Home and Community Living Administration / Home and Community Services Long-Term Care Manual

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Records Management

The purpose of this chapter is to provide general guidance and procedures regarding Records Management, including Records Retention and Public Records Requests.

Ask the Expert

Cynthia Mitchell HCS, Public Records Program Manager
360.725.2537 HCSPublicRecords@dshs.wa.gov

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BACKGROUND

The law requires DSHS and its employees to keep DSHS records for a specific period under approved record retention schedules. Failure to keep records under the approved record retention schedules, or failure to stop destruction of records when there is notice of potential lawsuit, or an active lawsuit, audit, or public records request, could subject the employee and DSHS to penalties and fines.

RECORDS MANAGEMENT

Records Management helps the administration and agency ensure compliance with RCW 40.14. It is the responsibility of the appointing authority to notify the HCS Public Records Program Manager (PRPM) of any staff change of their local records coordinator/custodian.

- Planned Box Disposition (PBD) Reports – Are distributed monthly to the designated records coordinator. Things to consider when reviewing your PBD report:
    - What type of records are scheduled for destruction?
    - View the contents of the box (Barcode, View Box)
    - Client records – check your Litigation Holds notices
        - Upon receipt of a Litigation Hold, request the records from the (State Records Center) (SRC) and place in a *separate file* cabinet with LOCK.
    - *Adult Protective Services (APS) – immediately forward to the APS Records Manager for coordination or approval of destruction.*

- Record Retention Schedules
- Record Management Training

PLEASE NOTE: If there is Potential Litigation - err on the side of preservation or contact your Public Records Coordinator. Refer to Administrative Policy 5.05 and Administrative Policy 5.07.

Record Coordinators and Custodians Responsibility:

Each Region has a Record Retention Coordinator.

Area Agencies on Aging – Each AAA has a Public Record Coordinator and a Record Retention Coordinator.

A Records Coordinator is responsible for providing assistance to those archiving program records according to the DSHS record retention schedule.

- Comply with procedures established by the Agency Records Officer, as outlined in AP 5.04.
- Assist the Agency Records Officer with records inventories.
- Review their unique DSHS Record Retention Schedules annually.
- Identify essential record series, establish office procedures for their preservation and protection.
- Establish procedures for compliance with the General Records Retention Schedule

and unique DSHS Records Retention Schedules record retention schedules including regular or periodic records disposition.

Prior to the destruction of any DSHS records, determine if those records need to be kept for a public records request, legal purpose (anticipated litigation or discovery), audit, or program requirement.

Employees Responsibility for Records Management:

- Take DSHS Records Management mandatory training annually.
- Consult with the HCS Public Records Program Manager on all matters relating to the maintenance, retention, transfer and/or destruction of public records in accordance with RCW 40.14.040.
- Comply with retention procedures established by this policy and division policies.
- Keep DSHS records the employee is responsible for until the records have met the end of their approved retention period or have been imaged in accordance with the Requirements for the Destruction of Non-Archival Paper Records After Imaging.
- Keep electronically stored information (ESI) in its original electronic format with metadata intact. (Printing and keeping a of ESI is not a substitute for the electronic version unless specifically approved by the State Records Committee).
- Keep any DSHS records created, sent, organized, received, or stored on DSHS or non-DSHS resources according to the retention schedule regardless of physical location.
- Prior to the destruction of any DSHS records, determine if those records need to be kept for a public records request, lawsuit, audit, or program requirement.

Records Coordinators Monthly Disposition Report Responsibility:

The below is an example of a Disposition Report for Office 9113. The records are scheduled for disposition 04/01/2023. The Disposition Report is due to HCS Records Manager by no later than 03/30/2023. (Disposition reports are one month ahead).

WASHINGTON STATE RECORDS CENTER
Planned Box Disposition Report

Report due back at the Records Center: 04/01/2023 **Disposal of these boxes start:** 04/01/2023

Agency: **Social And Health Services, Dept Of** Agency OFM Number: **300**

Office: **Shs/HCS Region 2 North (Everett)** Archives Office Number: **9113**

In signing this document I agree that all the information pertaining to the disposition of these records listed here are true and correct. I have not modified the original format of this report in any way other than completing the form as instructed. I acknowledge that if any information is removed from this report it will still be processed by the SRC as it appeared in its original format.

Records Officer Signature: _____

Legal Hold	L
Program Need Hold	P
Audit Hold	A
Return Disposition	R

Disposition Report ID: 12066 RMS Office ID: 2425

Total Boxes: 6

							Holds			Disp
Barcode	**Office**	**DAN**	**Transmittal Title/Series Title**	**Inclusive Dates**	**Cutoff Date**	**Disp Date/Type**	**L**	**P**	**A**	**R**
12345900	Shs/HCS Region 2 North (Everett)	74-05-05111	Case Record Social Services, Final Volume Case Record – Social Services, Final Volume	2/2014-8/2016	9/2016	9/2019 D				
12345910	Shs/HCS Region 2 North (Everett)	74-05-05111	Case Record Social Services, Final Volume Case Record – Social Services, Final Volume	1/2003-8/2016	9/2016	9/2019 D				
12345911	Shs/HCS Region 2 North (Everett)	74-05-05111	Case Record Social Services, Final Volume Case Record – Social Services, Final Volume	5/2012-8/2016	9/2016	9/2019 D				

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If you sign and return the above form, you are providing approval for boxes to be destroyed. If you need to hold any boxes for legal purposes or other program purposes, mark the appropriate column;

L = legal hold;

P = program hold;

A = audit hold; and

R = return boxes to your office

If you check the R column, *please provide an address where you want the boxes returned.*

If you do not return the form or return it blank, boxes will be returned to the address on the transmittal sheet.

Barcode Movement of Client Records:

Barcode is the DSHS records management system for social service and financial records. You will need to check Barcode for archived records.

- The SRC Barcode database is not connected to the DSHS Barcode database. The SRC does not track folders in BARCODE. Therefore, they cannot place folders in transit to you; consequently, the location in DSHS Barcode will read 999. You **must** move/track the folder into your location.

Should you experience difficulty moving the folder into your location, please follow the below steps in Barcode:

- At the top of the screen, select:
  SUBSYSTEMS
  - Select: **Wand**
  - Select: **UNITS** (far right)
    - Select: your **LOCATION** (and the staff person)
    - Select: **Wand** to (bottom left)
      Wand or type: the folder tracking tag (located under Barcode, bottom right and it starts with a period ".")
    - EXAMPLE: **DV1XVR**

You can keep entering folders and when done, click done.

