**LTC Manual -Chapter 7h – Appendices**

**Purpose**

This section contains various appendices that pertain to HCS programs, services, and case management activities.

**Section Summary**

Appendices

* 1. [Coordination with DDA](#Coordination_w_DDA)
	2. [Estate Recovery](#Estate_Recovery)
	3. [Resources](#Resources)
	4. [NGMA](#NGMA)
	5. [On-going Additional Resources (OAR)](#OAR)
		+ Meals
		+ Food for Service Animals
		+ Telephone Service
		+ Laundry
	6. [Requesting funding from the BHO/MCO when a client’s need for personal care is based primarily on a diagnosed psychiatric condition](#BHO)

**Appendix I: Coordination with Developmental Disabilities Administration (DDA)**

The Developmental Disabilities Administration (DDA) strives to transform lives by providing support and fostering partnerships that empower people to live the lives they want. Individuals with developmental disabilities may be served by DDA, HCS, the AAAs or a combination of these entities.

DDA implements Community First Choice (CFC), Roads to Community Living (RCL) and Medicaid Personal Care (MPC) programs just like HCS and the AAAs. All administrations operate these programs using the same program rules (WAC). What is important to remember is that no individual can be on the same program with two different administrations/agency.

The CFC and MPC programs are managed by DDA for:

* individuals of all ages who have a developmental disability, and
* children/youth who do not have developmental disabilities but who meet the functional eligibility criteria. This includes youth who are in foster care placements with Children’s Administration up to their 21st birthday.

Determination of developmental disability under [Chapter 388-823 WAC](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-823) does not guarantee eligibility for, or access to, paid services. Clients must still meet the eligibility requirements for the service. Access is governed by capacity and/or funding, unless it is a State Plan service.

When DDA determines that a person does not have the condition of developmental disability, DDA must coordinate access to other services including long-term care or other DSHS services for which the person may be eligible.

CFC and MPC services for adults are authorized by both HCS and DDA under the same federal and state rules. Clients cannot be authorized for CFC or MPC from both ALTSA and DDA at the same time. If HCS receives a request for services from an adult with a developmental disability, it is important to inform that individual of the availability of DDA case resource management to assess, authorize and provide services. The individual may receive CFC or MPC services from HCS while completing the enrollment process for DDA. Once DDA eligibility has been determined, the HCS/AAA worker should coordinate with the DDA case resource manager to transfer the case to DDA. **This coordination must be completed without a disruption of services to the client.**

Coordination/transfer of client services between DDA and HCS may occur for the following reasons:

* Adult DDA clients and applicants may request HCS services;
* Adults with disabilities who are determined to be DDA clients may also gain access to services from HCS that are not available from DDA (like Adult Day Health). While adults may receive COPES waiver services from HCS and state-only funded services (like employment services, SSP or Individual & Family Services) from DDA at the same time, they can only be enrolled in one waiver at any given time.
* Adults with developmental disabilities receiving HCS services may apply to DDA for services if they are not already DDA enrolled.

Communicate with a DDA case resource manager when there is a need to transfer or coordinate services.

* DDA will authorize client services available through DDA once a determination of developmental disability has been made.
* HCS will be the primary case manager in CARE when authorizing nursing facility or HCS waiver services (such as COPES) to DDA clients.
* Clients do not have to disenroll with DDA to receive HCS services.
* HCS may refer clients to DDA for a determination of developmental disability, but long-term care services will be initiated or continued by HCS pending the DDA determination. Services must not be interrupted during the transition from HCS to DDA for on-going service delivery.
* Developmental disability determination decisions by DDA may be appealed by the client, but not by department staff.

During the DDA eligibility determination process, the CARE record for an active HCS client must be transferred to DDA.

* DDA will add the HCS/AAA case manager to the DDA team in CARE so both DDA and HCS will have access to the client’s CARE record and assessment.
* HCS/AAA will be able to authorize payments as needed.

**Process for a DDA client requesting services from HCS:**

1. Referral received from DDA case resource manager or DDA client;
2. **Functional Eligibility** - Complete LTC assessment to establish functional eligibility;
3. **Financial Eligibility** - Notify financial on a 14-443 of transfer so financial record can be obtained from the DDA LTC Specialty Unit. If the client is a MAGI client on N05 coverage group there is no need to send a 14-443 to financial since they do not manage MAGI clients;
4. Authorize services once all program requirements are met.
5. Remember that a client can only receive MPC or CFC services from one agency at any given time. DDA cannot authorize MPC or CFC for the same time period that HCS has an open authorization and vice versa.

