSS
☐ Other: Explain			

Does client have?

☐ A Conservator	☐ Substitute Payee	☐ Someone with Power off Attorney	☐ Someone with Durable Power of Attorney for Health Care?

Client Name		MSSP #	
Assessment Date		Staff Code	

Family and Social Network

Who visits the client and how often?

How often does client leave the house and where does client go?

Describe the client's informal support system (direct help, emotional support, friendships, etc.)

Name	Relationship	Describe support provide, problems, quality:

Is there an apartment manager or neighbor who can be called if necessary?

☐ Yes ☐ No	If yes, who?	Phone (optional)

Other comments:

Environmental Safety

Must client climb stairs to enter or leave house?

☐ Yes ☐ No	Particular problems, describe:

Client Name		**MSSP #**	
Assessment Date		**Staff Code**	

Environmental Safety Special Equipment Checklist:

	Does Client **Have**?	Does Client **Need**?
Tub	☐ Yes ☐ No	☐ Yes ☐ No
Shower	☐ Yes ☐ No	☐ Yes ☐ No
Hand-held shower	☐ Yes ☐ No	☐ Yes ☐ No
Bath bench	☐ Yes ☐ No	☐ Yes ☐ No
Grab bars, toilet	☐ Yes ☐ No	☐ Yes ☐ No
Grab bars, shower	☐ Yes ☐ No	☐ Yes ☐ No
Grab bars, tub	☐ Yes ☐ No	☐ Yes ☐ No
Raised toilet seat	☐ Yes ☐ No	☐ Yes ☐ No
Emergency response system	☐ Yes ☐ No	☐ Yes ☐ No
Smoke alarm	☐ Yes ☐ No	☐ Yes ☐ No

Check any of the following which are problems:

☐ Loose rugs	☐ Inadequate kitchen facilities
☐ Electrical cords	☐ Inadequate bathroom facilities
☐ Cluttered house	☐ Inadequate heating
☐ Unclean house	☐ Inadequate cooling
☐ Unsafe stairs	☐ Phone Accessibility
☐ Other:	

Comments/Describe:

Formal Services Received Last Month (Pre-MSSP):

Describe/Comments:

IHSS: # ____ Hours

Transportation:

Meals:

Day Care:

Other:

Psychological Functioning

Client Name		MSSP #	
Assessment Date		Staff Code	

	Evidence of Problem? (Circle)			Comments/Describe:
Memory	None	Some	Severe	
Orientation	None	Some	Severe	
Judgment	None	Some	Severe	
Anxiety	None	Some	Severe	
Combative, Abusive, or Hostile Behavior	None	Some	Severe	
Depression	None	Some	Severe	
Delusions, Hallucinations	None	Some	Severe	
Paranoid Thinking, Suspiciousness	None	Some	Severe	
Wandering	None	Some	Severe	
Suicidal	None	Some	Severe	
Other	None	Some	Severe	

Adaptive/Coping Skills:

Other notes (optional)

Any indications observed of abuse, neglect, or exploitation?

Comments/Describe:

Who provided assessment information:

How reliable is this source?

x	
Staff Signature/Date	**Print Name**

Folstein Mini Mental Status Examination

Client Name		**MSSP #**	
Assessment Date		**Staff Code**	
Staff Name/Title			

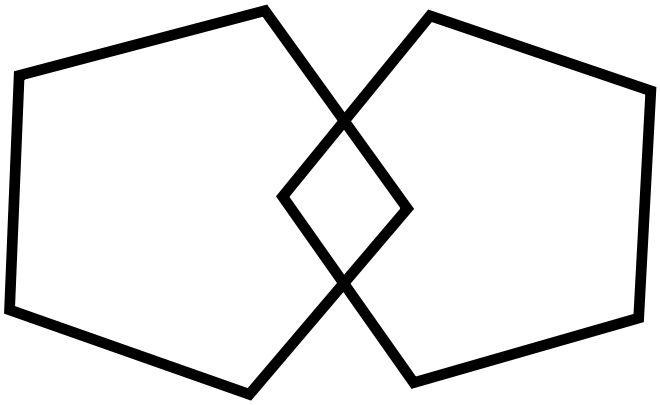
		Max Score	Score		
			Date:	Date:	Date:
1	**Orientation:** What is the…? ☐ Year ☐ Season ☐ Date ☐ Day ☐ Month	**5**			
2	Where are we? ☐ State ☐ Country ☐ Town ☐ Hospital ☐ Floor	**5**			
3	**Registration:** ☐ Apple ☐ Table ☐ Penny Repeat (immediately) 3 objects:	**3**			
4	**Attention/Calculation:** Serial 7's or spell WORLD backwards	**5**			
5	**Recall:** Remember 3 objects at 2 minutes: ☐ Apple ☐ Table ☐ Penny	**3**			
6	**Language:** Naming ☐ Pencil ☐ Watch	**2**			
7	Repeat "no if's, ands, or buts."	**1**			
8	Three stage command: "Take a paper in your left hand, Fold it in half, and put it on the floor."	**3**			
9	Reading and following a written command: "Close your eyes" (attached page)	**1**			
10	Write a sentence (attached page)	**1**			
11	**Visual-Spatial:** Copy design (attached page)	**1**			
	Total	**30**			
	Level of Consciousness: ☐ Alert ☐ Drowsy ☐ Stupor ☐ Coma				

Client Name		MSSP #	
Assessment Date		Staff Code	

Interpretation:

Total Score	
25-30	Normal
21-24	Mild intellectual impairment
16-20	Moderate intellectual impairment
Under 15	Severe intellectual impairment

CLOSE YOUR EYES



Functional Needs Assessment Grid

Client:							MSSP #:					Re/Assessment Date:
ADL/IADL FUNCTIONING	**Safe Functioning Level**						**Current Help**					**Instructions for ADL/IADL Functioning**
Related to Indepen Category Only 1.1 No Difficulty 1.2 Some Difficulty 1.3 Very Difficult ***ADLs**	**Independent**	**Verbal Assistance**	**Some Human Help**	**Lots of Human Help**	**Dependent**	**Para Medical**	**Device**	**Formal Help**	**Informal Help**	**Needs No Help**	**Needs More Help**	**Safe Functioning Level:** Mark the box indicating the level at which the client can perform the function with safety. **Current Help:** Mark the box(es) indicating the type (if any) of human help the client currently receives. **Needs More Help:** Mark the box if the client needs more help than currently receiving **Comments**
Eating*	1.	2	3	4	5	6						
Dressing*	1.	2	3	4	5							
Transferring*	1.	2	3	4	5							
Bathing*	1.	2	3	4	5							
Toileting*	1.	2	3	4	5	6						
Grooming*	1.		3	4	5							
Medications	1.	2	3	4	5	6						
Stair Climbing	1.	2	3	4	5							
Mobility Indoor	1.	2	3	4	5							
Mobility Outdoor	1.	2	3	4	5							
Housework	1.		3	4	5							
Laundry	1.			4	5							
Shopping & Errands	1.		3		5							
Meal Prep & Cleanup	1.	2	3	4	5							
Transportation	1.	2	3		5	6						
Telephone	1.	2	3		5							
Money Management	1.	2	3		5							

EQUIPMENT NEEDS	Has	Needs		Has	Needs
Tub	☐	☐	Grab Bar/Toilet	☐	☐
Shower	☐	☐	Grab Bar/Shower	☐	☐
Handheld Shower	☐	☐	Grab Bar/Tub	☐	☐
Bath Bench/Chair	☐	☐	Raised Toilet Seat	☐	☐
Smoke Alarm	☐	☐	Bedside Commode	☐	☐
Emergency Alarm Unit	☐	☐	Incontinence Supplies	☐	☐
Other:					

MENTAL FUNCTIONING (OPTIONAL FOR MSSP)	No Problem		Severe Problem	Comments
Memory	1	2	5	
Orientation	1	2	5	
Judgment	1	2	5	

Initial Psychosocial Summary

Client Name		MSSP#	
Summarize Current Circumstances, Problem Areas:			
Brief Client Description / Significant History			
Living Arrangements / Environmental Safety			
Cognitive / Psychological Functioning			
Physical Functioning			
Caregiver / Family And Social Network			
Formal Services			
Other / Financial / Legal			
X			
Staff Signature/Date		Print Name	

MSSP

Annual Reassessment

Functional Needs Assessment Grid

Client:							MSSP #:					Re/Assessment Date:
ADL/IADL FUNCTIONING	**Safe Functioning Level**						**Current Help**					**Instructions for ADL/IADL Functioning**
Related to Indepen Category Only 1.4 No Difficulty 1.5 Some Difficulty 1.6 Very Difficult ***ADLs**	**Independent**	**Verbal Assistance**	**Some Human Help**	**Lots of Human Help**	**Dependent**	**Para Medical**	**Device**	**Formal Help**	**Informal Help**	**Needs No Help**	**Needs More Help**	**Safe Functioning Level:** Mark the box indicating the level at which the client can perform the function with safety. **Current Help:** Mark the box(es) indicating the type (if any) of human help the client currently receives. **Needs More Help:** Mark the box if the client needs more help than currently receiving **Comments**
Eating*	1.	2	3	4	5	6						
Dressing*	1.	2	3	4	5							
Transferring*	1.	2	3	4	5							
Bathing*	1.	2	3	4	5							
Toileting*	1.	2	3	4	5	6						
Grooming*	1.		3	4	5							
Medications	1.	2	3	4	5	6						
Stair Climbing	1.	2	3	4	5							
Mobility Indoor	1.	2	3	4	5							
Mobility Outdoor	1.	2	3	4	5							
Housework	1.		3	4	5							
Laundry	1.			4	5							
Shopping & Errands	1.		3		5							
Meal Prep & Cleanup	1.	2	3	4	5							
Transportation	1.	2	3		5	6						
Telephone	1.	2	3		5							
Money Management	1.	2	3		5							

EQUIPMENT NEEDS

	Has	Needs		Has	Needs
Tub	☐	☐	Grab Bar/Toilet	☐	☐
Shower	☐	☐	Grab Bar/Shower	☐	☐
Handheld Shower	☐	☐	Grab Bar/Tub	☐	☐
Bath Bench/Chair	☐	☐	Raised Toilet Seat	☐	☐
Smoke Alarm	☐	☐	Bedside Commode	☐	☐
Emergency Alarm Unit	☐	☐	Incontinence Supplies	☐	☐
Other:					