- Records need to be tracked "in" and "out" from location 999

Transferring and Returning a Case in DMS NOTE: Chapter 5 Case Management provides information on Transferring a physical and electronic case record and paper file from one office to another. At any point during a case transfer, the social worker/case manager may request a case transfer consultation or case staffing.

DSHS PUBLIC RECORDS ACT:

The Department of Social and Health Services strongly supports principles of open government and transparency in its operations. ALTSA employees must comply with the Public Records Act (PRA) in granting access to records, with the exception of exempt confidential information, as outlined in DSHS Administrative Policy 5.02.

Adhering to AP 5.02, public records coordinators (PRC) must use the Agency Records request tracking system (ARRTS), to log, route, and track all public records requests received by DSHS.

At a minimum, ARRTS must be used to track receipt of the request, task assignments, requests for clarification, issuance of a five-day letter, due date, extensions of time granted, and completion of the request with time recorded for each task. Copies of relevant documents affecting the request must be uploaded into ARRTS, including the request, five-day letter, extension letters, and response cover letters.

To avoid a potential privacy breach, PRCs must carefully review records being disclosed to determine if any parts are exempt.

WHAT IS THE PUBLIC RECORDS ACT?

- The Public Records Act (PRA) was passed by Initiative in 1972. Chapter 42.56 RCW provides the statutory groundwork for disclosure of public records.
- The PRA requires all public records maintained by state and local agencies be made available to all members of the public when requested, with the exception of narrow statutory exemptions.

- Agencies must respond promptly and provide fullest assistance to requesters
- Anyone has the right to make a public records request
- Transparency is DSHS value
- DSHS Administrative Policy 5.02 outlines DSHS policy for processing public records requests.

WHAT IS A PUBLIC RECORDS REQUEST?

The process to seek access to public records held by DSHS, including client records.

WHAT RECORDS ARE PUBLIC RECORDS?

All records an agency holds are public records regardless of content or format. A public record is defined in RCW 42.56.010(3) as any writing that is prepared, owned, used or retained by any state or local government agency that contains information that relates to the conduct of the government or the performance of any governmental or proprietary function. The term "Writing" is very broadly defined in the PRA to include not only traditional written records, but also photos, maps, videos, voicemails, emails, text messages and tweets (RCW 42.56.010(4)).

Examples of Public Records:

- Hard copy client file and subject files
- Files on network shares
- Database records
- Email
- Calendars
- Back up tapes for servers and on multi-function devices
- Records on personal devices used to conduct business
- Handwritten notes
- Text messages
- Facebook postings
- DSHS YouTube videos
- Voicemail

RECEIVING/RESPONDING TO PUBLIC RECORDS REQUESTS:

A request for public records may be made by any means, including in writing, in person, by e-mail, or by telephone. Use of the Request for DSHS Records Form (DSHS 17-041) is optional but encouraged to clarify the scope of the request and verify the identity of the requester for confidential records. The central point of contact for DSHS for the public is the DSHS public records officer, but requests may be received by any DSHS employee at any DSHS location. Verbal requests must be transcribed within one business day and forwarded to hcspublicrecords@dshs.wa.gov.

Employees Responsibility: Every employee must comply with the Public Records Act in granting access to records. Records created, used, and kept by employees in the course of doing business are considered to be public records of DSHS. DSHS employees generally have no expectation of privacy in any records stored on DSHS administered IT resources nor in public records stored on non-DSHS administered IT resources. To comply with obligations under the Public Records Act, these records may be indexed, searched, accessed, collected and distributed without notice to the employee or

employees who created, contributed to, or otherwise used the records, unless notice is required by law or contract.

Employees who receive a public records request must immediately send all record requests to HCSPublicRecords@dshs.wa.gov. RCW 42.56. 520 provides that a response to a request for public records must be made within five business days. The day the request is received does not count as one of the five days. Weekends and holidays observed by the agency are also excluded in the calculation. All employees must comply with preserving and the destruction of records, as described in DSHS Administrative Policy 5.04

If the record/s can easily be given to the requester at the time of the request and does not require redaction, please include HCSPublicRecords@dshs.wa.gov as a cc. If the request is verbal, the employee receiving the request must transcribe and transmit the request to HCSPublicRecords@dshs.wa.gov within one business day.

PRC Responsibility:

DSHS public records coordinators are the primary employees designated to process and respond to public records requests in accordance with this policy and agency procedures set by the DSHS public records officer. If employees other than public records coordinators respond to public records requests, they must also follow administrative policy 5.02. Public records coordinators must have trained back-up staff and procedures to handle and respond to public record requests when they are unavailable. Public records coordinators also serve as a resource and provide training to other staff and requesters on issues involving public records requests.

When requested by a PRC to respond to public records requests, employees must:

i. Search for records within their control that are responsive to the request. This responsibility includes any public records of the department created, sent, organized, received, or stored on DSHS and non-DSHS administered IT resources and includes those kept on or off DSHS property.
ii. Provide access to original records or copies of records in the format requested by the public records coordinator. This responsibility includes connecting any external devices, including non-DSHS administered IT resources such as laptops or external drives, to the network or otherwise granting access to records as needed for indexing, searching, and collecting records in response to a public records request.
iii. Provide search terms to assist with an email search, preserve identified records in their original format (including metadata for electronic records) and retain them, even if a printed copy exists, until the public records coordinator notifies you that retention is no longer needed, ensuring no employee redactions or alterations.

When the Public Records Coordinator receives a records request, he/she will:

1. Keep accurate notes including the date, the name of the person requesting the information, their address and a phone number you can reach them at, and the specific information that he/she is requesting.
2. Compose and send a letter within 5 business days. The day the request is received does not count as one of the five days.
3. The "five-day letter" must do one of the following:
    - Produce the requested records;
    - Provide the specific internet address where the records may be located on the DSHS website;
    - Seek clarification of the request;
    - Deny the request and give the statutory basis for denial; or
    - Estimate when the records will be produced and explain why that time is needed.