**Process for non-DDA enrolled children turning 18 and transferring to HCS**

Children who do not meet DDA eligibility criteria, but have personal care needs are case managed through DDA until they are 18 unless they remain in an extended foster care placement. As long as the youth (age 18, 19 or 20) is in foster placement DDA retains the case and continues to provide case management related to MPC and CFC services. At age 18 or upon leaving foster care between the ages of 18 and 21, if the client requests to continue receipt of personal care services, a referral must be made to HCS for LTC eligibility and ongoing case management. Once eligibility has been established, the MPC or CFC services will be transferred from DDA to HCS without disruption.

**Functional Eligibility –**

1. 2 months prior to the client’s 18th birthday, the DDA case resource manager will:
	1. Make a referral to HCS, and
	2. Notify other agencies (e.g., Children’s and HCA) as appropriate of the transfer.
2. 30 days prior to the client’s 18th birthday, HCS will:
	1. complete the assessment,
	2. confirm the qualified provider,
	3. accept the transfer from DDA, and
	4. authorize services on or after the 18th birthday. The case will be transferred per the usual process to the AAA for ongoing case management, if appropriate.
3. For non-DDA enrolled clients who remained in foster care after the 18th birthday and are now leaving foster care between the ages of 18 and 21 and continue to need personal care services,
	1. the DDA case resource manager will:
		1. Make a referral to HCS, and
		2. Coordinate with Children’s Administration throughout the transition.
	2. The HCS worker will:
		1. determine LTC eligibility,
		2. confirm client’s choice of qualified provider,
		3. authorize services after the 18th birthday, and
		4. transfer the case per the usual process to the AAA for ongoing case management, if appropriate.
	3. DDA and HCS will coordinate to ensure the transition of services for the client is a seamless as possible and to ensure there is **no disruption of services** to the client and no duplication of service payments to the provider(s).

**Financial Eligibility**

Working with financial systems will be different depending on the program under which the individual is receiving services. When the individual needs to apply for Medicaid through HCS, and is not already on SSA/SSI, then a NGMA determination will need to be made.

When the HCS case manager receives the case, notify the financial unit about the change of case management and ask to be added to the AREP screen in ACES.

1. **Foster Care** – Youth can choose to stay in this program until they are age 21. Financial eligibility does not need to be established until they leave the program or turn 21 years of age, whichever comes first.
	* 1. If notified by the client or Children’s Administration that they are leaving the program prior to the 21st birthday, notify financial on a 14-443 of the referral. If appropriate, fast track to prevent a disruption of services.
		2. Notify financial 60 days prior to 21st birthday of the need to send a financial packet and determine financial eligibility.
2. **Children’s Health Insurance Program (CHIP)** – Children remain eligible on this medical program until they are 19 years of age as long as required premiums are paid.
3. Verify financial eligibility at review time;
4. Notify financial 60 days prior to 19th birthday of the need to coordinate transfer of the financial record from the MEDS unit within HCA.
5. **Medicaid (Title 19**) – Children remain eligible on this medical program until they are 19 years of age.
6. Verify financial at review time;
7. Notify financial 60 days prior to 19th birthday of the need to coordinate transfer of the financial record from the DDA LTC Specialty Unit and/or HCA.
8. **Undocumented Children (State Funds only)** – Children remain eligible on this medical program until they are 19 years of age.

For youth needing LTC services from HCS upon aging out of this program, DDA must make a referral to HCS *at least* six (6) months prior to the 19th birthday to allow adequate time for intake and eligibility determination.

1. Verify financial eligibility when file is transferred from DDA. Financial eligibility is determined by the DDA LTC Specialty Unit.
2. Terminate services on the 19th birthday. There are no other Medicaid services available.
3. Refer to community resources.
4. Authorize services once all program requirements are met.

**Appendix II: Estate Recovery**

The state of Washington’s Estate Recovery Program was enacted July 27, 1987. In 1993, federal law mandated that all states enact estate recovery programs.

State law, [RCW 43.20B.080](http://apps.leg.wa.gov/RCW/default.aspx?cite=43.20B.080), requires staff to fully disclose in advance, both verbally and in writing, the terms and conditions of estate recovery to all persons offered long-term care services subject to recovery of payments. **All Aging and Long-Term Support Administration (ALTSA) services except Adult Protective Services (APS) are subject to recovery.**

The state does not place a lien on assets or try to recover against an estate until the death of the medical assistance recipient with the exception of a recipient permanently residing in a medical institution who is required to pay participation. The state will defer recovery until the death of a surviving spouse, a registered domestic partner, and/or while there is a surviving child who is under age 21, blind, or disabled.