MENTAL FUNCTIONING (OPTIONAL FOR MSSP)

	No Problem		Severe Problem	Comments
Memory	1	2	5	
Orientation	1	2	5	
Judgment	1	2	5	

Folstein Mini Mental Status Examination

Client Name		**MSSP #**	
Assessment Date		**Staff Code**	
Staff Name/Title			

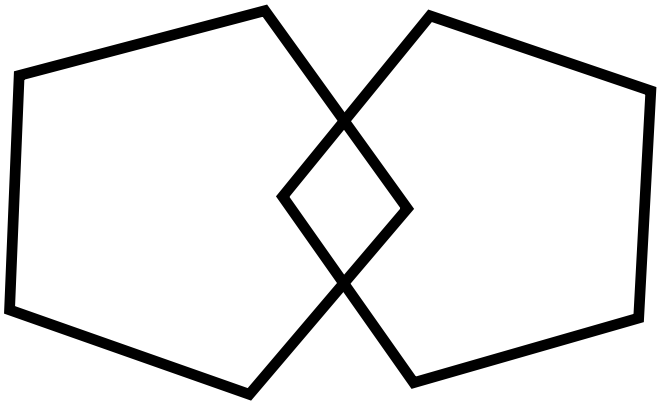
		Max Score	Score		
			Date:	Date:	Date:
1	**Orientation:** What is the…? ☐ Year ☐ Season ☐ Date ☐ Day ☐ Month	**5**			
2	Where are we? ☐ State ☐ Country ☐ Town ☐ Hospital ☐ Floor	**5**			
3	**Registration:** ☐ Apple ☐ Table ☐ Penny Repeat (immediately) 3 objects:	**3**			
4	**Attention/Calculation:** Serial 7's or spell WORLD backwards	**5**			
5	**Recall:** Remember 3 objects at 2 minutes: ☐ Apple ☐ Table ☐ Penny	**3**			
6	**Language:** Naming ☐ Pencil ☐ Watch	**2**			
7	Repeat "no if's, ands, or buts."	**1**			
8	Three stage command: "Take a paper in your left hand, Fold it in half, and put it on the floor."	**3**			
9	Reading and following a written command: "Close your eyes" (attached page)	**1**			
10	Write a sentence (attached page)	**1**			
11	**Visual-Spatial:** Copy design (attached page)	**1**			
	Total	**30**			
	Level of Consciousness: ☐ Alert ☐ Drowsy ☐ Stupor ☐ Coma				

Client Name		MSSP #	
Assessment Date		Staff Code	

Interpretation:

Total Score	
25-31	Normal
21-25	Mild intellectual impairment
16-21	Moderate intellectual impairment
Under 15	Severe intellectual impairment

CLOSE YOUR EYES



Client's Physicians and Other Health Professionals

Client's Last Name	First Name	MI	MSSP #

NAME: SPECIALTY: ADDRESS:	MSSP Assessment Date Last seen by HP?	1	2	3	4
PHONE: MEDI-CAL PAYS? ☐ Yes ☐ No	MSSP Assessment Date Last seen by HP?	5	6	7	8

NAME: SPECIALTY: ADDRESS:	MSSP Assessment Date Last seen by HP?	1	2	3	4
PHONE: MEDI-CAL PAYS? ☐ Yes ☐ No	MSSP Assessment Date Last seen by HP?	5	6	7	8

NAME: SPECIALTY: ADDRESS:	MSSP Assessment Date Last seen by HP?	1	2	3	4
PHONE: MEDI-CAL PAYS? ☐ Yes ☐ No	MSSP Assessment Date Last seen by HP?	5	6	7	8

MSSP Client's Medications Including: Nonprescription Medications, Vitamins and Minerals

Client's Last Name	First Name	MI	MSSP #

Date	Medication	Dosage	#/ Freq Taken	Doctor	Covered By Medi-Cal? Yes or No

MSSP Staff		Date:	
(Optional) Sent for Review to Doctor(s):		Date:	

MSSP Reassessment Summary

MSSP Site			
Client Name			
MSSP Number		**Staff Code**	
Date of Reassessment			
Staff Signature/Title			

These are general guidelines: include only information, which is pertinent to develop and support a care plan. Focus on changes. It is not necessary to include information in more than one section of the summary. Place it where it has most relevance.

1. **Client Description**: (*Age, living arrangement, physical appearance and presentation*).

2. **Health**: (*Diagnosis: changes in general health status, health practices, medical compliance, nutrition, continence; problematic signs or symptoms, frequency and adequacy of health care*).

3. **Medications**: (*Medication use/interactions, ability to self manage*).

4. **ADL/IADL Functioning Levels**: (*Changes in ambulatory status, functional abilities, assistive devices, areas of unmet need; support for LOC finding*).

5. **Caregiver**: (*Formal and informal support, reliability and skill level of caregiver, degree of caregiver stress, evidence of caregiver health or financial problems*).

6. **Environmental Safety**: (*Adequacy of home; safety and accessibility considerations*).

7. **Cognitive/Psychological**: (*Chagnes in orientation, memory, ability to resolve problems, depression, mental health: response to losses: significance of current problems to client*)

8. **Social Network**: (*Family, friends, quality of relationships, losses, leisure activities*).

9. **Abuse**: (*Evidence of abuse, neglect, exploitation*).

10. **Finances**: (*Entitlements, ability to manage own affairs, problematic expenses, indication of exploitation or mismanagement*)

11. **Services**: (Include purchased, referred services; services refused)

12. **Client Concerns**: (What the client and family want from MSSP)

13. **Indications for Care Management**:

DEINSTITUTIONALIZED INDIVIDUALS

Background:
In May 2002, an amendment to the MSSP waiver was approved that allows MSSP care managers to begin working with individuals while they are still residents of an institution (acute hospital or nursing facility). Prior to this, MSSP services could not be provided until the resident was already discharged and living in the community. Under this amendment, Deinstitutional Care Management (DCM) services can be provided during the last six months of an institutional stay to facilitate the resident's successful discharge to community living. The services available under DCM include all of the services currently offered under the waiver: care management to assist in the planning and preparation for discharge, and the actual purchase of some goods and services (i.e., installation of a ramp, provision of money management).

Waiver Status of Recipients of DCM Services:
Although waiver services may be provided to an institutionalized resident, the individual cannot actually be enrolled into the MSSP waiver and sites can neither bill for services provided nor count the resident in their caseloads until the date of discharge from the institution.

Individuals receiving services under DCM have the same rights as waiver clients, including access to State Fair Hearings to resolve disputes.

DCM is currently being tested at three pilot sites, prior to statewide implementation, anticipated for September 2004. Copies of the screening tool (Initial Interview for Deinstitutionalization Services) and the assessment instrument (Deinstitutionalization Assessment) are attached.

Initial Interview for Deinstitutionalization Services

Resident's Name:		Date of Interview:
Address:		Date of Birth:
		Age:
Phone:		Marital Status:
Educational Level:	Race:	Primary Language:
Translation to be provided by:		
Interview participants other than resident:		

Insurance Information	
SSN:	Medicare/RRB#:
Medi-Cal#:	Other Insurance:

Legal Guardian/Conservator/Durable Power of Attorney (circle)	
Translator needed? Y/N	
Name:	Phone:
Address:	

Emergency Contact (address & phone; include relationship to resident)**:**

Physician:	Phone:
Address:	

Referral Source:

1. How long have you been living here?
2. Where were you living before you moved here?
3. How was the decision made to move to a nursing facility? Whose idea was it? Why? If it was someone else's idea, what was your role in the decision?
4. What other options did you know about?
5. What were your expectations or plans when you moved here (e.g., long or short stay)? How well have your expectations been met? Why/why not?
6. What activities do you participate in here at the facility?
7. Are there benefits to living here beyond the services and activities? If so, please explain

(e.g., friends, social life, near family, faith-based services)
8. What do you like and dislike about living here (specific examples)?
9. Have you considered moving before? Why are you considering it now? Have you discussed this with anyone?
10. Have you had experience working with a personal care assistant (other than in a facility)? How did it work for you?
11. If you were to leave this facility today, where would you go?
12. What would be your ideal living situation?
What assistance and services would you need to achieve the situation you described?
☐dressing ☐grooming ☐meal prep. ☐laundry ☐shopping ☐eating ☐transferring ☐bathing/showering ☐transportation ☐respirator care ☐catheter care ☐bowel care ☐suctioning ☐overnight care Others, please list:
13. What barriers/fears would you anticipate in moving?

14. What friends/family live in the area? Do you have contact with them? Would they support you in moving?
15. What connections do you have to the community now (e.g., church, service groups)?
16. Are you currently on any waiting list(s) for Section 8 housing or other community services? If so, which ones?
17. When you lived in the community before, what experience(s) did you have (if any) with local service programs (e.g., previous IHSS client, prior contact with APS)?
The next step would be to gather information to see what would be necessary for you to live in the community. It also involves determining if there are services that could meet your needs and ensure a successful and safe move. You will be the primary decision-maker throughout the process. Our experience has shown that planning for a successful move may work best is we do it with some friends and family members who know and care about you, and who you are comfortable with participating in the decisions. It can be helpful to get other's ideas; we might overlook something or just not know about some options. Getting others involved can also be very important in making clear some of our expectations for the changes a move would bring.
18. Are there family members/friends you would like us to meet with to discuss this information?
19. Would you like to continue this process by participating in a transition assessment?
Yes No (circle one)

Deinstitutionalization Assessment

SECTION 1: DIAGNOSES

Diagnoses: Check diagnosis here if (1) it is provided by a health care provider, or (2) you see it written in a medical record (including hospital discharge forms, nursing facility admission forms, etc.), or (3) if resident or informant can state them. Note source in Comments section. Statements should be confirmed by resident's medical records.