The "five-day letter" must include the following:

- ARRTS Request ID #
- Date request received;
- Describe records requested
- State if request is under PRA or other law (such as RCW 13.50 or RCW 26.23)
- Include whether more information is needed (such as an authorization)
- Include dates for requester to respond by
- Estimate of time for first installment or entire response if known
- Notice of potential production fees under RCW 42.56.120 and WAC 388-01-080
- Format of response if known (native format if requested)
- PRC contact name and information

Estimate Reasonable Response Time

- If final production is not sent with five-day letter, PRC must provide time estimate and explain why more time is needed to:
    - Clarify the request
    - Locate and assemble the records (including routing in DSHS),
    - Notify third parties affected by request or
    - Review and redact exempt information
    - Exception to reasonable time: Client request for own records from HIPAA covered programs – must produce in 30 calendar days with only one 30 day extension allowed

Clarify as Needed

- Explain what records we have and try to determine what requestor wants
- May do by phone or in writing, including by email

- If requestor does not clarify and we cannot identify or locate records requested without clarification, state that request may be denied if they don't respond within ## days
- If request is too broad, cannot deny but inform and work with requester - you can ask for narrowing of scope or prioritization, but they don't have to agree
- Confirm clarification in writing and resolve discrepancies in five day letter: "We understand your request to be for …. Let us know by XX date if this understanding is not correct."
- When in doubt, contact requestor

OBTAINING CONSENT TO SHARE CONFIDENTIAL INFORMATION (DSHS 14-012)

- You are required to obtain consent prior to sharing confidential information about a client. Use DSHS 14-012 form to document this consent.
- The client or representative (e.g. Durable Power of Attorney (DPOA) or guardian)[1] may sign this form. The instructions on the consent form (DSHS 14-012) under the signatures portion of the instructions explain who can sign the consent form. In those cases where the client understands but can only make a mark in the signature box, a mark is sufficient. In these cases, a witness should sign and then make a note about the client's inability to properly sign and the reason.
- You must use this form in order to obtain, use, or share confidential information about a client for the purpose of providing services to the client. If you need to list multiple providers on the consent form and cannot fit all the information in the blanks provided, you may mark the box, "See attached list," and attach a list to the consent form to accommodate all information. **Please see LTC Chapter 2A.**

VERIFY RIGHT TO CONFIDENTIAL RECORDS

- Consider who is making request
- Client requesting own records – verify identity
- Third party requesting unredacted client records – written authorization
- Requests about employees – most information is not confidential but get identification or authorization to avoid redactions
- Special considerations for email
  -Insufficient to prove identity
  -Use secure email for any emails including client information outside the state government network (.wa.gov)
- If not verified, deny request for confidential records
- Need for authorization for client records applies to subpoenas and some court orders

- Prohibition of requests for lists of individuals for commercial purposes – use Declaration on Commercial Purposes form 27-155.

Retaining records: DSHS employees must retain public records, in accordance with applicable retention schedules and administrative policy 5.04.

Employees must retain all public records, including those created on:

- Hard Drives
- Local Personal Folders
- Portable Storage Media (Flash drives, CD, DVD, USB drives)
- Portable Devices (Laptops, Smartphones, tablets)
- Network Drives
- SharePoint Sites
- Office, Desk and Filing Cabinets
- Recording Devices (Cameras, video cameras, audio recordings, and surveillance video).
- Personal Devises or locations outside of DSHS
- Follow AP 5.02 - all staff must search their records and assist PRCs to produce records.

Adequate Search

- Adequate search is required to fully assist the requester.
- Documentation of the search conducted is strongly recommended. Use DSHS Forms 02-629 (PRC) and 02-630 (employee) as appropriate.
- Notes can be placed in the task resolution in ARRTS
- Databases to be searched CARE, BARCODE, TIVA, ACD, ACES, etc.

For high profile requests and potential litigation, The PRC may provide you with the Employee records search form 02-630.

PUBLIC DISCLOSURE – AAA RESPONSIBILITY

Once a case is transferred from DSHS to a AAA, the AAA is responsible to produce all client records within the designated records set.

If client records are requested and the client is Case Managed by a AAA, the HCS public records coordinator will:

- Prepare the 5-day letter and forward the 5-day letter including the request to the appropriate AAA for response by the designated date.

The AAA public records coordinator will:

- Respond to the records request per the contract with DSHS.

- Send HCS public records coordinator a copy of the closure letter sent to the requester once the request is complete, including the time spent by all AAA staff of fulfilling the request.

PUBLIC DISCLOSURE – INDIVIDUAL PROVIDERS (IP) AND CONSUMER DIRECT CARE NETWORK WASHINGTON (CDWA)

Effective October 1, 2021, staff receiving a public records request for records relating to an IP should forward the request to HCSPubliceRecords@dshs.wa.gov

The PRC will be responsible for processing the request. The PRC will review the request to determine what records are being requested, and who the owner of record is for the date range of the records requested.

- DSHS is the owner of record up to hire date of the IP with the Consumer Directed Employer (CDE). Prior to April 2022.
- As of April 2022, CDE is the owner of record for all IP's hired through CDE.
- **Please forward all inquiries directly to**: infolegal@consumerdirectcare.com. For records owned, maintained, or used by DSHS, the PRC will process the request as usual.

DISCLOSURE OF GUARDIAN AD LITEM (GAL) INFORMATION

It is the Case Manager's (CM) responsibility to provide records to the client or their designated representative when conducting day to day business activity. For all public record requests, they should be submitted to hcspublicrecords@dshs.wa.gov (GAL requests for APS see https://intra.altsa.dshs.wa.gov/aps/sharepoint.htm.

DISCLOSURE OF ADMINISTRATIVE HEARING RECORDS

The Case Manager provides the case record and all relevant information to the administrative hearing coordinator. This should not be treated as a public records request. **Please see LTC Chapter 26**.

DISCLOSURE OF ADULT PROTECTIVE SERVICES (APS) INFORMATION

Please Refer all APS records request to APSPublicRecords@dshs.wa.gov.

FORMS

17-041 Request for Records

17-063 Authorization
14-012 Consent
02-629 Dshs Coordinator Search Document
02-630 DSHS Employee Records Search Request

Related RCWs and WACs

RCW 42.56	Public Records Act
RCW 40.14	Preservation and Destruction of Public Records
RCW 13.50	Keeping and Release of Records By Juvenile
RCW 26.23	State Support Registry
WAC 388-01	Dshs Organization/Disclosure of Public Records

RELATED ADMINISTRATIVE POLICIES AND CHAPTERS

Administrative Policy 5.01	Privacy Policy -- Safeguarding Confidential Information
Administrative Policy 5.02	Public Records Requests
Administrative Policy 5.03	Client Rights Relating to Protected Health Information
Administrative Policy 5.04	Records Retention
Administrative Policy 5.05	Management of the Litigation Discovery Process
Administrative Policy 5.07	Employees Response to Litigation Related Documents
LTC Chapter 2A	Privacy
LTC Chapter 26	Administrative Hearings

ACRONYMS

ACD	Agency Contracts Database
ACES	Automated Client Eligibility System
AAA	Area Agency on Aging
ALTSA	Aging and Long-Term Support Administration
AP	Administrative Policy (DSHS)
APS	Adult Protective Services
ARRTS	Agency Records request tracking system
Barcode	ESA's primary document management system and used by other DSHS administrations. ALTSA images client correspondence including social and financial records.
CARE	Comprehensive Assessment for Reporting and Evaluation
CDE	Consumer Direct Employer
CM	Case Manager
DA	Discovery Accelerator
DPOA	Durable Power of Attorney
ESA	Economic Services Administration
ESI	Electronically Stored Information