Estate recovery program recovers the cost of long-term care services and related hospital and prescription drug services from a recipient’s estate. Federal and State laws also allow states to recover all Medicaid costs. The estate recovery laws have changed several times since the program was enacted. The department recovers from estates according to the law in effect at the time the services were received. Effective January 1, 2014, the estate recovery rules have been amended to no longer include all Medicaid services as subject to recovery. The estate recovery handout ([DSHS 14-454](https://www.dshs.wa.gov/sites/default/files/FSA/forms/pdf/14-454.pdf)) has been amended.

To meet disclosure requirements, you must provide the following documents to all prospective and new clients and verbally explain both the estate recovery program and the community service options available:

* Columbia Legal Services Article: [Estate Recovery](http://www.lawhelp.org/documents/1542715172EN.pdf?stateabbrev=/WA/) and;
* Home and Community Services (HCS) publication: [Medicaid and Options for Long-Term Care Services for Adults (DSHS 22-619x)](https://www.dshs.wa.gov/SESA/publications-library?combine&field_program_topic_value=All&field_job__value=22-619&field_language_available_value=All)
* [Estate Recovery Information Sheet](https://www.dshs.wa.gov/sites/default/files/SESA/publications/documents/Estate%20Recovery%20Insert.pdf)
* [Estate Recovery Repaying the State for Medical and Long Term Care (LTC)](https://www.dshs.wa.gov/sites/default/files/FSA/forms/pdf/14-454.pdf) DSHS form 14-454

**Services Exempt from Recovery**

* Services received prior to 7/26/87, when the Estate Recovery Program was enacted
* Services received prior to 7/25/93, specific criteria in WAC 182-527-2746
* Adult Protective Services provided to a frail elder or vulnerable adult and paid for only by state funds.

 **Assets Not Subject to Recovery**

* Certain properties belonging to American Indians/Alaska Natives (explained in WAC 182-527-2746);
* Government reparation payments specifically excluded by federal law as long as such funds have been kept segregated and not commingled with other countable resources and remains identifiable.

 **Recovery Process**

* The Office of Financial Recovery (OFR) administers Estate Recovery collections for the Department of Social and Health Services (DSHS).
* DSHS recovers from the estate of a deceased client. "Estate" includes all real property (land or buildings) and all other property (mobile homes, vehicles, savings, other assets) the client owned or had an interest in when the client died. A home transferred to a spouse or to a minor, blind or disabled child prior to the client's death, is not considered part of the client's estate. This is a legal transfer under Medicaid rules and does not affect the client's eligibility.
* DSHS recovers from estates according to the estate recovery law in effect at the time the services were received.
* DSHS will file a lien or make a claim against property that is included in the deceased client's estate. Prior to filing a lien against real or titled property, the department shall give notice and an opportunity for a hearing to the probate estate's personal representative, if any, or any other person known to have title to the affected property.
* DSHS will defer recovery:
* While there is a surviving child, who is less than 21 years of age, blind or disabled, per [Chapter 182-527 WAC](http://apps.leg.wa.gov/wac/default.aspx?cite=388-527).
* Until the death of a surviving spouse (if any). When the surviving spouse dies, recovery action will be taken against property in which the deceased client had an interest in at the time of death.
* If the client's heirs would experience undue hardship, and they meet the undue hardship criteria specified in [WAC 182-527](http://apps.leg.wa.gov/WAC/default.aspx?cite=182-527) .

**Resident Personal Funds Held By a Facility**

Within 30 days after the resident's death, the nursing facility or community residential facility (Adult Family Home, Adult Residential Care, or Assisted Living) must convey the resident's personal funds held by the facility to the Office of Financial Recovery (OFR) or to the individual or probate jurisdiction administering the resident's estate. OFR may authorize release of funds to pay for burial costs, either before or after it receives the funds.

**Prepaid Burial Plan or Contract**

DSHS can recover from the balance of funds in a prepaid funeral service contract or plan that is not used to pay for burial expenses if the plan or contract is sold by a funeral home or cemetery regulated by the state. This includes prepaid funeral service contracts sold by a funeral home and funded through insurance.

Funeral plans or trusts established by a lawyer or sold by an insurance agent are not affected by this law.

**Discovery of Decedent's Estate**

The primary sources from which OFR finds out about a decedent's estate are:

* ACES Computer reports. ACES produces a report monthly of medical recipients who have died. Form letters generated from these reports are mailed to the recipient's last known address as shown on the report. The letter asks survivors or estate handlers to answer questions related to estate assets and whether probate has been or will be filed.
* The Superior Court Office Management Information System (SCOMIS) report is sent to OFR from the Office of the Administrator for the Courts. The report lists monthly probate and non-probate filings for each county.
* As of 7/1/95 state law requires the personal representative of the probated estate and the notice agent of the non-probated estate to send a copy of the notice to creditors to OFR.
* Current Washington law allows parties to dispose of debts and personal property in estates that are valued under $100,000.00 by affidavit of successor instead of probate/non-probate. As of 7/1/95, the person claiming to be a successor of the decedent is required to send a copy of the affidavit of successor to OFR.