	Comments
A. Endocrine/Metabolic: ☐Diabetes Mellitus ☐Hypothyroidism/Hyperthyroidism ☐Dehydration/ fluid & electrolyte imbalances ☐Liver Disease (hepatic fa cirrhosis) ☐Other disorders of digestive system (mouth esophagus, stomach, intestines, gall bladder, pancreas) Nutritional Imbalances (e.g., malnutrition, vitamin deficier high cholesterol, Hyperlipidemia) ☐Other disorders of hormonal or metabolic system.	
B. Heart/Circulation: ☐Congestive Heart Failure (CHF) ☐Anemia/Coagulation Defects/Other blood diseases ☐Angina/Coronary Artery Disease/Myocardial Infarction (MI) ☐Disorders of heart rate or rhythm ☐Disorders of blood vessels or lymphatic system ☐Hypertension (HTN) (high blood pressure) ☐Hypotension (low blood pressure) ☐Other heart conditions (including valve disorders)	
C. Musculoskeletal/Neuromuscular: ☐Amputation ☐Hip fracture/replacement ☐Parkinson's Disease ☐Arthritis (e.g., Osteoarthritis, Rheumatoid Arthritis) ☐Other fracture/joint disorders/Scoliosis/Khyphosis ☐Osteoporosis/Other bone disease ☐Multiple Sclerosis/ALS ☐Contractures/Connective Tissue Disorders ☐Muscular Dystrophy ☐Spinal Cord Injury ☐Paralysis Other than Spinal Cord Injury ☐ Other chronic pain/fatigue (e.g., Fibromyalgia, Migraines, headaches) ☐Other Musculoskeletal, Neuromuscular, or Peripheral Nerve Disorders	
D. Brain/Central Nervous System: ☐Alzheimer's Disease ☐Other Dementia ☐Seizure Disorder ☐Traumatic Brain Injury ☐Cerebral Vascular Accident (CVA, stroke) ☐Other brain disorders	
E. Respiratory: ☐Pneumonia/Acute Bronchitis/ Influenza ☐Asthma/Emphysema/Chronic Bronchitis/ Chronic Obstructive Pulmonary Disease (COPD) ☐Tracheostomy ☐Ventilator Dependent ☐Other respiratory condition	
F. Disorders of Genitourinary System/ Reproductive System: ☐Renal Failure, other kidney disease ☐Incontinence ☐Urinary Tract Infection (UTI), current or recently recurrent ☐Other disorders of GU system (bladder, urethra) ☐Vaginal Problems ☐Testicular/Prostate Problems	

G. Documented Mental Illness: ☐Schizophrenia ☐Depression ☐Anxiety Disorder (e.g., phobias, post-traumatic stress disorder, obsessive-compulsive disorder) ☐Bipolar/Manic-Depressive ☐Other mental illness diagnosis (e.g., Personality Disorder)	
H. Sensory: ☐Deaf ☐Heard of hearing ☐Blind ☐Visual Impairment (e.g., cataracts, retinopathy, glaucoma, macular degeneration) ☐Other sensory disorders	
I. Infections/Immune System: ☐Allergies ☐Cancer in past 5 years ☐Diseases of the skin ☐HIV positive ☐AIDS (diagnosed) ☐Other infectious disease ☐Auto-Immune Disease (other than rheumatism)	
J. Other: ☐Alcohol or Drug Abuse ☐Behavioral diagnoses (not found in Part G above) ☐Terminal Illness (prognosis ≤ 12 months) ☐Wound, Burn, Bedsore, Pressure Ulcer ☐Other: specify	

SECTION 2: HEALTH-RELATED SERVICES

Check only one box per row.

HEALTH-RELATED SERVICES NEEDED	Person is Indepe-ndent	**CURRENT** FREQUENCY OF HELP/SERVICES NEEDED FROM OTHER PERSONS						**COMMENTS:** Any changes anticipated by date of discharge. Specify who will assume current help activities and source of payment, if any.
		1 to 3 times/ month	Weekly	2 to 6 times/ week	1 to 2 times/ day	3 to 4 times/ day	Over 4 times/ day	
Interventions related to BEHAVIORS								
CONDITION – REQUIRES NURSING ASSESSMENT or skilled medical monitoring by persons trained and overseen by nurse. Condition may be unstable or deteriorating (e.g., infections, gangrene, dehydration, malnutrition, terminal condition, exacerbation, AIDS) and/or result from multiple health risks in person unable to manage them or to communicate problems.								
IV CHEMOTHERAPY								
EXERCISES/RANGE OF MOTION								
IV FLUIDS								
IV MEDICATIONS (Drips or boluses, not chemotherapy)								
MEDICATION ADMINISTRATION (not IV) OR ASSISTANCE with pre-selected or set-up meds								
MEDICATION MANAGEMENT – Set-up and/or monitoring (for effects, side effects, adjustments) AND/OR blood levels								

OSTOMY-RELATED SKILLED SERVICES								
OXYGEN								
PAIN MANAGEMENT								
POSITIONING IN BED OR CHAIR every 2-3 hours								
RESPIRATORY TREATMENTS: Nebulizers, IPPB Treatments, BI-PAP, C-PAP (does NOT include inhalers)								
IN-HOME DIALYSIS								
TPN (Total Parenteral Nutrition)								
TRANSFUSIONS								
TRACHEOSTOMY CARE								
TUBE FEEDINGS								
ULCER – Stage 2								
ULCER – Stage 3 or 4								
URINARY CATHETER-RELATED SKILLED TASKS (irrigation, straight catheterizations)								
OTHER WOUND CARE (not catheter sites, ostomy sites, or IVs)								
VENTILATOR-RELATED INTERVENTIONS								
OTHER (specify):								

	5+ DAYS/WEEK	1 TO 4 DAYS/WEEK	
SKILLED THERAPIES: PT, OT, Speech. Other (specify).			

SECTION 3: PLANNING ISSUES FOR HEALTH:

Priorities and Support Needs	Comments: What needs to be done, when, by whom
☐medical supplies ☐adaptive equipment ☐preventative health care ☐pain management ☐exercise ☐evaluations (OT, hearing, vision, etc.) ☐pharmacy ☐community doctor ☐therapy ☐dentist ☐specialist ☐other:	
Resources	
☐own equipment ☐other:	

SECTION 4: PLANNING ISSUES FOR HOUSING

Priorities	Comments: What needs to be done, when, by whom
☐access to home ☐utilities ☐appliances ☐telephone ☐access to rooms ☐furniture ☐bathroom modifications ☐change of address ☐equipment ☐location ☐ kitchen modifications ☐keys for care providers ☐subsidized housing ☐pet accommodations ☐independent housing ☐shared housing	
Resources	
☐donated funds ☐own furniture ☐ donated furniture ☐Indep. Living Center ☐service clubs (e.g., Kiwanis, Rotary) ☐ subsidy programs e.g., LIHEAP, Section 8)	

SECTION 5: PLANNING ISSUES FOR FINANCIAL MATTERS

Priorities	Comments: What needs to be done, when, by whom
☐determine amount and sources of income ☐establish bank account ☐establish direct deposit ☐eligibility for Food Stamps ☐ current bills/debts that require action ☐ develop a budget ☐money management services ☐credit history may be problematic	
Resources	
☐SSI ☐Social Security ☐VA ☐other pension ☐personal savings ☐family support	

SECTION 6: PLANNING ISSUES FOR INDEPENDENCE/SELF-DETERMINATION

Priorities	Comments: What needs to be done, when, by whom
Assistance with: ☐memory ☐emotional support ☐communication equipment ☐health care advocate ☐support group ☐decision-making ☐legal advice ☐living will ☐ power of attorney ☐record keeping ☐ back-up plan for emergencies ☐other (specify):	

Previous experience/contact with community agencies (e.g., IHSS, APS); nature of this experience.	
Resources	
☐family ☐friends ☐religious/spiritual group ☐social clubs ☐Indep. Living Center	

SECTION 7; PLANNING ISSUES FOR SOCIAL & RECREATIONAL NEEDS

Priorities	Comments: What needs to be done, when, by whom
☐visits from friends/family ☐phone calls ☐peer support ☐religious/spiritual affiliation ☐meet neighbors ☐private time ☐ ethnic/cultural traditions ☐future events to plan for (birthdays, holidays, etc.) ☐hobbies (either to maintain or develop) ☐other (specify):	
Resources	
☐family/friends ☐volunteer opportunities ☐place of worship ☐other (specify):	

SECTION 8: PLANNING ISSUES FOR TRANSPORTATION

Priorities	Comments: What needs to be done, when, by whom
☐transportation from NF to new residence (self & belongings) ☐routine transportation (e.g., bus, taxi, Dial-A-Ride) (schedules, tokens/scrip) ☐mobility training ☐will require escort	
Resources	
☐own vehicle ☐family ☐friends ☐ volunteer ☐public program (e.g., Paratransit discount) ☐other (specify):	

Resident's Name:		Care Manager:
Diagnoses:		Date:

ADL/IADL FUNCTIONAL GRID

Cognitive/Behavioral Issues that affect Functioning:

Use instructions to score ADLs/IADLs. **Functioning Level in Facility**: Indicates the level at which the resident now performs the function. **Current Help**: Indicates the type (if any) of human assist the resident receives. **Anticipated for Discharge**: **Will Need (More) Help or Change in Help**: Note initial assessment of help/resources needed for resident to make a successful transition to community. Include IADLs resident may not be performing while living in the facility

COMMENTS INSTRUCTIONS

Comments need to support the scoring. Indicate how resident currently performs the activity. Identify source of limitation; note devices, formal/informal assistance and who is assisting the resident; note difficulties related to fatigue, length of time to complete, etc.

		Functioning Level in Facility						Current Help				Anticipated For Discharge
ADLs - Activities of Daily Living	**COMMENTS**	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Para Medical	Device	Formal Help	Informal Help	No Help	Will Need (More) Help or Change in Help
Eating		☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6					
Dressing		☐ 1	☐ 2	☐ 3	☐ 4	☐ 5						
Transferring		☐ 1	☐ 2	☐ 3	☐ 4	☐ 5						
Bathing		☐ 1	☐ 2	☐ 3	☐ 4	☐ 5						
Toileting		☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6					
Grooming		☐ 1		☐ 3	☐ 4	☐ 5	☐ 6					
IADLs - Instrumental Activities of Daily Living												
Stair Climbing		☐ 1	☐ 2	☐ 3	☐ 4	☐ 5						
Mobility Indoor		☐ 1	☐ 2	☐ 3	☐ 4	☐ 5						
Mobility Outdoor		☐ 1	☐ 2	☐ 3	☐ 4	☐ 5						
Housework		☐ 1	☐ 2	☐ 3	☐ 4	☐ 5						
Laundry		☐ 1			☐ 4	☐ 5						
Shopping/Errands		☐ 1		☐ 3		☐ 5						
Meal Prep/Cleanup		☐ 1	☐ 2	☐ 3	☐ 4	☐ 5						
Transportation		☐ 1	☐ 2	☐ 3		☐ 5	☐ 6					
Telephone		☐ 1	☐ 2	☐ 3		☐ 5						
Medications		☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6					
Money Management		☐ 1	☐ 2	☐ 3		☐ 5						

Evaluations Needed	
Check Evaluations needed	
	Physical Therapy
	Nutrition
	Speech
	Occupational Therapy
	Other:

Comments

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in the Executive Summary of this request, the individual or his or her legal representative will be:

   a. Informed of any feasible alternatives under the waiver; and

   b. Given the choice of either institutional or home and community-based services.