GAL	Guardian Ad Litem
IP	Individual Provider
PBD	Planned Box Disposition
PHI	Protected Health Information
PRA	Public Records Act
PRC	Public Records Coordinator
PRR	Public Records Request
PRPM	Public Record Program Manager
RC	Records Coordinator
SRC	State Records Center
TIVA	Tracking Incidents of Vulnerable Adults (previously known as ADS Registry)
RCW	Revised Code of Washington
WAC	Washington Administrative Code

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
5/23/2025	C. Mitchell	Updated all links, added DSHS Public Records Act & examples, added What is a Public Records Request & definition, updated Examples of Public Records, added Verify Right to confidential Records, and changed the order of some info	

Privacy

The purpose of this section is to address the importance of safeguarding client's information, which includes client protected health information (PHI), to:

- Protect the privacy rights of clients when DSHS uses, obtains, maintains, or discloses client confidential information;
- Ensure responsible information governance and management practices;
- Promote public trust and confidence in the use of services provided by the DSHS; and
- Maintain the confidentiality, integrity, and availability of PHI and other confidential information, while protecting against any reasonably anticipated threats, hazards, and inappropriate uses or disclosures.

What is Privacy?

The right of a person to be free from intrusion into or publicity concerning matters of a personal nature. *(Merriman Webster Legal Dictionary)*

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Cynthia Mitchell HCS Division Privacy Program Manager
360.725.2537 cynthia.mitchell@dshs.wa.gov

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BACKGROUND

Employees who work at the Department work daily with many confidential records and must act to protect those records and the privacy rights of individuals. The Department is a Hybrid Covered Entity under the HIPAA Privacy Rule, which requires safeguards for client information and the reporting of any breach of security of client information. As a covered entity, DSHS must notify affected clients of Health Information Portability and Accountability Act (HIPAA) privacy rights. (45 CFR 164.520) DSHS programs that are designated as Health Care Components or HCCs are part of the Hybrid Covered Entity.

The obligations of Department employees are set out in DSHS Administrative Policy 5.01 and the IT Security Policy 15.10. The rights of clients are described in DSHS Administrative Policy 5.03

Employees must follow DSHS policies and procedures in the DSHS information security manuals for accessing, handling, and disclosing confidential information. In addition, employees of HCCs (including BAOUs) must follow the HIPAA rules for use or disclosure of PHI.

DSHS PRIVACY POLICIES

Administrative Policy 5.01- Privacy Policy
Establishes Privacy Officer and Coordinators; HIPAA Hybrid; General Requirements to protect Confidential Information.

Administrative Policy 5.03- Client Rights
Client Rights to Protected Health Information

Administrative Policy 5.08- DSHS Minimum Physical Security Standards

DEFINITIONS AND EXAMPLES

Breach: The acquisition, access, Use, Disclosure, or loss of Confidential Information in a manner not permitted by state and federal law that compromises the security, privacy, or integrity of the Confidential Information.

Breach Notification Rule: Requires covered entities and Business Associates (contractors) to provide notification following discovery of a breach of unsecured Protected Health Information (PHI; and the enforcement rule which provides authority and procedures for OCR investigations, imposition of penalties, and administrative hearings.

Business associate: A person who, on behalf of DSHS other than in the capacity of a member of the workforce, performs a function or activity involving the use or disclosure of protected health information (PHI) to carry out essential functions or perform services for DSHS. "Business associates" include subcontractors that create, receive, maintain or transmit PHI on behalf of the business associate and downstream contractors.

Client: A person who receives services or benefits from DSHS. This term includes, but is not limited to, consumers, recipients, applicants, residents of DSHS facilities or institutions, patients, and parents receiving support enforcement services. Clients include persons who previously received services or benefits and persons applying for benefits or services.

Client confidential information: Personally Identifiable Information, including PHI, which identifies a client, and that state or federal laws protect from improper disclosure or use.

Covered entity: A covered entity is a health plan, a health care clearinghouse, or a health care provider who transmits information electronically in connection with a HIPAA transaction (see 45 CFR 160.103). As defined in 45 CFR 164.103, DSHS is a hybrid entity that has designated programs as health care components within the administrations/divisions as provided on the DSHS website. As a hybrid entity, only its health care components (including BAOUs) are subject to the HIPAA rules**. See BAOUs definition in AP 5.01.**

HIPAA: The Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d et seq. To implement HIPAA, the U.S. Department of Health and Human Services Office for Civil Rights (OCR) has adopted the HIPAA Privacy Rule, Security Rule, Breach Notification Rule, and Enforcement Rule (See 45 CFR Parts 160 and 164).

HIPAA Rules: References to the "HIPAA rules" apply to the following rules that OCR enforces;

- **The HIPAA Privacy Rule:** protects the privacy of individually identifiable health information;
- **The HIPAA Security Rule:** sets national standards for the security of electronic protected health information;
- **The HIPAA Breach Notification Rule**: requires covered entities and business associates to provide notification following a breach of unsecured PHI; and the enforcement rule which provides authority and procedures for OCR investigations, imposition of penalties, and administrative hearings.

Hybrid entity: A single legal entity:

1. That is a covered entity;
2. Whose business activities include both covered and non-covered functions; and
3. That designates health care components in accordance with the HIPAA privacy rule. DSHS is a hybrid entity under the HIPAA privacy rule.

Individually identifiable: Means that a record contains information, which reveals or can likely be associated with the identity of the person or persons to whom the record pertains.

Examples:

- Names, addresses, client ID numbers, and unique characteristics. Also, may be known as *individually identifiable health information or "IIHI*".

Minimum necessary: The minimum amount of protected health information (PHI) needed to accomplish the purpose of a request for PHI or the use of PHI needed to perform one's job.

- The Privacy Rule requires that DSHS make reasonable efforts to ***limit the use of PHI to the minimum necessary*** for the intended purpose.

Protected health information (PHI): Individually identifiable health information about a client that is transmitted or maintained by a DSHS health care component in any form or medium. PHI includes demographic information that identifies the individual or about which there is reasonable basis to believe can be used to identify the individual. Individually identifiable health information in DSHS records about an employee or others who are not clients is not protected health information. See administrative policy 5.03 for provisions relating only to PHI of clients.

Use: Access to an application or analysis of confidential information within DSHS.

Willful neglect: The conscious, intentional failure or reckless indifference to the obligation to comply with the HIPAA rules. (See 45 CFR 160.401).