**Interest Assessed on Past Due Debt**

The recovery debt becomes past due and accrues interest at a rate of one percent per month beginning nine months after the earlier of the filing of the department’s creditor’s claim in the probate, or the recording of the department’s lien. Criteria for waiving interest are in WAC 182-527-2792.

**References**

* [Chapter 43.20B RCW](http://apps.leg.wa.gov/RCW/default.aspx?cite=43.20B)
* [Chapter 74.39A RCW](http://apps.leg.wa.gov/RCW/default.aspx?cite=74.39A)
* [RCW 18.39.250](http://apps.leg.wa.gov/RCW/default.aspx?cite=18.39.250) & [18.39.255](http://apps.leg.wa.gov/RCW/default.aspx?cite=18.39.255)
* [RCW 68.46.050](http://apps.leg.wa.gov/RCW/default.aspx?cite=68.46.050)
* [RCW 70.129.040](http://apps.leg.wa.gov/RCW/default.aspx?cite=70.129.040)
* [RCW 74.46.711](http://apps.leg.wa.gov/RCW/default.aspx?cite=74.46.711)
* [Chapter 182-527 WAC](http://apps.leg.wa.gov/wac/default.aspx?cite=388-527)
* [WAC 388-96-384](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-96-384)

**Appendix III: Resources**

* [ALTSA and DDA Service Comparison Chart](http://intra.altsa.dshs.wa.gov/hcs/documents/Service%20Comparison%20Chart.pdf)
* [ACES and RAC codes cheat sheet for all core programs (i.e., CFC, MPC, HCBS waivers, etc.)](https://teamshare.dshs.wa.gov/sites/hcs/FP/Documents/ACES%20and%20RAC%20codes%20for%20ALTSA%20and%20DDA%20services.doc?Web=1)
* [Social Service Authorization Manual (SSAM)](http://intra.dda.dshs.wa.gov/ddd/p1servicecodes/)
* [Medicaid Programs – LTSS Chart (ACES coverage group cheat sheet)](https://teamshare.dshs.wa.gov/sites/hcs/FP/Documents/Medicaid%20Programs%20-%20LTSS%20Chart.doc?Web=1)

**Appendix IV: Non Grant Medical Assistance (NGMA)**

Effective January 1st, 2014, clients under 65 years of age no longer need to be determined disabled in order to access medical coverage as long as the household’s countable income is below 133% of the FPL. Disability must still be determined if the client is under 65 years of age and needs to access HCBS waiver services, regardless of income.

Blindness or disability is already established for clients who receive SSI or Social Security Disability benefits. Clients who are 18 – 64 who do not receive SSI/SSDI must have their disability determined via the Non-Grant Medical Assistance (NGMA) Program.

Disability through the NGMA process is completed by a Department of Disability Determination Services (DDDS) adjudicator. Eligibility is determined based on the SSI disability criteria ([WAC 182-512-0050](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-475-0050)):

* + Blind (as defined in [WAC 182-512-0050](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-475-0050)); or
	+ Disabled - the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

To determine if a NGMA is needed, look at the SSI criteria (aged, blind or disabled):

1. Clients who are on SSI/SSA Disability, blind, or 65 or older, are already categorically related and a NGMA is NOT needed:
	1. Determine if a financial application has been submitted (unless already on Medicaid), and
	2. Authorize services - use Fast Track if appropriate.
2. For clients under age 65 who appear to meet SSI disability criteria, use the NGMA process to determine the disability. Clients who do NOT appear to meet SSI disability criteria still have the right to pursue NGMA if they wish. Explain the program criteria for severity and durational requirements to clients. If the client wishes to continue, complete the packet. If the client withdraws, notify the financial services specialists within 5 days and refer the client to other community resources or access state-funded resources if appropriate.
3. A client who receives MAGI-based medical coverage must be determined disabled using the **NGMA process** if they need to access waiver services. However, a NGMA is not needed in order to authorize MPC or CFC services.

**Instructions for Completing NGMA Referral in Barcode**

The NGMA transmittal form can be accessed from the Forms Menu of the ECR.



When you select “NGMA” from the Menu you should see the following screen:



At the top right hand corner of the screen are checkboxes to indicate whether this is an Initial Application, Re-examination, or a Fair Hearing review.

On the first line of the transmittal summary there are checkboxes to indicate where the Transmittal Summary should be sent. This will be pre-selected based on the client's office of record. You may change this location by selecting a different checkbox.