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, **and CCR, Title 22, Division 3, Subdivision 1, Chapter 3, Article 18, Sections 50951 (Right to State Hearing), 50953 (State Hearing Procedures), and 50955 (Fair Hearing, Assistance in Filing)** to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in the Executive Summary of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.

3. The following are attached to this Appendix:

   a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing:

   b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;

   c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and

   d. A description of how the individual (or legal representatives) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E **and CCR, Title 22, Division 3, Subdivision 1, Chapter 3, Article 18, Sections 50951 (Right to State Hearing), 50953 (State Hearing Procedures), and 50955 (Fair Hearing, Assistance in Filing).**

ATTACHMENT TO APPENDIX D-4

A copy of the form(s) used to document freedom of choice and to offer a fair hearing.

- Application for the Multipurpose Senior Services Program (MSSP)
- Application for the Multipurpose Senior Services Program (MSSP) Under Medi-Cal Institutional Deeming Procedures
- Request for Deinstitutional Services
- Client Rights in MSSP
- Your Right To Appeal This Decision
- Request for a State Hearing Form

Application for the Multipurpose Senior Services Program

MSSP Site					
Applicant's Name					
Medi-Cal #		Phone			
Street Address				Apt #	
City/State/Zip					

I am applying to participate in the Multipurpose Senior Services. Program (MSSP). I agree to cooperate with the MSSP staff that will determine my eligibility for the program and, if I am accepted, will work with me to obtain the social and health services that I need.

If I am eligible and choose to participate, I understand that:

- I may change my mind at any time, withdraw from the program and decide to continue living where I am. I will not be forced to make a change in my living arrangements.
- Discharge or voluntary withdrawal from MSSP will not affect other medical or social benefits that I am eligible to receive.
- MSSP is an alternative to living in a nursing facility. I prefer to participate in MSSP and remain in my home.
- I do not have to answer any questions that are not relevant to the determination of services I am to receive.
- I will participate in the process of deciding the services that I need. I will be notified of the services I am to receive and any subsequent changes made to these arrangements.
- All claims submitted in my behalf for Medicare, Medi-Cal and social services will be tracked by the MSSP staff.
- All information in my MSSP case record is confidential. This includes health information, and non-health information. My non-health information, as released by my authorization, will be seen only by staff and consultants of MSSP, those providing services to me, and as otherwise provided by law.
- My health information that I authorize to be provided to MSSP shall be maintained as confidential as required by the Health Insurance Portability and Accountability Act (HIPAA). I acknowledge that the MSSP site has provided me with a notice of HIPAA privacy practices.
- As is the case with other Medi-Cal long-term care services that I receive, because MSSP are also funded by Medi-Cal, the State may also seek recovery for those services from my estate after my death.

- I have the right to have care management provided by MSSP or another qualified organization.
- I will only receive MSSP services as long as federal and state funds are available. Furthermore, I will no longer be eligible for MSSP if: the cost for serving me exceeds amounts budgeted for my care; MSSP determines that I can no longer benefit from services; the imminent risk of my being institutionalized no longer exists; or if I become ineligible for Medi-Cal benefits.
- I may request a state hearing if my application for participation is denied, if I am discharged from the program, or if I am dissatisfied with services I receive.

All questions I have at this time concerning MSSP have been fully answered. When I have further questions, I should contact:

MSSP Staff		**Phone**	

Applicant's signature:	

I have explained MSSP and the nature of the involvement requested of the applicant. I have answered the questions about MSSP asked by the applicant, or by persons asking on behalf of this applicant. I have given the applicant a copy of this form, and a copy of either "Client Rights" or the County's equivalent notice.

I hereby witness the above signature:

MSSP signature		**Date:**	

Client received a copy of this form on this date:	

Application for MSSP Under Medi-Cal Institutional Deeming Procedures

MSSP Site					
Applicant's Name					
Medi-Cal #		Phone			
Street Address				Apt #	
City/State/Zip					

I am applying to participate in the Multipurpose Senior Services. Program (MSSP). I agree to cooperate with the MSSP staff that will determine my eligibility for the program and, if I am accepted, will work with me to obtain the social and health services that I need.

If I am eligible and choose to participate, I understand that:

- I may change my mind at any time, withdraw from the program and decide to continue living where I am. I will not be forced to make a change in my living arrangements.
- Discharge or voluntary withdrawal from MSSP will affect my eligibility for other Medi-Cal benefits. My Medi-Cal benefits are dependent upon my continuing eligibility for MSSP: if I am no longer eligible for, or voluntarily withdraw from MSSP, Medi-Cal benefits will end.
- MSSP is an alternative to living in a nursing facility. I prefer to participate in MSSP and remain in my home.
- I do not have to answer any questions that are not relevant to the determination of services I am to receive.
- I will participate in the process of deciding the services that I need. I will be notified of the services I am to receive and any subsequent changes made to these arrangements.
- All claims submitted in my behalf for Medicare, Medi-Cal and social services will be tracked by the MSSP staff.
- All information in my MSSP case record is confidential. This includes health information, and non-health information. My non-health information, as released by my authorization, will be seen only by staff and consultants of MSSP, those providing services to me, and as otherwise provided by law.
- My health information that I authorize to be provided to MSSP shall be maintained as confidential as required by the Health Insurance Portability and Accountability Act (HIPAA). I acknowledge that the MSSP site has provided me with a notice of HIPAA privacy practices.
- As is the case with other Medi-Cal long-term care services that I receive, because MSSP are also funded by Medi-Cal, the State may also seek recovery for those

services from my estate after my death.

- Information in my case record is confidential. It will be seen only by staff and consultants of MSSP, those providing services to me, and as otherwise provided by law.
- I have the right to have care management provided by MSSP or another qualified organization.
- I will only receive MSSP services as long as federal and state funds are available. Furthermore, I will no longer be eligible for MSSP if: the cost for serving me exceeds amounts budgeted for my care; MSSP determines that I can no longer benefit from services; the imminent risk of my being institutionalized no longer exists; or if I become ineligible for Medi-Cal benefits.
- I may request a state hearing if my application for participation is denied, if I am discharged from the program, or if I am dissatisfied with services I receive.

All questions I have at this time concerning MSSP have been fully answered. When I have further questions, I should contact:

MSSP Staff		**Phone**	

Applicant's signature:	

I have explained MSSP and the nature of the involvement requested of the applicant. I have answered the questions about MSSP asked by the applicant, or by persons asking on behalf of this applicant. I have given the applicant a copy of this form, and a copy of either "Client Rights" or the County's equivalent notice.

I hereby witness the above signature:

MSSP signature		**Date:**	

Client received a copy of this form on this date:	

Request for Deinstitutional Services

MSSP Site			
Applicant's Name			
Medi-Cal #		Phone	
Street Address		Apt #	
City/State/Zip			

I am requesting services from the Multipurpose Senior Services Program (MSSP). Specifically, I am requesting assistance in transitioning from living in a facility to living in the community. I understand that:

- I may change my mind at any time, withdraw from the program, and decide to continue living where I am. I will not be forced to make a change in my living arrangements.
- Discharge or voluntary withdrawal from these deinstitutional services will not affect other medical or social benefits that I am eligible to receive.
- I will participate in the process of determining the deinstitutional services that I need. I will be notified of the services I am to receive and any subsequent changes made to these arrangements.
- I do not have to answer any questions that are not relevant to the determination of services I am to receive.
- All information regarding my MSSP case record is confidential. This includes health information, and non-health information. My non-health information, as released by my authorization, will be seen only by staff and consultants of MSSP, those providing services to me, and as otherwise provided by law.
- My health information that I authorize to be provided to MSSP shall be maintained as confidential as required by the Health Insurance Portability and Accountability Act (HIPAA). I acknowledge that the MSSP site has provided me with a notice of HIPAA privacy practices.
- I will only receive deinstitutional services as long as federal and state funds are available.
- I understand that, at the time of my death, the state is required to recover the costs of certain Medi-Cal services I have received. Medi-Cal services that are subject to recovery include costs of a nursing facility and other long-term care services such as MSSP.
- I may request a State Hearing if my request for services is denied, if I am discharged from services, or if I am dissatisfied with the services I receive. A hearing may be requested by writing to:

State Hearings Division
State Department of Social Services
744 P Street, Mail Station 19-37
Sacramento, CA 95814

I may also request a hearing by calling the Public Inquiry and Response Unit:

Toll-Free Number: 1.800.952.5253
TDD for the Deaf: 1.800.952.8349

All questions I have at this time concerning MSSP have been fully answered. When I have further questions, I should contact:

MSSP Staff		**Phone**	

Applicant's signature:	***x***

I have: explained the deinstitutional services, MSSP, and the nature of the involvement requested of the individual; answered the questions asked by the individual, or by persons asking on behalf of this individual; and I have provided a copy of this form to the individual.

I hereby witness the above signature:

MSSP signature	***x***	**Date:**	

Individual received a copy of this form on this date:	

Client Rights in MSSP

Welcome to the Multipurpose Senior Services Program (MSSP). The goal of our care management services is to prevent or delay nursing facility placement for our clients. We do this by arranging for and monitoring various supportive services available in the community.

Your care manager will work with you to identify your strengths, resources, priorities, interests and needs. You will have a formal assessment of your situation at least once a year. At that time a plan for your services, called a Care Plan, will be developed. In arranging services for you, your care manager must first assess and use the assistance available through your family and friends; programs available in the community are the next priority. If there remains a need for additional services when those resources have been exhausted, MSSP may be able to purchase some services for you. The services that may be available through MSSP include: Adult Day Care, Housing Assistance, Chore and Personal Care, Care Management, Respite, Transportation, Meal Services, Protective Services, and Communication Services.

Both you and your care manager have responsibilities in MSSP.