ALL CLIENT INFORMATION IS CONFIDENTIAL

All information about clients served on behalf of DSHS is confidential, including:

- The fact that they get assistance (except yes/no)
- Type of assistance or services received
- Demographic information of clients (name, address, SSN, client ID#, photos)

WHERE PRIVACY APPLIES:

- Information Technology - Creation, Transmission, Storage
- Maintaining and Storing Records
- Configuration and Access to Physical Spaces
- Interactions with Clients – In Person, Phone, Mail, Email

COMMON CAUSES IN REPORTED INCIDENTS

- Wrong Email Address (Autofill!)
- Wrong Fax Number
- Excel Sheet errors
- Theft from car

OTHER POOR PRACTICES

- Leaving Devices Unsecure and Unattended
- Using Unsecure Channels of Communication
- Disposing of PHI Improperly
- Accessing PHI Out of Curiosity
- Sharing PHI on Social Media
- Discussing confidential information in a public area or in an area where the public could overhear the conversation.

BEST PRACTICES FOR PROTECTING CONFIDENTIAL INFORMATION

- Encrypt electronic devices
- Do not leave client information in a vehicle unattended
- Check email addresses before sending an email (or fax numbers when faxing)
- Check that envelopes are stuffed and addressed properly
- Do not download or store confidential records on your home computer
- Do not share client information with unauthorized third parties – (e.g. media, union representative, etc.)
- Do not send client-related emails to your personal email account or outside the network
- Properly dispose of confidential records (hot trash)
- Don't use identifiable information when others can overhear or if not needed

HIPAA BASICS

Health Insurance Portability and Accountability Act of 1996 Required rules for privacy, national standards for electronic health care transactions.

Privacy Rule (2002) – regulates the circumstances under which covered entities may use and disclose Protected Health information and requires covered entities to have safeguards in place to protect the privacy of the information.

Security Rule (2003) – requires covered entities to implement certain administrative, physical, and technical safeguards to protect electronic information.

Breach Notification Rule (2009) – requires covered entities and Business Associates to provide notification following discovery of a breach of unsecured protected health information.

Rules implementing HIPAA are in 45 CFR parts 160 and 164. All rules apply to Business Associates of covered entities and their subcontractors.

HIPAA BASICS – EXCLUSIONS

HIPAA does not apply to anyone who is not a covered entity or covered entity's business associate.

Information that is not protected health information:

- Education records covered by Family Educational Rights and Privacy Act
- (FERPA) or students' health records
- Employment records held by DSHS in its role as employer (i.e. workforce
- members)
- Records of persons deceased more than 50 years

OVERVIEW OF HIPAA

- Privacy Rule – Keep PHI private
- Security Rule – Keep PHI secure
- Breach Notification Rule – If you don't keep PHI private and secure, you have to notify!
    - PHI = Protected Health Information (defined term under HIPAA)

SPECIAL CONSIDERATIONS FOR MAILING

- Use of First-Class mail or delivery services with tracking
- Carefully check the name and address of the intended recipient
- Check the contents before sealing and make sure there is nothing included that is intended for a different client
- Update names and addresses when notified of correction or change
- Report as potential breach if mailing sent to unintended recipient

STANDARD: DE-IDENTIFICATION OF PROTECTED HEALTH INFORMATION

- Names
- Telephone numbers
- Fax numbers
- Electronic mail addresses
- Social security numbers
- Medical record numbers
- Health plan beneficiary numbers
- Account numbers
- Certificate/license #s
- Device identifiers & serial #s
- Web Universal Resource Locators (URLs)
- Internet Protocol (IP) address #s

- Vehicle identifiers and serial numbers, including license plate numbers
- Biometric identifiers, including finger and voice prints
- Full face photographic images and any comparable images
- Any other unique identifying #, characteristic, or code (e.g. client ID)
- All geographic subdivisions smaller than a State
- All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death

PROCEDURE FOR MANAGING A PRIVACY BREACH

A privacy breach occurs when there is unauthorized access to or collection, use, disclosure, or disposal of Client PHI. All incidents are presumed a breach unless proven otherwise. An example of a privacy breach would be lost, stolen, or personal information mistakenly emailed to the wrong person.

Step 1: Reporting the Breach

If a Breach or potential Breach of Confidential Information is discovered, staff at a minimum must notify within one (1) business day of discovery:

1) The technology operations center (TOC) at ETOC@dshs.wa.gov; and
2) The administration's or division's Privacy Coordinator. (Please see DSHS Privacy Coordinators.)
3) For Breaches involving over 500 individuals, or potentially over 500 individuals, staff must also notify the DSHS Privacy Officer at DSHSprivacyofficer@dshs.wa.gov. The DSHS Privacy Officer may also be consulted on other Breaches as appropriate and necessary.

Step 2: Containing the Breach

It is necessary to immediately contain the breach. Some examples of containing a breach are:

- Ensuring a police report has been filed if the breach involved criminal activity;
- recovering records;
- and confirming deletion of emails sent to wrong persons.

Privacy Breach Questionnaire: The Privacy Breach Questionnaire must be completed.

Once information is provided to us, we can determine the nature of the notification needed to ensure the breach is fully disclosed to clients affected, and whether or not additional steps are necessary to protect clients from identity theft or unwanted intrusion into their personal information.

Privacy Breach Questionnaire can be found here.
Internal Lost-Stolen Data Checklist can be found here.

Step 3: Evaluating the risks associated with the breach

The Risk Assessment is vital and required by HIPAA. The designated Privacy Coordinator must complete the HIPAA breach risk assessment in the DSHS Privacy Breach Application (PBA) for incidents that are determined to be a HIPAA Breach along with the DSHS security breach report. The DSHS security breach report is available for completion in the privacy breach application once an incident is determined to be a breach.

The following factors will be among those considered when assessing the risks:

1) **Persons affected by the breach**
    a) How many clients are affected by the breach?

2) **Protected Health Information Involved**
    a) What data elements have been breached?
        - Name, social security number, date of birth, and financial information that could be used for identity theft are examples of PHI.

3) **Description and Extent of Breach:**
    a) What caused the breach?
    b) Was the information PHI?
    c) Is there a risk of ongoing or further exposure of the information?
    d) Was the information secured? Meaning was it encrypted or otherwise unusable, unreadable, or indecipherable to unauthorized individuals?
    e) Does the confidential information involve records of clients held by a program that is a HCC of the Department or a business associate (inside or outside of DSHS) of a HCC component as listed in DSHS hybrid entity designation?

For a list of the Department's HCCs click here.

4) **Four Part Test**: (The HIPAA breach risk assessment applies the four-part test required by HIPAA to adequately document the determination that the incident is not a Breach).