Financial Eligibility for NGMA must be determined before the Transmittal Summary can be sent to DDDS. Indicate Yes or No that eligibility has been established.

Boxes 1-6 contain information from ACES for the client selected. This data may not be changed through this form. If the information about the client is incorrect, ACES must be updated first.

Box 7 and 8 will be pre-selected from information via an ACES interface. This information may be corrected by changing the checkbox selected.

Box 9 and 10 allow input for Usual Occupation and Education respectively. These are not mandatory fields.

Box 11 is for the current date of application.

Box 12 is for the requested retro medical time period. Retro medical may not be requested more than 3 months prior to a medical application.

A date must be entered into number 12, Retro Medical Coverage. If retro medical is not needed or requested, enter today's date in field number 12.

**Requesting Retro Medical from a Previous Application**

**Example:** The client applies for medical on 2/12/2010 and wishes to have retro medical considered back to 6/1/2010.

If these dates are entered into fields 11 and 12, an invalid date popup warning will appear.



An additional application date box will appear. Enter the date of the application that the retro medical is being requested for. The retro medical coverage date cannot be more than 3 months prior to the original application date.

 

Box 13 has a checkbox to indicate if the client is deceased.

Boxes 14 through 19 include information about who sent the form and the date it was sent to DDDS. Only box 14 can be changed.

**Attaching Documents**

Certain documents must be attached to the Transmittal Summary before the document can be submitted to DDDS. This is done by clicking the 'Attach Image' button at the bottom of the screen. The documents that must be attached are listed in red to the left of the button.



When the 'Attach Image' button is clicked, the ECR will open and the My ECR tab will be on top. The NGMA (DDDS) filter will be pre-selected with the NGMA document types.



Highlight the documents that you would like to attach to the NGMA Transmittal Summary. On the right hand side of the ECR there will be a new button above the 'New Tickler' button. Once you have all of the documents highlighted, click the 'Attach' button.

You may go to the 'Attached Docs' tab to see which documents have been attached.

Hit the ECR's 'Exit' button to return to the NGMA screen. If the documents have been attached the document types should have changed from red to green.

If there are more than 50 pages in the documents that are attached, a warning message will appear.



When the popup is closed the Attach Image button will be replaced with a 'Select Pages' button.



Clicking the 'Select Pages' button will open a new screen listing all of the documents attached with the number of pages for each document.



The total number of pages for the documents attached is listed at the bottom of the screen. To only attach a few pages of the document, select the document by highlighting the line the document is on. You may view the document by clicking the 'View Image' button at the bottom of the screen.

Enter the page numbers for the document in the Pages to Print column.



When finished, click the 'Done' button. Then click the 'Submit' button again.

Once everything has been completed on the Transmittal Summary screen, you may preview the document or submit the document.



Submitting the document will create an ODI document with an assignment to the appropriate DDDS office. You will be asked to click OK to commit the form to the ECR.

**Appendix V: Ongoing Additional Requirements (OAR)**

**WAC 388-473-0010 through 0050**

Ongoing Additional Requirements (OAR) may provide financial assistance to eligible individuals for costs associated with:

* [meals](#Meals),
* [telephone](#Telephone),
* [laundry](#Laundry), and
* [food for service animals](#Food_for_Srvc_Animals)
	+ [Clarifying information regarding service animals](#Clarifying_Info_Srvc_Animals)

Definition from the Economic Services Administration (ESA) Social Services Manual:

An **"Ongoing Additional Requirement"** is a benefit that is needed by a person that maintains their independent living situation or allows them to live in an environment that is as independent as possible.

[Eligibility Criteria](#Eligibility)

[Benefit Review Cycle](#Review_Cycle)

**Eligibility Determination Process**

1. A person may request Ongoing Additional Requirements (OAR) benefits from either their financial worker or case manager. If the request is made to the financial worker, the financial worker must give a referral to the case manager.
2. The case manager verifies the need and determines eligibility for these benefits through an assessment.  This may include an interview, collateral contacts, or a home visit. Document the reason for the request for benefits as well as the facts supporting the approval or denial of benefits in the SER.
3. Notify the financial worker via 14-443 (HCS/AAA) or 15-345 (DDA) of your decision. Include a summary of the request for benefits as well as the facts supporting the approval in the comments box.
4. Ongoing Additional Requirement benefits are not approved if:
	1. The assistance they are requesting is available to them through another program, or
	2. The person lives in a licensed adult family home or assisted living facility.
5. If Ongoing Additional Requirements benefits are approved, the financial worker will notify the person and generate payment.
6. Review eligibility for OAR as requested by a financial worker.