It is your responsibility to:

- Provide information necessary for the development of your Care Plans.
- Cooperate with your care manager and the other providers of services you receive.
- Communicate with your care manager about any problems or concerns as they arise.

It is your care manager's responsibility to:

- Inform you of your rights and responsibilities, including your right to have any complaint or grievance addressed by our local office, and your right to file a request for a Medi-Cal State Hearing at any time if you disagree with any decision made by our program.
- Coordinate the services identified in your Care Plan.
- Provide counseling and guidance.
- Notify you prior to any major changes affecting your Care Plan, including case closure.
- Keep your information confidential.

It is our intention to deliver high quality services that meet your expectations. However, should you have a complaint, question, or if you are dissatisfied with our decisions or services, please talk it over with your care manager. If you and your care manager cannot resolve the issue, you may ask for a meeting with your care manager's supervisor who is ***[Enter Supervisor's Name]*** at

[Enter Supervisor's Phone Number].

You may have a family member or representative with you at any time to meet with our program staff.

It has been our experience that most questions can be resolved at the local program level. However, you have the right to initiate a request for a formal Medi-Cal State Hearing at any time. The best way to request a hearing is to fill in the information on the attached form and send it to:

State Hearings Division
State Department of Social Services
744 P Street, Mail Station 19-37
Sacramento, CA 95814

You may also request a hearing by calling the Public Inquiry and Response Unit:

Toll-Free Number: 1.800.952.5253
TDD For the Deaf: 1.800.952.8349

Your Right to Appeal This Decision

If you are dissatisfied with the action described in the attached Notice, you may request a State Hearing before an Administrative Law Judge at the State Department of Social Services. This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. If you decide to request a hearing, you must do so within 90 days of the date of the attached Notice.

If you ask for a hearing before the effective date of the action, your services may continue unchanged under certain circumstances until the hearing or until you receive your hearing decision.

REPRESENTATION
You can represent yourself at the State Hearing. A friend, attorney or any other person can also represent you, but you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number listed below for Public Inquiry and Response.

HOW TO REQUEST A STATE HEARING
You may request a hearing in writing. You may use the form on the other side of this statement. If you do not use this form, make sure you provide your NAME, ADDRESS, and PHONE NUMBER, along with a DESCRIPTION OF THE ACTION with which you disagree. Please indicate that the action involves MSSP BENEFITS, and if you will need an INTERPRETER at the hearing, specify the language and dialect. Mail your request to:

State Hearings Division
State Department of Social Services
744 P Street, Mail Station 19-37
Sacramento, CA 95814

Fax (916) 229-4110 (State Hearings Support)

You may also request a hearing by calling the Public Inquiry and Response Unit:

Toll-Free Number: 1-800-952-5253
TDD For the Deaf: 1-800-952-8349

REQUEST FOR A STATE HEARING FORM

Name		Phone
Street Address		
City	State	Zip Code

I am requesting a State Hearing because of an action by the Multipurpose Senior Services Program, related to the following:

☐ Discontinuance	☐ Denial	☐ Reduction

The reason for my request is:

REQUEST FOR SPECIAL ACCOMMODATION
(Complete this section only if it applies to you)

I am requesting the hearing be conducted:

☐	By telephone because:	
	☐ I am homebound.	
	☐ I live more than _____ hours from the MSSP or county Social Services office.	
☐	In my home because:	
☐	I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)	
	Language:	Dialect:

The information you provide on this form is needed to process your request for a hearing. Processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may do so by contacting Public Inquiry and Response. Any information you provide may be shared with the MSSP office and with the U.S. Department of Health and Human Services.

ATTACHMENT TO APPENDIX D-4

A description of the agency's procedure(s) for

- informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver.
- allowing individuals to choose either institutional or home and community-based services.

STATE PROCEDURES

The care manager is responsible for informing each individual of the feasible alternatives for obtaining necessary services and giving each eligible client the choice of receiving necessary care and services in a nursing facility or in an in-home living arrangement. The client's assigned care manager is also the person at the local MSSP site responsible for informing the client (or their legal representative) of the feasible service alternatives and choice of living arrangements.

Pursuant to the MSSP Site Manual (page 3-7), the care manager shall ensure that:

- **Clients, their legal representative, relatives or involved persons are informed of the choice of either participating or not participating in the MSSP Medicaid Waiver program.**
- **The client is informed regarding the site's informal grievance procedure and formal appeal rights; termination procedures; and the client's right to refuse or discontinue services.**
- **The client's choice is documented on the Application Form at time of:**
  1. **Initial application for the Waiver program, or**
  2. **Reapplication after a client's termination from participation in the program.**
- **Waiver participants are given free choice of all qualified waiver providers for each service included in their care plan.**

ATTACHMENT TO APPENDIX D-4

A description of how the individual (or legal representatives) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

PROCESS TO REQUEST A FAIR HEARING

Pursuant to the MSSP Site Manual, Waiver participants shall be informed of the right to an appeal or to request a fair hearing. The care manager shall ensure that a Waiver participant is notified of such a right if:

- **The choice of home- and community-based services versus institutional care was not offered (Site Manual, page 3-7).**
- **The Waiver participant was denied his/her choice of services, type of service, service provider, type of provider, or amount of service (Site Manual, page 3-13).**

b. FREEDOM OF CHOICE DOCUMENT

Specify where copies of this form are maintained:

The Application is the MSSP freedom of choice document. It is kept in the client's case record.

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

___ Registered nurse, licensed to practice in the State

___ Licensed practical or vocational nurse, acting within the scope of practice under State law

___ Physician (M.D. or D.O.) licensed to practice in the State

___ Social Worker (qualifications attached to this Appendix)

X ~~Case~~ **Care** Manager (**Social Work Care Manager [SWCM] or Nurse Care Manager [NCM]. Minimum qualifications for the NCM are stated on page D-2 of this Waiver. Minimum qualifications for the SWCM are: Must have a masters degree in social work, psychology, counseling, rehabilitation, gerontology or sociology, plus one year working with the elderly; or a bachelors degree in one of the above fields and two years experience with the elderly.)**

___ Other (specify):

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

___ At the Medicaid agency central office

___ At the Medicaid agency county/regional offices

___ By ~~case~~ **care** managers

___ By the agency specified in Appendix A

___ By consumers

X Other (specify): **Local MSSP site.**

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the

appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

___ Every 3 months

___ Every 6 months

X Every 12 months

X Other (specify):
Although reviews will be conducted every 12 months, the local care management staff may determine that more frequent reviews are necessary.

Based upon client needs, if new services or supports are required prior to the scheduled reassessment, the care plan will be amended to include the new service or support.

APPENDIX E-2

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

Individual client care plans are approved by the local site supervisor prior to implementation, with guidance from the MSSP Site Manual. This manual provides sites with information to support the effective operation of the MSSP statewide. It is developed and maintained by the California Department of Aging (CDA) with review and approval from the California Department of Health Services (DHS).

A Utilization Review (UR) is conducted by CDA at each site biennially (every two years), at which time a sample of care plans are reviewed by CDA nursing staff. Parallel Reviews (PR) are conducted by DHS, the State Medicaid Agency, periodically, at which time DHS nursing staff review a sample of care plans and visit the respective enrolled clients in their homes. A copy of each UR report is forwarded to DHS prior to mailing to each respective MSSP site and a copy or each PR report will be shared with CDA and maintained on file at DHS.

In addition, via an interagency agreement between DHS and CDA, DHS must review and approve prior to release or implementation, any MSSP waiver-related regulations, policies, procedures, and protocols, including those related to care plan development and implementation.

In both the CDA UR and DHS review, the care plan will be evaluated relative to:

- **Qualifications of the individual responsible for development of the care plan are appropriate.**
- **Updated at a minimum of every twelve months, and more frequently as required by the client's situation.**
- **Meets statutory and waiver requirements for service type, amount, frequency, duration and provider type.**
- **Services are furnished under a written plan of care.**
- **Services are appropriate to meet assessed need.**
- **Approved waiver services are provided in a timely manner.**

Written reports of findings will be documented with a required corrective action plan, if necessary.

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.

2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

ATTACHMENT TO APPENDIX E-2

A copy of the plan of care form (and instructions) to be utilized in this waiver.

MSSP Care Plan

Client Name:		MSSP #:		Care Plan Conference Date:	
Client Goal/ Outcome:		Problem(s) #			
		Problem(s) #			

Date	Problem #	Problem Statement	Service Provider Type (I, R, P, C)	Plan/Intervention	Date Resolved/ Comments

MSSP Staff Signatures:			
PCM:	Date:	SCM:	Date:
I acknowledge receipt and acceptance of this care plan, and receipt of the notice regarding my rights to a fair hearing if I am dissatisfied with the action(s) affecting MSSP-funded services.		x Client's Signature	

Instructions for Care Plan

The care plan document will be completed fully and accurately for each MSSP client. The sites may modify the care plan form; however, the basic integrity and all components of the form must be maintained, and ample space given to each section to facilitate recording the required information. Whatever the format, the care plan document **will** include the following components: (A sample care plan form follows.)

A. Goal/Outcome

1. This section will address client goals/outcomes for identified needs or problems; it should reflect the client's input and consider the client's preferences **(CMS Protocol I[1], pages 19, 20, and 23).**

2. The care plan should describe a desired achievement, not a therapeutic process, unless it references the expected outcome or goal of the therapy.

3. The goal is the desired end result to be achieved. The goal will specify the skills to be acquired, behaviors to be changed, information to be provided, health or psychosocial conditions to be met, etc. For example:

   - "Client will develop the ability to __."
   - "Client will be provided with ___ to prevent skin breakdown, health deterioration, etc."
   - "Client will be given information regarding __ to maintain ___."

4. The outcome identifies the anticipated result or benefit to be obtained from the service provided and may be connected to multiple problems. The client's response to the service provided shall be addressed in the progress notes.

B. Date

Enter the date that the problem/need was identified. Dating the problems will ensure that care plans are updated/revised when warranted by changes in the client's condition and goals **(CMS Protocol, page 20).**

C. Problem #

The "Problem #" section will list client problems in a sequential manner. The care plan problem numbers remain the same as long as the problem is active. Numbers will be added sequentially as additional problems are

[1] CMS Regional Office Protocol for Conducting Full Reviews of State Medicaid Home and Community-Based Services Waiver Programs; Version 1.2; December 20, 2000; Revised March 11, 2003 to reflect agency name change).

identified, including new problems identified during annual reassessments. Numbering problems facilitates identification of activities in developing and monitoring care plans **(CMS Protocol, pages 20 and 23).**

D. Problem Statement

1. This section of the care plan must contain descriptive problem statements. Problem statements are derived from areas of concern or problem areas identified in the re/assessments for which specific services are provided and/or in which care management activities are initiated.