    - **Part 1:** Nature and extent of PHI involved, including types of identifiers and ability to identify individual.
    - **Part 2:** Nature of person who acquired, accessed, used or received the PHI:
    - **Part 3:** Risk whether PHI was actually accessed or acquired by unauthorized individual:
    - **Part 4:** Mitigation Actions taken as a result of the breach: **(Steps taken to ensure that the incident won't happen again).**

Mitigation is required by HIPAA under 45 CFR 164.530(f). To the extent practicable, DSHS and its employees must mitigate any harmful effect known to the agency of a breach or a use or disclosure of PHI that violates DSHS policies and procedures and the HIPAA Rules. Mitigation actions must be documented and provided to the DSHS privacy officer upon request.

Examples of Mitigation Actions:

- Verbally counseled responsible employee on HIPAA and administrative policies for managing the protection of PHI.
- Completed LC- HIPAA Mandatory Training
- Reviewed DSHS Information Security Standard Manual: Chapters 3, 7, 8

Step 4: Notification

If notification is required as a result of a breach of confidential information, employees must contact their administration or division privacy coordinator. Breach notice letters must contain any specific language that the applicable law requires and be sent within the required time. Any notification letters required by HIPAA or RCW 42.56.590 must be reviewed and approved by the program's designated privacy coordinator, or the DSHS privacy officer or designee.

For breach incidents that do not trigger a legal requirement for notification, it is up to the program to determine to notify. However, DSHS strongly encourages notification.

1) **When to Notify Affected Individuals**
   a) Notification to affected individuals must be made in the most expedient time possible, without unreasonable delay, and no more than thirty (30) calendar days after the breach was discovered. An agency may delay notification to the consumer for up to an additional fourteen (14) days to allow for notification to be translated into the primary language of the affected consumers.

2) **How to Notify Affected Individuals**
   a) Written notice. (i) Written notification by first-class mail to the individual at the last known address of the individual or, if the individual agrees to electronic notice and such agreement has not been withdrawn, by electronic mail. The notification may be provided in one or more mailings as information is available.
   b) Under HIPAA, a deceased person's Protected Health Information (PHI) is protected for 50 years from death. If the affected individual is known to be deceased, the covered entity must send notification via first-class mail to either the next of kin or personal representative of the individual.

3) **Substitute Service**
   a) If the covered entity has insufficient or out-of-date contact information for fewer than 10 individuals, the covered entity may provide substitute notice by an alternative form of written notice, by telephone, or other means.

4) **What must be Included in the Notification**
   (a) The notification must be written in plain language; and
   (b) The notification must include, at a minimum, the following information:
   (c) The name and contact information of the reporting agency;

(d) A list of the types of personal information that were or are reasonably believed to have been the subject of a breach;
(e) A time frame of exposure, if known, including the date of the breach and the date of the discovery of the breach; and
(f) The toll-free telephone numbers and addresses of the major credit reporting agencies if the breach exposed personal information.

ATTORNEY GENERAL AND FEDERAL TRADE COMMISSION WEBSITES

If affected individuals are concerned about their identity or credit being impacted, they can find information on actions to take to protect themselves on the websites of the Washington State Office of the Attorney General at: http://www.atg.wa.gov/identity-theftprivacy and for the Federal Trade Commission at: http://www.ftc.gov/bcp/edu/microsites/idtheft//.

THREE MAJOR CREDIT REPORT AGENCIES

In addition, the affected individuals can contact the three major credit report agencies:

- *Equifax*, PO Box 740241, Atlanta, GA 30374, www.equifax.com, 1-800-685-1111
- *Experian*, PO Box 2002, Allen, TX 75013, www.experian.com, 1-888-397-3742
- *TransUnion*, PO Box 2000, Chester, PA 19016, www.transunion.com, 1-800-916-8800

OTHERS TO NOTIFY

a. NOTICE TO THE SECRETARY
   i. If a breach affects fewer than 500 individuals, the covered entity may notify the Secretary of such breaches on an annual basis. Reports of breaches affecting fewer than 500 individuals are due to the Secretary no later than 60 days after the end of the calendar year in which the breaches are discovered.
   ii. If a breach affects 500 or more individuals, covered entities must notify the Secretary without unreasonable delay and in no case later than 60 days following a breach.

b. MEDIA
   i. If a breach affects more than 500 individuals, the covered entity is required to notify prominent media outlets serving the state or jurisdiction.
      - This is typically done in the form of a press release to local media outlets servicing the affected area. Similar to individual notices and notices to the secretary, media notification must be provided without unreasonable delay and in no case later than 60 days following discovery of the breach must include the same information required for the individual notice.
   ii. AP Policy 2.07 requires press releases to go through the DSHS Office of Communications.

c. STATE ATTORNEY GENERAL OFFICE (AGO) (RCW 42.56.590)

- Under 42.56.590(7) for any breach over 500, a covered entity must also notify the AGO no more than thirty days after the breach was discovered.

(a) The notice to the attorney general must include the following information:
(i) The number of Washington residents affected by the breach, or an estimate if the exact number is not known;
(ii) A list of the types of personal information that were or are reasonably believed to have been the subject of a breach;
(iii) A time frame of exposure, if known, including the date of the breach and the date of the discovery of the breach;
(iv) A summary of steps taken to contain the breach; and
(v) A single sample copy of the security breach notification, excluding any personally identifiable information.
(b) The notice to the attorney general must be updated if any of the information identified in (a) of this subsection is unknown at the time notice is due.

DESTRUCTION OR RETURN REQUIREMENT:

If you receive healthcare information that you are not authorized to receive, *contact the sender to notify so they are aware you have received the information in error,* and then destroy the information without further dissemination.

- You may also follow the sender's instruction on how to return the health care information to the entity *and confirm no further dissemination*.

CORRECTIVE AND DISCLIPLINARY ACTION FOR VIOLATIONS

Employees found to be in violation of DSHS policies and procedures relating to confidentiality of PHI or other Confidential Information may receive corrective or disciplinary action, up to and including dismissal. Training and other mitigation steps may also be required as a result of Breaches or violations of confidentiality laws. DSHS and its employees are subject to civil and criminal fines and sanctions by the Department of Health and Human Services – Office for Civil Rights for violations of the HIPAA Rules. Civil penalties for violations of HIPAA Rules may be imposed up to $50,000 per violation for a total of up to $1,500,000 for violations of each requirement during a calendar year. Criminal penalties may total up to $250,000- and ten-years imprisonment.

FOR MORE INFORMATION

If you are unsure about appropriate use or disclosure of PHI, or if you need more information about your obligations to protect the privacy of information, consult the following resources:

- Your employer's administrative and IT security policies
- Your employer's Privacy Officer

- 45 CFR Parts 160 and 164 (The Privacy Rule, which establishes federal protection for the privacy of health information.