[**WAC 388-473-0010**](http://apps.leg.wa.gov/wac/default.aspx?cite=388-473-0010)**: (click on link to view current WAC)**

**What are ongoing additional requirements and how do I qualify?**

An individual may qualify for OAR if he/she is active in one of the following programs:

(a) Temporary assistance for needy families (TANF), or tribal TANF;

(b) State family assistance (SFA);

(c) Pregnant women assistance (PWA);

(d) Refugee cash;

(e) Aged, blind, or disabled (ABD) cash assistance; or

(f) Supplemental security income (SSI).

Once determined eligible the financial workers will authorize ongoing additional requirement benefits by increasing the individual’s monthly cash assistance benefit.

The following review cycle table shows when the need for OAR is reviewed:

|  |  |
| --- | --- |
| REVIEW CYCLE |
| Program | Frequency (Months) |
| TANF/RCA | 6 Months |
| ABD | 12 Months |
| SSI | 24 Months |
| All | Any time need or circumstances are expected to change |

[**WAC 388-473-0020**](http://apps.leg.wa.gov/wac/default.aspx?cite=388-473-0020)**: (click on link to view current WAC)**

**When do we authorize meals as an ongoing additional requirement?**

Additional requirement benefits for meals will be authorized when all of the following conditions are determined to be true:

(a) You meet the criteria in WAC 388-473-0020;

(b) You are physically or mentally impaired in your ability to prepare meals; and

(c) Getting help with meals would meet your nutrition or health needs and is not available to you through another federal or state source; such as the community options program entry system (COPES), medicaid personal care (MPC), or informal support, such as a relative or volunteer.

The department decides whether to authorize this benefit as restaurant meals or home-delivered meals.

* Restaurant meals are authorized when:

(a) You are unable to prepare some of your meals;

(b) You have some physical ability to leave your home; and

(c) Home-delivered meals are not available or would be more expensive.

* Home-delivered meals are authorized when:

(a) You are unable to prepare any of your meals;

(b) You are physically limited in your ability to leave your home; and

(c) Home-delivered meals are available.

[**WAC 388-473-0040**](http://apps.leg.wa.gov/wac/default.aspx?cite=388-473-0040)**: (click on link to view current WAC)**

**Food for service animals as an ongoing additional requirement.**

A "service animal" is an animal that is trained for the purpose of assisting or accommodating a person with a disability's sensory, mental, or physical disability.

Benefits for service animal food is authorized when it is determined that the animal is necessary for your health and safety and supports your ability to continue to live independently.

[**WAC 388-473-0050**](http://apps.leg.wa.gov/wac/default.aspx?cite=388-473-0050)**: (click on link to view current WAC)**

**Telephone services as an ongoing additional requirement.**

Benefits for telephone services are authorized when it has been determined that without a telephone, your life would be endangered, you could not live independently, or you would require a more expensive type of personal care.

[**WAC 388-473-0060**](http://apps.leg.wa.gov/wac/default.aspx?cite=388-473-0060)**: (click on link to view current WAC)**

**Laundry as an ongoing additional requirement.**

Benefits for laundry are authorized when it has been determined that you:

* Are not physically able to do your own laundry; or
* Do not have laundry facilities that are accessible to you due to your physical limitations.

[**WAC 388-478-0050**](http://apps.leg.wa.gov/wac/default.aspx?cite=388-478-0050)**: (click on link to view current WAC)**

**Payment standards for ongoing additional requirements.**

The payment standards for OAR are as follows:

* Restaurant meals: $187.09 per month (or $6.04 per day with the payment rounded down to the nearest dollar amount);
* Laundry: $11.13 per month;
* Service animal food: $33.66 per month;
* Home delivered meals: The amount charged by the agency providing the meals;
* Telephone: The local telephone flat rate for the area; or the Washington telephone assistance program (WTAP) rate, whichever is less.

***Clarifying Information for WAC 388-473-0040 regarding Service Animals***

**What is a service animal?**

The ADA defines a service animal as any guide dog, signal dog, or other animal individually trained to provide assistance to an individual with a disability. If they meet this definition, animals are considered service animals under the ADA regardless of whether they have been licensed or certified by a state or local government.

Service animals perform some of the functions and tasks that the individual with a disability cannot perform for him or herself.  Guide dogs are one type of service animal, used by some individuals who are blind. This is the type of service animal with which most people are familiar. But there are service animals that assist persons with other kinds of disabilities in their day-to-day activities.

Some examples include:

* Alerting persons with hearing impairments to sounds.
* Pulling wheelchairs or carrying and picking up things for persons with mobility impairments.
* Assisting persons with mobility impairments with balance.