   Note: the medical diagnosis and the description of a client's function can be linked to describe a problem, but the diagnosis alone does not define the problem or substantiate the need for services; and a need by itself, without detail in the body of the assessment, does not substantiate a service purchase. Care plans must address specific needs identified for each client, rather than reflect an abbreviated, or "cookie cutter" process **(CMS Protocol, page 19).**

2. If there are problem areas identified that will not be addressed in the care plan, an explanation should be documented in the progress notes.

3. The problem areas identified for the care plan shall:

   a. Illustrate the need for care management,

   b. Substantiate the need for service delivery, including informal, referred, and purchased services,

   c. Clearly describe the circumstances within the client's informal and referred service resources that necessitate a purchase with waived service dollars.

   d. Reflect the interdisciplinary team collaboration on assessment findings. During the care planning conference, problems not identified prior to the conference should be added.

E. Service Provider Type

The Service Provider and Type section will list the service provider for all services (purchased and referred). The type of provider(s) for each service will also be entered:

I = Informal: a service provided without cost through the client's network of family, friends, or other informal helpers.

R = Referred: a service provided without cost through referral to a formal organized program or agency.

P = Purchased: a service purchased by MSSP through Waived Services funds.

C = Care Management: specific activities or interventions carried out by the care manager.

More than one provider type may be entered for an individual service.

F. Plan/Intervention

The Plan/Intervention section lists information pertinent to the problem and outlines possible actions, plans or solutions to solve the problem. Interventions that have the greatest probability of success are those that consider the client's preferences, perception of the problem or situation, and are compatible with the client's beliefs, values, and attitudes (CMS Protocols, pages 18, 20, and 23).

G. Date Resolved/Comments

This section contains information regarding status of care management intervention, whether the problem was resolved or if it needs further monitoring, other pertinent comments regarding services, and client input/response regarding choices and concerns, if appropriate.

APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.

2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

   _X_ Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

   ____ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

   ____ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

   ____ Other (Describe in detail):

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:

   a. When the individual was eligible for Medicaid waiver payment on the date of service;

   b. When the service was included in the approved plan of care;

   c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

   ____ Yes

   _X_ No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

   _X_ All claims are processed through an approved MMIS.

   ____ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

   ____ The Medicaid agency will make payments directly to providers of waiver services.

   _X_ The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

   ____ The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

   ____ Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

   Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

ATTACHMENT TO APPENDIX F

Billing Process and Records Retention

BILLING PROCESS AND RECORDS RETENTION

All MSSP clients shall be Medi-Cal eligible. The MSSP site verifies this eligibility at the time a client is enrolled by obtaining a printout of either:

- **A Medi-Cal Point-Of-Service device printout;**
- **A Medi-Cal Eligibility Data System (MEDS) Screen; or**
- **A certification from either the Claims and Real time Eligibility System (CERTS), or the Automated Eligibility Verification System (AEVS).**

Claims submitted for each client are run through the California Medi-Cal Management Information System (CAMMIS) to check for Medi-Cal eligibility prior to payment. Individuals served by the program may:

- **Reside in the community, or**

- **Be in their last 180 days of stay in a hospital or nursing facility and pending discharge into the community. For those in an institution, although some program services may be received, program eligibility is not finalized and billing cannot occur until the discharge action is implemented. Waiver eligibility cannot be established until the individual is actually transferred to a community residence that meets Waiver requirements.**

Once program eligibility is established, clients receive health and psychosocial assessments to determine their problems, strengths, and needs. Next, a care plan is prepared that identifies services to be pursued in response to these problems and needs. The care plan lists:

1. **The services being managed. This includes both the services tracked in the data system (purchased under the Waiver and obtained through referral to specified funding sources) and those obtained on referral to other sources;**

2. **The vendor;**

3. **The units of service; and**

4. **The cost of services authorized and delivered for all tracked services (Waived and Referred).**

Care management follow up or care plan implementation includes at a minimum:

1. **Monthly telephone contact;**

2. **Quarterly face-to-face contact;**

3. **Minimum annual care plan review, with more frequent reviews as necessitated by client's situation;**

4. **Recertifications of level of care at least every six months; and**

5. **Reassessment and new care plan annually.**

Delivery of necessary and appropriate services is verified throughout the care management process. Sub-vendor billings are verified against the care plan by the site prior to payment.

BILLING PROCESS

1. **For non-institutionalized clients residing in the community, each site prepares a monthly billing for each client's services. The monthly billing is submitted to DHS's fiscal agent, Electronic Data Systems (EDS), who edits the claim, pays it under the Home- and Community-Based Services (HCBS) Federal Financial Participation (FFP) rate, and includes the client, service and payment data in CAMMIS.**

2. **Services for institutionalized individuals may be billed as follows:**

   A. **Qualifies for MSSP**
   For those individuals who are discharged into the community as planned, the cumulative total of care management and other services received while in the institution is billed and paid as a special single unit of deinstitutional care management under the HCBS FFP rate. This billing cannot occur before the person leaves the institution and is enrolled in the waiver.

   B. **Does not qualify for MSSP**
      - **For those individuals who are discharged into the community with a Medi-Cal aid code not covered by the Waiver, the cumulative total of care management and other services received while in the institution is billed and paid as a special single unit of deinstitutional care management under the Administrative Case Management FFP. This billing will be initiated immediately upon discharge utilizing the individual's institutional aid code.**

      - **For those individuals who either die or decide not to follow through with discharge plans, the cumulative total of care management and other services received while in the institution is billed and paid as a special single unit of deinstitutional care management under the Administrative Case Management FFP. This billing will be initiated effective the date of death, or as soon as the decision to abort discharge planning is made.**

RECORDS RETENTION

An audit trail is maintained by the sites and the State that consists of the client case record, sub-vendor billings and the electronic record of client services in CAMMIS. Sites and sub-vendors are required to maintain records of funds expended for Waiver services for a minimum of four years following the date of service.

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1
COMPOSITE OVERVIEW
COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE:

YEAR	FACTOR D	FACTOR D'*	FACTOR G*	FACTOR G'*
1	**$2,727**	**$12,512**	**$22,844**	**$3,530**
2	**$2,727**	**$13,776**	**$23,529**	**$3,724**
3	**$2,727**	**$15,167**	**$24,235**	**$3,929**
4	**$2,727**	**$16,699**	**$24,962**	**$4,145**
5	**$2,727**	**$18,386**	**$25,711**	**$4,373**

***Factors D', G, and G' are based upon Year Over Year (YOY) percentage increases from CMS 372s for Fiscal Years 1994/95 through 2001/02.**

(Factor D is based upon projected level funding through Year 5 of the Waiver.)

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

LOC: **NF**

YEAR	UNDUPLICATED INDIVIDUALS		
	Total	Community Deemed	Institutionally Deemed*
1	**16,335**	**15,519**	**816**
2	**16,335**	**15,519**	**816**
3	**16,335**	**15,519**	**816**
4	**16,335**	**15,519**	**816**
5	**16,335**	**15,519**	**816**

***Institutional Deeming will be limited to 5% of the waiver population. The percentages of waiver population will be distributed as shown above.**

EXPLANATION OF FACTOR C:

Check one:

X The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

____ The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform CMS in writing of any limit that is less than factor C for that waiver year.

APPENDIX G-2
METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: **NF**

The July 25, 1994 final regulation defines Factor D as:

> "The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following pages.

APPENDIX G-2 FACTOR D LOC: NF Demonstration of Factor D estimates: Waiver Year 1 2004/05

Column A Waiver Service Code	Type	Description	Column B Unduplic. Recipients	Column C Ave. # Annual Users/Units	Column D Ave. Unit Cost	Column E Total
1.0	DAY	Adult Day Support Center	120	45	47.20	254,880
1.0	HOUR	Adult Day Support Center	20	90	23.78	42,804
1.1	DAY	Adult Day Care	120	20	38.50	92,400
1.1	HOUR	Adult Day Care	20	5	20.31	2,031
2.2	OTO	Minor Home Repair/Maintenance	1,800	4	77.21	555,912
2.3	OTO	Non-medical Home Equipment	2,700	4	161.74	1,746,792
2.4	OTO	Emergency Move	200	1	386.05	77,210
2.5	OTO	Restoration of Utility Services	65	1	330.90	21,509
2.6	OTO	Temporary Lodging	40	1	111.17	4,447
3.1	DAY	Chore	200	2	20.37	8,148
3.1	HOUR	Chore	1,000	40	20.28	811,200
3.2	DAY	Personal Care	50	2	82.73	8,273
3.2	HOUR	Personal Care	500	13	39.71	258,115
3.2	VISIT	Personal Care	100	8	82.73	66,184
3.2	ITEM	Personal Care	100	8	55.15	44,120
3.3	DAY	Health Care	100	8	110.30	88,240
3.3	HOUR	Health Care	100	8	82.73	66,184
3.3	VISIT	Health Care	100	8	110.30	88,240
3.7	DAY	Protective Supervision	75	10	165.45	124,088
3.7	HOUR	Protective Supervision	50	10	82.73	41,365
3.9	DAY	Professional Care Assistance	50	4	153.69	30,738
3.9	HOUR	Professional Care Assistance	750	20	39.71	595,650
3.9	VISIT	Professional Care Assistance	250	10	77.21	193,025
4.3	VISIT	Purchased Care Management	75	10	104.79	78,589
4.3	HOUR	Purchased Care Management	150	5	55.15	41,363
4.3	OTO	Purchased Care Management	35	5	135.07	23,638
4.3	MONTH	Purchased Care Management	35	5	104.79	18,337
4.6	DAY	Deinstitutional Care Management	752	1	2570.00	1,932,640
4.6	OTO	Deinstitutional Care Management	64	1	2570.00	164,480
5.1	DAY	Respite In-home	1,000	12	121.29	1,455,480
5.1	HOUR	Respite In-home	400	40	32.33	517,280
5.2	HOUR	Respite Out of Home	25	8	43.09	8,618
5.2	DAY	Respite Out of Home	100	10	162.29	162,290
6.3	HOUR	Transportation-Escort	1,000	30	8.44	253,200
6.4	OWT	Transportation	4,000	20	13.52	1,081,600
7.1	MEAL	Meals-Congregate	50	26	5.05	6,565
7.2	MEAL	Meals-Home Delivered	750	72	6.62	357,480
7.3	OTO	Food	2,000	6	39.43	473,160
8.3	HOUR	Social Reassurance	380	22	13.92	116,371
8.3	DAY	Social Reassurance	25	2	37.66	1,883
8.3	MONTH	Social Reassurance	100	11	13.90	15,290
8.4	HOUR	Therapeutic Counseling	250	8	57.00	114,000
8.5	VISIT	Money Management	300	4	44.32	53,184
8.5	HOUR	Money Management	300	12	27.67	99,612
9.1	HOUR	Communication-Translation	100	4	63.34	25,336
9.2	OTO	Communication-Device	1,250	4	40.47	202,350
9.2	MONTH	Communication-Device	5,000	11	19.04	1,047,200
50.0	MONTH	Care Management – Site	16,335	9	126.44	18,588,577
60.0	MONTH	Site Administration	16,335	9	84.96	12,490,394
Grand Total (Sum of Column E)						44,550,472
TOTAL ESTIMATED UNDIPLICATED RECIPIENTS						16,335
Factor D (Divide total by number of recipients						2,727