RESOURCES

Related RCWs and CFRs

RCW 42.56.590	Personal information—Notice of security breaches
45 CFR 164.520	Notice of Privacy Practices for Protected Health Information
45 CFR 160	General Requirements
45 CFR 164	Security and Privacy

Related Administrative Policies

Administrative Policy 5.01	Privacy Policy -- Safeguarding Confidential Information
Administrative Policy 5.03	Client Rights Relating to Protected Health Information
IT Security Policy 15.10	Information and Technology Security
DSHS information security manuals	DSHS Information Security Manual
Administrative Policy 2.07	Visual Communications Policy
Administrative Policy 5.08	DSHS Minimum Physical Security Standards

Related links and websites

HIPAA Breach Notification Rule	HIPAA Breach Notification Rule
HIPAA Covered Programs (HCC List)	Department's HCC List
http://www.atg.wa.gov/identity-theftprivacy	WA State Office of the Attorney General
http://www.ftc.gov/bcp/edu/microsites/idtheft//	The Federal Trade Commission
www.equifax.com	Equifax
www.experian.com	Experian
www.transunion.com	TransUnion

Sample letters and forms

Sample RCW 42-56-590 Client Notification Letter
Sample HIPAA breach notification letter by HCC
Privacy Breach Questionnaire
Internal Lost-Stolen Data Checklist

CONTACTS

DSHSprivacyofficer@dshs.wa.gov	The DSHS Privacy Officer
ETOC@dshs.wa.gov	The technology operations center (TOC
DSHS Privacy Coordinators	DSHS Privacy Coordinators

ACRONYMS

AGO	Attorney General Office
AP	Administrative Policy
BAOU	Business Associate Organizational Units
FERPA	Family Educational Rights and Privacy Act
HCC	Health Care Component
HIPAA	Health Information Portability and Accountability Act
IP	Internet Protocol
OCR	Office for Civil Rights
PBA	Privacy Breach Application
PHI	Protected Health Information
TOC	Technology Operations Center
URL	Universal Resource Locators

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
5/21/2025	Cynthia Mitchell	Updated the Purpose, added Privacy definition Added DSHS Privacy Policies Added more info about breach notification rule Removed unsecure phi info Added Business Associate definition Added Client definition Added Client Confidential Information definition Updated definition of Covered Entity Updated HIPAA Rules Added Individually identifiable: Updated Hybridization Updated Min Necessary definition Added PHI definition Added Use definition Added Willful neglect definition Added Where Privacy Applies Added Common Causes in Reported Incidents Added HIPAA Basics Removed – when HIPAA does not apply AND added HIPAA Basics – and Exclusions Added Overview of HIPAA Added Requirements of Mitigation to Part 4 Updated Step 4: Notification information Updated when to Notify affected indiv	

		Updated how to notify affect indiv Updated substitute service Updated what must be Included in the Notification Updated Three major credit report agencies Changed Consequences for Breaches to - Corrective and disciplinary action for violations Updated definition to 45 CFR Parts 160 and 164 Updated cfr's Updated links/websites Updated 42.56.590 client notification letter Updated contracts and acronyms	

Legal Holds & Discovery

The purpose of this section is to provide guidance for the management and preservation of records and documents involved in Litigation and/or potential Litigation.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Cynthia Mitchell Discovery Program Manager
360.715.2537 cynthia.mitchell@dshs.wa.gov

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BACKGROUND

When a Lawsuit or a Tort Claim has been filed or reasonably anticipated, employees who work at the Department are under an obligation to retain all records in its possession which could reasonably be considered relevant to the matter. Along with current records, any related records developed after a Litigation Hold Notice for a Tort Claim should be retained as well. The obligation is ongoing until the Claim has concluded.

Employees must be familiar with Administrative Policy 5.05 (Management of the Litigation Discovery Process), and Administrative Policy 5.07 (Employee Response to Litigation Related Documents), because any employee may:

- Be involved in litigation
- Need to determine if an event may lead to litigation
- Receive a litigation hold notice
- Receive a litigation related document, such as a subpoena, court order, notice of deposition, tort claim, or lawsuit
- Receive direction through their chain of command or the Office of the Attorney General to identify, preserve, collect or produce DSHS records

DEFINITIONS

DSHS records: Any document or recorded information, regardless of physical form or characteristics, created, sent, organized or received by the agency in the course of public business, including paper documents, e-mail, drawings, graphs, charts, audio and video recordings, photographs, phone records, data compilations, planners, calendars, diaries, draft documents, electronically stored information (ESI) and metadata.

Litigation hold notice: A written communication that instructs 'affected individuals' who are likely to have DSHS records pertaining to a legal issue to take immediate action to identify and preserve the records for future retrieval.

Preservation: The process of locating and safeguarding DSHS records from destruction that reasonably and likely relate to a potential or actual lawsuit or tort claim.

Reasonably anticipated litigation: A reasonable expectation that an event may lead to the filing of a lawsuit or a tort claim against DSHS or its employees. There is no formal standard to determine whether an event will lead to a lawsuit.

Tort claim: A formal written filing with the state office of risk management under RCW 4.92.100 in which the claimant alleges that certain kinds of harm or damages were caused by the state of Washington, its agencies or state employees in which people claim they have been harmed by torts (wrongful acts), including negligence, by government agencies or their employees.

WHAT TO DO IF YOU RECEIVE A LITIGATION HOLD NOTICE

1. Stop what you are currently working on and read the entire Litigation Hold Notice.

2. Follow all instructions in the Litigation Hold Notice. For example, if you have records about the circumstanced described in the Notice, suspend normal records retention practices and place those records on litigation hold until further notice.

3. Distribute the Hold Notice to any staff that may potentially hold related program records.

4. Ensure that you and your staff understand and are complying with the elements of the Hold Notice.

5. Locate and Identify DSHS records you may have that relate to the Litigation issues.
    - You must make a reasonable good faith effort to identify relevant records that are in your possession. This includes:
        - Searching desk files
        - File cabinets
        - Email and other electronic files that may contain information relevant to the Litigation issues.

6. Separate and preserve:
    a. Located email or other electronic records.
        - Do not print out hard copies of the electronic records and then turn around and delete the electronic record. You must preserve the original electronic version of located record.
    b. Identified hard copy documents that may be relevant.
        - Duplicate records should be reserved.

7. Err on the side of preserving the records:
        - If you have questions about whether certain records fall under the directive of the Litigation Hold Notice, you are instructed to err on the side of preserving the records.

8. Contact your administration's Discovery Coordinator or the DSHS Discovery Manager if you have questions or need assistance.