A service animal is not a pet.

**Social Worker Responsibilities:**

1. Use the following criteria to determine if the person's need for a service animal qualifies as an Ongoing Additional Requirement.

The animal:

a. Must help the person with a sensory, mental, or physical disability.

b. The training does not need to be formal, but the animal should be trained to help the person with tasks related to the disability. Do not ask for proof of training.

**EXAMPLE 1** The client indicates the dog is to help with the blindness to get around. If the use of the animal in assisting the client seems questionable, you can request verification from the client's medical professional that the animal provides assistance with the disability.

**EXAMPLE 2** The dog is used to calm down the patient.  It seems questionable.  You can ask the client to provide a statement from the treating doctor, psychiatrist, or other medical professional on how the animal helps the clients with the disability.

When it has been determined that the above conditions are met, you may approve Ongoing Additional Requirements by notifying the Financial Worker of your decision using the 14-443 (HCS/AAA) or 15-345 (DDA). Include a summary of the request as well as the facts supporting the approval

**Requesting Funding from the Behavioral Health Organization (BHO) or Managed Care Organization (MCO):**

When a client’s need for personal care is based primarily on a psychiatric condition **AND** the criteria in the two boxes below are met, a request for funding should be submitted by the Primary Case Manager (PCM) to the Behavioral Health Organization (BHO) or the Managed Care Organization (MCO).

Within 2-5 days of completing an assessment in which the criteria below is met, a request for funding should be submitted to the BHO/MCO. A timely request for funding is vital to ensure care plan coordination is achieved. In addition, this process ensures the social services authorization and ETR (if needed) are done timely.

***Criteria for BHO/MCO funding of a client’s personal care***

***The client must meet criteria from both boxes below:***

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| ***Psychiatric Disability Criteria****:*1. The client has a primary diagnosis of a serious mental illness (example: schizophrenia, bi-polar disorder, major depressive disorder); and that psychiatric diagnosis is the primary reason for client’s need for assistance with personal care.
* The client has behaviors or symptoms of a mental illness that cause impairment and functional limitations in self-care/self-management activities; and it is these behaviors or symptoms of mental illness that are the primary reason for client’s need for assistance with personal care.

**Please note**: If the client has the following diagnoses: intellectual disabilities, Alzheimer’s/dementia, traumatic brain injury, substance use disorder, and these are the primary reason the client requires assistance with personal care, **do not submit this form**.  |

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| ***Involvement with Mental Health Services Criteria:***In addition to the above criteria being met, the client should also have involvement with mental health services in **one** of the three ways below: 1. The client is currently receiving mental health services;

**OR**1. The client is transitioning from Western or Eastern State Hospital and will be receiving mental health services;

**OR**1. The client’s mental health needs are being met through the Residential Support Waiver (RSW) and additional services (beyond those provided through RSW) are not needed.
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**Are you unsure if your client meets the criteria above?**

If so, request a care conference with your supervisor and the designated Care Coordination Contact listed on the third tab of the [BHPC Contact List](http://intra.altsa.dshs.wa.gov/hcs/documents/Behavioral%20Health%20Personal%20Care%20Contact%20List.xlsx). Review the client’s care plan, including diagnoses, treatments, behaviors, etc., and why you think this client’s need for personal care is because of behaviors or symptoms of a mental illness.

**Is this a new request for funding?**

If so, and the client is currently receiving services from the local BHO/MCO, please contact the client’s local mental health professional/case manager to coordinate the care plan and ensure the CARE assessment has accurate information (diagnoses, treatments, behaviors, etc.).

1. Fax Consent form to the client’s local mental health professional/case manager.
2. Call the client’s local mental health professional/case manager and explain the following information:
	1. An assessment has been completed and you are calling to discuss the case and review the care plan.
	2. Inform of client’s planned living setting (in-home or residential).
	3. Review client’s mental health diagnoses and treatment plan.
	4. Review what services are being provided by the local mental health professional/agency as well as what services are being provided through long-term care services. At this time, discuss if there are any service(s) missing in the client’s care plan and what types of services or supports may be available to address these gaps. The goal of this conversation is to develop a coordinated care plan to meet the client’s needs.
	5. Incorporate any information from the local mental health professional/case manager into the assessment.
3. Add this local mental health professional/agency’s information on the [DSHS form 13-712](http://forms.dshs.wa.lcl/formDetails.aspx?ID=3563), Behavioral Health Personal Care (BHPC) Request for BHO/MCO Funding.

**Please note**: If the client is receiving behavior support services through an ALTSA paid provider, and is not currently receiving mental health services through the BHO/MCO, then coordinate with the ALTSA paid provider to ensure accuracy of the assessment.