AVERAGE LENGTH OF STAY	322

APPENDIX G-2 FACTOR D LOC: NF Demonstration of Factor D estimates: Waiver Year 1 2005/06

Column A Waiver Service Code	Type	Description	Column B Unduplic. Recipients	Column C Ave. # Annual Users/Units	Column D Ave. Unit Cost	Column E Total
1.0	DAY	Adult Day Support Center	120	45	47.20	254,880
1.0	HOUR	Adult Day Support Center	20	90	23.78	42,804
1.1	DAY	Adult Day Care	120	20	38.50	92,400
1.1	HOUR	Adult Day Care	20	5	20.31	2,031
2.2	OTO	Minor Home Repair/Maintenance	1,800	4	77.21	555,912
2.3	OTO	Non-medical Home Equipment	2,700	4	161.74	1,746,792
2.4	OTO	Emergency Move	200	1	386.05	77,210
2.5	OTO	Restoration of Utility Services	65	1	330.90	21,509
2.6	OTO	Temporary Lodging	40	1	111.17	4,447
3.1	DAY	Chore	200	2	20.37	8,148
3.1	HOUR	Chore	1,000	40	20.28	811,200
3.2	DAY	Personal Care	50	2	82.73	8,273
3.2	HOUR	Personal Care	500	13	39.71	258,115
3.2	VISIT	Personal Care	100	8	82.73	66,184
3.2	ITEM	Personal Care	100	8	55.15	44,120
3.3	DAY	Health Care	100	8	110.30	88,240
3.3	HOUR	Health Care	100	8	82.73	66,184
3.3	VISIT	Health Care	100	8	110.30	88,240
3.7	DAY	Protective Supervision	75	10	165.45	124,088
3.7	HOUR	Protective Supervision	50	10	82.73	41,365
3.9	DAY	Professional Care Assistance	50	4	153.69	30,738
3.9	HOUR	Professional Care Assistance	750	20	39.71	595,650
3.9	VISIT	Professional Care Assistance	250	10	77.21	193,025
4.3	VISIT	Purchased Care Management	75	10	104.79	78,589
4.3	HOUR	Purchased Care Management	150	5	55.15	41,363
4.3	OTO	Purchased Care Management	35	5	135.07	23,638
4.3	MONTH	Purchased Care Management	35	5	104.79	18,337
4.6	DAY	Deinstitutional Care Management	752	1	2570.00	1,932,640
4.6	OTO	Deinstitutional Care Management	64	1	2570.00	164,480
5.1	DAY	Respite In-home	1,000	12	121.29	1,455,480
5.1	HOUR	Respite In-home	400	40	32.33	517,280
5.2	HOUR	Respite Out of Home	25	8	43.09	8,618
5.2	DAY	Respite Out of Home	100	10	162.29	162,290
6.3	HOUR	Transportation-Escort	1,000	30	8.44	253,200
6.4	OWT	Transportation	4,000	20	13.52	1,081,600
7.1	MEAL	Meals-Congregate	50	26	5.05	6,565
7.2	MEAL	Meals-Home Delivered	750	72	6.62	357,480
7.3	OTO	Food	2,000	6	39.43	473,160
8.3	HOUR	Social Reassurance	380	22	13.92	116,371
8.3	DAY	Social Reassurance	25	2	37.66	1,883
8.3	MONTH	Social Reassurance	100	11	13.90	15,290
8.4	HOUR	Therapeutic Counseling	250	8	57.00	114,000
8.5	VISIT	Money Management	300	4	44.32	53,184
8.5	HOUR	Money Management	300	12	27.67	99,612
9.1	HOUR	Communication-Translation	100	4	63.34	25,336
9.2	OTO	Communication-Device	1,250	4	40.47	202,350
9.2	MONTH	Communication-Device	5,000	11	19.04	1,047,200
50.0	MONTH	Care Management – Site	16,335	9	126.44	18,588,577
60.0	MONTH	Site Administration	16,335	9	84.96	12,490,394
Grand Total (Sum of Column E)						44,550,472
TOTAL ESTIMATED UNDIPLICATED RECIPIENTS						16,335
Factor D (Divide total by number of recipients						2,727

AVERAGE LENGTH OF STAY	322

APPENDIX G-2 FACTOR D LOC: **NF** Demonstration of Factor D estimates: Waiver Year 1 2006/07

Column A Waiver Service Code	Type	Description	Column B Unduplic. Recipients	Column C Ave. # Annual Users/Units	Column D Ave. Unit Cost	Column E Total
1.0	DAY	Adult Day Support Center	120	45	47.20	254,880
1.0	HOUR	Adult Day Support Center	20	90	23.78	42,804
1.1	DAY	Adult Day Care	120	20	38.50	92,400
1.1	HOUR	Adult Day Care	20	5	20.31	2,031
2.2	OTO	Minor Home Repair/Maintenance	1,800	4	77.21	555,912
2.3	OTO	Non-medical Home Equipment	2,700	4	161.74	1,746,792
2.4	OTO	Emergency Move	200	1	386.05	77,210
2.5	OTO	Restoration of Utility Services	65	1	330.90	21,509
2.6	OTO	Temporary Lodging	40	1	111.17	4,447
3.1	DAY	Chore	200	2	20.37	8,148
3.1	HOUR	Chore	1,000	40	20.28	811,200
3.2	DAY	Personal Care	50	2	82.73	8,273
3.2	HOUR	Personal Care	500	13	39.71	258,115
3.2	VISIT	Personal Care	100	8	82.73	66,184
3.2	ITEM	Personal Care	100	8	55.15	44,120
3.3	DAY	Health Care	100	8	110.30	88,240
3.3	HOUR	Health Care	100	8	82.73	66,184
3.3	VISIT	Health Care	100	8	110.30	88,240
3.7	DAY	Protective Supervision	75	10	165.45	124,088
3.7	HOUR	Protective Supervision	50	10	82.73	41,365
3.9	DAY	Professional Care Assistance	50	4	153.69	30,738
3.9	HOUR	Professional Care Assistance	750	20	39.71	595,650
3.9	VISIT	Professional Care Assistance	250	10	77.21	193,025
4.3	VISIT	Purchased Care Management	75	10	104.79	78,589
4.3	HOUR	Purchased Care Management	150	5	55.15	41,363
4.3	OTO	Purchased Care Management	35	5	135.07	23,638
4.3	MONTH	Purchased Care Management	35	5	104.79	18,337
4.6	DAY	Deinstitutional Care Management	752	1	2570.00	1,932,640
4.6	OTO	Deinstitutional Care Management	64	1	2570.00	164,480
5.1	DAY	Respite In-home	1,000	12	121.29	1,455,480
5.1	HOUR	Respite In-home	400	40	32.33	517,280
5.2	HOUR	Respite Out of Home	25	8	43.09	8,618
5.2	DAY	Respite Out of Home	100	10	162.29	162,290
6.3	HOUR	Transportation-Escort	1,000	30	8.44	253,200
6.4	OWT	Transportation	4,000	20	13.52	1,081,600
7.1	MEAL	Meals-Congregate	50	26	5.05	6,565
7.2	MEAL	Meals-Home Delivered	750	72	6.62	357,480
7.3	OTO	Food	2,000	6	39.43	473,160
8.3	HOUR	Social Reassurance	380	22	13.92	116,371
8.3	DAY	Social Reassurance	25	2	37.66	1,883
8.3	MONTH	Social Reassurance	100	11	13.90	15,290
8.4	HOUR	Therapeutic Counseling	250	8	57.00	114,000
8.5	VISIT	Money Management	300	4	44.32	53,184
8.5	HOUR	Money Management	300	12	27.67	99,612
9.1	HOUR	Communication-Translation	100	4	63.34	25,336
9.2	OTO	Communication-Device	1,250	4	40.47	202,350
9.2	MONTH	Communication-Device	5,000	11	19.04	1,047,200
50.0	MONTH	Care Management – Site	16,335	9	126.44	18,588,577
60.0	MONTH	Site Administration	16,335	9	84.96	12,490,394
Grand Total (Sum of Column E)						44,550,472
TOTAL ESTIMATED UNDIPLICATED RECIPIENTS						16,335

Factor D (Divide total by number of recipients	2,727
AVERAGE LENGTH OF STAY	322

APPENDIX G-2 FACTOR D LOC: **NF** Demonstration of Factor D estimates: Waiver Year 1 2007/08

Column A Waiver Service Code	Type	Description	Column B Unduplic. Recipients	Column C Ave. # Annual Users/Units	Column D Ave. Unit Cost	Column E Total
1.0	DAY	Adult Day Support Center	120	45	47.20	254,880
1.0	HOUR	Adult Day Support Center	20	90	23.78	42,804
1.1	DAY	Adult Day Care	120	20	38.50	92,400
1.1	HOUR	Adult Day Care	20	5	20.31	2,031
2.2	OTO	Minor Home Repair/Maintenance	1,800	4	77.21	555,912
2.3	OTO	Non-medical Home Equipment	2,700	4	161.74	1,746,792
2.4	OTO	Emergency Move	200	1	386.05	77,210
2.5	OTO	Restoration of Utility Services	65	1	330.90	21,509
2.6	OTO	Temporary Lodging	40	1	111.17	4,447
3.1	DAY	Chore	200	2	20.37	8,148
3.1	HOUR	Chore	1,000	40	20.28	811,200
3.2	DAY	Personal Care	50	2	82.73	8,273
3.2	HOUR	Personal Care	500	13	39.71	258,115
3.2	VISIT	Personal Care	100	8	82.73	66,184
3.2	ITEM	Personal Care	100	8	55.15	44,120
3.3	DAY	Health Care	100	8	110.30	88,240
3.3	HOUR	Health Care	100	8	82.73	66,184
3.3	VISIT	Health Care	100	8	110.30	88,240
3.7	DAY	Protective Supervision	75	10	165.45	124,088
3.7	HOUR	Protective Supervision	50	10	82.73	41,365
3.9	DAY	Professional Care Assistance	50	4	153.69	30,738
3.9	HOUR	Professional Care Assistance	750	20	39.71	595,650
3.9	VISIT	Professional Care Assistance	250	10	77.21	193,025
4.3	VISIT	Purchased Care Management	75	10	104.79	78,589
4.3	HOUR	Purchased Care Management	150	5	55.15	41,363
4.3	OTO	Purchased Care Management	35	5	135.07	23,638
4.3	MONTH	Purchased Care Management	35	5	104.79	18,337
4.6	DAY	Deinstitutional Care Management	752	1	2570.00	1,932,640
4.6	OTO	Deinstitutional Care Management	64	1	2570.00	164,480
5.1	DAY	Respite In-home	1,000	12	121.29	1,455,480
5.1	HOUR	Respite In-home	400	40	32.33	517,280
5.2	HOUR	Respite Out of Home	25	8	43.09	8,618
5.2	DAY	Respite Out of Home	100	10	162.29	162,290
6.3	HOUR	Transportation-Escort	1,000	30	8.44	253,200
6.4	OWT	Transportation	4,000	20	13.52	1,081,600
7.1	MEAL	Meals-Congregate	50	26	5.05	6,565
7.2	MEAL	Meals-Home Delivered	750	72	6.62	357,480
7.3	OTO	Food	2,000	6	39.43	473,160
8.3	HOUR	Social Reassurance	380	22	13.92	116,371
8.3	DAY	Social Reassurance	25	2	37.66	1,883
8.3	MONTH	Social Reassurance	100	11	13.90	15,290
8.4	HOUR	Therapeutic Counseling	250	8	57.00	114,000
8.5	VISIT	Money Management	300	4	44.32	53,184
8.5	HOUR	Money Management	300	12	27.67	99,612
9.1	HOUR	Communication-Translation	100	4	63.34	25,336
9.2	OTO	Communication-Device	1,250	4	40.47	202,350
9.2	MONTH	Communication-Device	5,000	11	19.04	1,047,200
50.0	MONTH	Care Management – Site	16,335	9	126.44	18,588,577
60.0	MONTH	Site Administration	16,335	9	84.96	12,490,394
Grand Total (Sum of Column E)						44,550,472

TOTAL ESTIMATED UNDIPLICATED RECIPIENTS	16,335
Factor D (Divide total by number of recipients	2,727
AVERAGE LENGTH OF STAY	322

APPENDIX G-2 FACTOR D LOC: NF Demonstration of Factor D estimates: Waiver Year 1 2008/09

Column A Waiver Service Code	Type	Description	Column B Unduplic. Recipients	Column C Ave. # Annual Users/Units	Column D Ave. Unit Cost	Column E Total
1.0	DAY	Adult Day Support Center	120	45	47.20	254,880
1.0	HOUR	Adult Day Support Center	20	90	23.78	42,804
1.1	DAY	Adult Day Care	120	20	38.50	92,400
1.1	HOUR	Adult Day Care	20	5	20.31	2,031
2.2	OTO	Minor Home Repair/Maintenance	1,800	4	77.21	555,912
2.3	OTO	Non-medical Home Equipment	2,700	4	161.74	1,746,792
2.4	OTO	Emergency Move	200	1	386.05	77,210
2.5	OTO	Restoration of Utility Services	65	1	330.90	21,509
2.6	OTO	Temporary Lodging	40	1	111.17	4,447
3.1	DAY	Chore	200	2	20.37	8,148
3.1	HOUR	Chore	1,000	40	20.28	811,200
3.2	DAY	Personal Care	50	2	82.73	8,273
3.2	HOUR	Personal Care	500	13	39.71	258,115
3.2	VISIT	Personal Care	100	8	82.73	66,184
3.2	ITEM	Personal Care	100	8	55.15	44,120
3.3	DAY	Health Care	100	8	110.30	88,240
3.3	HOUR	Health Care	100	8	82.73	66,184
3.3	VISIT	Health Care	100	8	110.30	88,240
3.7	DAY	Protective Supervision	75	10	165.45	124,088
3.7	HOUR	Protective Supervision	50	10	82.73	41,365
3.9	DAY	Professional Care Assistance	50	4	153.69	30,738
3.9	HOUR	Professional Care Assistance	750	20	39.71	595,650
3.9	VISIT	Professional Care Assistance	250	10	77.21	193,025
4.3	VISIT	Purchased Care Management	75	10	104.79	78,589
4.3	HOUR	Purchased Care Management	150	5	55.15	41,363
4.3	OTO	Purchased Care Management	35	5	135.07	23,638
4.3	MONTH	Purchased Care Management	35	5	104.79	18,337
4.6	DAY	Deinstitutional Care Management	752	1	2570.00	1,932,640
4.6	OTO	Deinstitutional Care Management	64	1	2570.00	164,480
5.1	DAY	Respite In-home	1,000	12	121.29	1,455,480
5.1	HOUR	Respite In-home	400	40	32.33	517,280
5.2	HOUR	Respite Out of Home	25	8	43.09	8,618
5.2	DAY	Respite Out of Home	100	10	162.29	162,290
6.3	HOUR	Transportation-Escort	1,000	30	8.44	253,200
6.4	OWT	Transportation	4,000	20	13.52	1,081,600
7.1	MEAL	Meals-Congregate	50	26	5.05	6,565
7.2	MEAL	Meals-Home Delivered	750	72	6.62	357,480
7.3	OTO	Food	2,000	6	39.43	473,160
8.3	HOUR	Social Reassurance	380	22	13.92	116,371
8.3	DAY	Social Reassurance	25	2	37.66	1,883
8.3	MONTH	Social Reassurance	100	11	13.90	15,290
8.4	HOUR	Therapeutic Counseling	250	8	57.00	114,000
8.5	VISIT	Money Management	300	4	44.32	53,184
8.5	HOUR	Money Management	300	12	27.67	99,612
9.1	HOUR	Communication-Translation	100	4	63.34	25,336
9.2	OTO	Communication-Device	1,250	4	40.47	202,350
9.2	MONTH	Communication-Device	5,000	11	19.04	1,047,200
50.0	MONTH	Care Management – Site	16,335	9	126.44	18,588,577
60.0	MONTH	Site Administration	16,335	9	84.96	12,490,394

Grand Total (Sum of Column E)	44,550,472
TOTAL ESTIMATED UNDIPLICATED RECIPIENTS	16,335
Factor D (Divide total by number of recipients	2,727
AVERAGE LENGTH OF STAY	322

APPENDIX G-3
METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual(e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

Not applicable.

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

Not applicable.

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

The Waiver does not pay for room and board.

APPENDIX G-4
METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

_X_ The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

____ The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

APPENDIX G-5

FACTOR D'

LOC: **NF**

NOTICE: On July 25, 1994, CMS published regulations which changed the definition of factor D'. The new definition is:

> "The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

> The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.
>
> The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

> If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.
>
> Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

APPENDIX G-5

FACTOR D' (cont.)

LOC: **NF**

Factor D' is computed as follows (check one):

____ Based on CMS Form 2082 (relevant pages attached).

____ Based on CMS Form 372 for years ____ of waiver # ____, which serves a similar target population.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

X Other (specify):
Based on CMS Form 372 for year 2001/02 of Waiver #0141.

APPENDIX G-6

FACTOR G

LOC: **NF**

The July 25, 1994 final regulation defines Factor G as:

> "The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

____ Based on institutional cost trends shown by CMS Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

X Based on trends shown by CMS Form 372 for years **2001/02** of waiver # **0141**, which reflect costs for an institutionalized population at this LOC. ~~Attached is an explanation of any adjustments made to these numbers.~~

____ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.

____ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

____ Other (specify):

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

APPENDIX G-7

FACTOR G'

LOC: **NF**

The July 25, 1994 final regulation defines Factor G' as:

"The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

APPENDIX G-7

FACTOR G'

LOC: **NF**

Factor G' is computed as follows (check one):

____ Based on CMS Form 2082 (relevant pages attached).

____ Based on CMS Form 372 for years ____ of waiver # ____, which serves a similar target population.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

X Other (specify):
Based on CMS Form 372 for year 2001/02 of Waiver #0141.

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY

LOC: **NF**

YEAR 1 **2004//05**

FACTOR D:	**$2,727**		FACTOR G:	**$22,844**
FACTOR D':	**$12,512**		FACTOR G':	**$3,530**
TOTAL:	**$15,239**	≤	TOTAL:	**$26,374**

YEAR 1 **2005//06**

FACTOR D:	**$2,727**		FACTOR G:	**$23,529**
FACTOR D':	**$13,776**		FACTOR G':	**$3,724**
TOTAL:	**$16,503**	≤	TOTAL:	**$27,253**

YEAR 1 **2006//07**

FACTOR D:	**$2,727**		FACTOR G:	**$24,235**
FACTOR D':	**$15,167**		FACTOR G':	**$3,929**
TOTAL:	**$17,894**	≤	TOTAL:	**$28,164**

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY (cont.)

LOC: **NF**

YEAR 1 **2007//08**

FACTOR D:	**$2,727**		FACTOR G:	**$24,962**
FACTOR D':	**$16,699**		FACTOR G':	**$4,145**
TOTAL:	**$19,426**	≤	TOTAL:	**$29,107**

YEAR 5 **2008//09**

FACTOR D:	**$2,727**		FACTOR G:	**$25,711**
FACTOR D':	**$18,386**		FACTOR G':	**$4,373**
TOTAL:	**$21,113**	≤	TOTAL:	**$30,084**