**Using DSHS form 13-712 to request funding from the BHO/MCO:**

1. Complete [DSHS form 13-712](http://forms.dshs.wa.lcl/formDetails.aspx?ID=3563), Behavioral Health Personal Care (BHPC) Request for BHO/MCO Funding.
	1. Detail the behaviors and caregiver interventions on this form, and what personal care is needed.
	2. This information helps the BHO/MCO quickly determine how the client’s mental health is impacting their need for personal care.
	3. The CARE assessment should also reflect the behaviors and caregiver interventions noted on form 13-712.

**Please note:** if the exceptional rate or hours requested is unusually high, consider a care conference with the designated Care Coordination Contact listed on the third tab of the [BHPC Contact List](http://intra.altsa.dshs.wa.gov/hcs/documents/Behavioral%20Health%20Personal%20Care%20Contact%20List.xlsx) prior to submitting the request for funding. If you are unsure if the rate is unusually high, staff with your Supervisor. This step allows the BHO/MCO to ask clarifying questions and ensures collaboration of the care plan.

1. Send DSHS form 13-712, CARE Assessment Details, and CARE Service Summary to the Funding Request Contact listed on the first tab of the [BHPC Contact List](http://intra.altsa.dshs.wa.gov/hcs/documents/Behavioral%20Health%20Personal%20Care%20Contact%20List.xlsx) via secure email using the **template email and subject line language provided**.



1. The BHO/MCO will review the packet and determine if the established criteria listed above has been met.
	* The BHO/MCO should confirm receipt of request within 2 days of receiving, and must respond with a decision to approve, counter-offer, or deny the request within 5 business days of receiving a complete packet. If decision will exceed 5 business days, the BHO/MCO representative will contact the PCM. If you do not receive a response within 5 days you should escalate the communication through the assigned escalation contact listed on either the fourth (HCS) or fifth (AAA) tabs of the [BHPC Contact List](http://intra.altsa.dshs.wa.gov/hcs/documents/Behavioral%20Health%20Personal%20Care%20Contact%20List.xlsx).
	* If the request is denied, a clear rationale for why the request did not meet criteria and/or what services will be provided to the client should be written on the form.
2. Once the BHO/MCO signs, completes, and returns the DSHS form 13-712:
	1. Document the approval or denial from the BHO/MCO in an SER.
	2. Scan and email a copy of the completed DSHS form 13-712 to: MCOBHOforms@dshs.wa.gov
	3. Submit completed DSHS form 13-712 to the Document Management Systems (DMS) via HOTMAIL to be included in client’s electronic case record (ECR).
3. If the funding amount approved by the BHO/MCO exceeds the daily rate or monthly hours generated by CARE, complete the following (an ETR is not needed for Expanded Community Services (ECS) or Specialized Behavior Support (SBS) services):
	1. Create an ETR in CARE requesting the amount exceeding the CARE generated rate.
		1. The ETR type selection will be “BHO/MCO-Rate” or “BHO/MCO-Hours”.
		2. In the Request Description section, indicate that the additional amount has been approved by the BHO/MCO.
		3. Use custom start and end dates if the BHO/MCO approved the funding for a timeframe other than the client’s plan period.
	2. Submit the ETR through your agency’s process who will then submit the ETR to the LTC ETR Committee for review and approval.
4. After ETR is approved and form is approved, on the P1 authorization(s) for client’s personal care:
	1. Change the rate on the authorization to match the approved rate on the form.
	2. Select/confirm/update the reason code:
		1. Approved – select reason code “MCO\_BHO Client/ MCO\_BHO Funded” for the Personal Care service line and the Personal Care Add-On service line.
		2. Denied – change/remove reason code.
	3. If the client is on the Residential Support Waiver (RSW) and the personal care provider is authorized an ECS or SBS add-on rate, also select the reason code “MCO\_BHO Client/ MCO\_BHO Funded” for that service line.
5. Set a reminder for at least a week before the end of the BHO/MCO funding approval period (or CARE plan period) so that another request can be made to the BHO/MCO to ensure continued funding.
6. If the client’s case is transferred to another office/agency, ensure the next PCM/agency is aware of the BHO/MCO’s approval period and when another request will be necessary.
7. At next assessment, if client meets the criteria in the boxes above, request funding from the BHO/MCO following the same process noted above.

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| ***Another request for funding to the BHO/MCO is necessary when:**** An annual assessment is completed
* A significant change assessment is completed
* An interim assessment is completed and there is a change in client’s in-home care hours or rate (e.g. informal support change, QA correction)
* Client moves from in-home to residential and now has a daily rate
* The last BHOs transition to MCOs later in 2019
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