OBLIGATION TO PRESERVE RECORDS

Employees are required to preserve potentially relevant records relating to all legal related proceedings until the matter concludes and the records retention policy permits destruction. This includes records in any form including all electronically stored information and metadata.

CONSEQUENCES

Serious penalties could be imposed on the Department if employees fail to take reasonable steps to locate and preserve potentially relevant information. In addition, employees could be subject to disciplinary action for failure to comply.

RESOURCES

Contacts

Discovery Coordinators

Related RCWs

RCW 4.92 Actions and Claims Against State

Related Administrative Policies

Administrative Policy 5.05	Management of the Litigation Discovery Process
Administrative Policy 5.07	Employees Response to Litigation Related Documents

WHAT TO DO IF YOU ARE SUED OR INVOLVED IN A LAWSUIT:

- Lawsuits Against the State and Employees - What to Do

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
5/22/2025	Cynthia Mitchell	Updated Links	

Assessment and Care Planning

Chapter 3 describes the intent and process of performing an assessment and developing a care plan.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Dru Aubert Care Management Unit Manager
360.725.2524 dru.aubert@dshs.wa.gov

For questions or clarification needs on limited English proficient persons, contact:

Linda Garcia Americans with Disabilities/Limited English Proficiency/Voter Registration Assistance Program Manager
360.968.9745 linda.garcia1@dshs.wa.gov

For questions or clarification needs about the bed rail policy, contact:

vacant, ALTSA HQ Ancillary Services Program Manager

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GOALS AND FUNCTIONS OF THE CARE ASSESSMENT

What are the functions of an assessment?

To develop a plan of care with an applicant and/or current long-term services and supports recipient, the CM/SSS must:

- Perform an in-person interview with the individual requesting long-term services and supports, in their home or place of residence, or another location that is convenient to the individual;
- Obtain and review documentation/information;
- Document the individual's abilities, resources, preferences, and goals;
- Assure that available supports are not supplanted; and
- Use the information to assist in determining eligibility for long-term services and supports programs.

Assist the individual to develop a plan that:

- Is person-centered by incorporating the individual's choices, preferences, strengths, and goals;
- Identifies items and services, within resource limitations (acknowledging health and safety risk factors and personal goals) either by paid resources or other means;
- Provides clear instructions to caregivers of the individual's preferences related to services within program limits;
- Makes providers aware of the client's authorized services to determine if they can adequately perform the tasks assigned; and
- Makes appropriate referrals to community resources based on abilities, preferences and/or mandatory referral policy.

What is the function of the CARE tool?

The state establishes eligibility for services using the Comprehensive Assessment Reporting Evaluation (CARE) tool. The CARE tool functions as an assessment, service planning, and care coordination tool and is used to determine program eligibility and establish the amount of care (daily rate or monthly hours) a client is eligible to receive. See related WACs and RCW in the Resources Section for program rules that establish total hours and how much the department pays toward the cost of services.

The CARE tool is also used to document eligibility for other Community First Choice (CFC) and waiver services such as Personal Emergency Response Systems (PERS), home-delivered meals, Adult Day Care, Adult Day Health, environmental modifications, etc.

HCS/AAA: Who is eligible for an assessment?

Individuals eligible for an assessment are adults, 18 years of age or older, who:

- Apply for Core long-term care services
- Are likely to be eligible for Medicaid nursing facility care/coverage within 180 days or voluntarily request an assessment to reside in a nursing facility assessment
- Apply for Aging Network services.
  Assess these individuals without regard to financial eligibility and prioritize in the following order:
  1. Individuals with an Adult Protective Services (APS) case who may need case management or other long-term services and supports
  2. Individuals on Hospice
  3. Individuals in a hospital or in the community and in jeopardy of imminent harm or institutionalization (hospitalization or nursing facility)
  4. Individuals who are otherwise at risk of being in a nursing facility in their present situations
  5. Residents of nursing facilities who have imminent discharge potential to a community-based setting; and
  6. All other requests for services.

Who completes the CARE assessments?

HCS: The Home and Community Services (HCS) Social Service Specialist (SSS) or Nursing Care Consultant (NCC) completes:

- All Initial assessments.
  - *EXCEPTION: Asian Counseling and Referral Service (ACRS) and Chinese Information and Service Center (CISC) complete Initial assessments in King County for specific ethnic populations*
- Annual and Significant Change assessments for individuals residing in residential settings
- Nursing Facility Level of Care (NFLOC) evaluations unless case managed by the Area Agency on Aging (AAA) or the Developmental Disability Administration (DDA). HCS should coordinate with AAA or DDA as needed to determine NFLOC (see Chapter 10 for more information on Nursing Facility Case Management and Relocation)
- New assessments of former Aging and Long-Term Support Administration (ALTSA)-funded clients. (Individuals who have been terminated from all ALTSA services for more than one year and are requesting services again)
- New assessments for individuals currently on non-Core services applying for Core services; and
- New assessments of individuals requesting Adult Day Health only.

APS or HCS (based on regional office protocol): APS staff complete assessments for protective services.

AAA: The AAA/Aging Network Case Manager (CM) or nurse completes assessments for individuals:

- Receiving ALTSA-funded long-term services and supports in their home after services are initially authorized
- Moving from their own home to a residential or nursing facility setting
- Veteran Directed Care (VDC) assessments for participants in the VDC program
- On non-Core programs with the Aging Network, and
- Receiving Adult Day Health only after services are initially authorized.

DDA: DDA Case Resource Managers (CRM) complete assessments for individuals who are DDA-enrolled and receiving services funded through DDA, for children under the age of 18 who are not DDA enrolled but are eligible for personal care services, or for an individual being screened for a move to a nursing facility by DDA.

Types of CARE Assessments

When do I complete an Initial assessment?

Complete an in-person Initial CARE assessment with an individual who requests Core services from ALTSA for the first time or for clients who have been terminated from all ALTSA-funded services for more than one year and are requesting services again.

What is an Initial/Reapply assessment?

This is an in-person CARE assessment for clients who are reapplying for Core services within one year of the last in-person assessment.

When do I complete an Annual CARE assessment?

- To continue to obtain federal funding, the federal government requires an in-person assessment to be performed at least annually to determine program eligibility. A new in-person assessment must be performed and moved to *Current* by the last day of the same month the previous in-person assessment was moved to *Current*. The Plan Period for each assessment is displayed on the Assessment Main screen.
- Services may not be authorized on a pending assessment. The assessment must be moved to Current before services can be authorized.

When do I perform a Significant Change assessment?

A Significant Change assessment is necessary to assess changes in client condition so the plan of care can be revised to reflect updates in care tasks and caregiver instructions. Perform an in-person, Significant Change assessment when there has been a reported change in the client's cognition, Activities of Daily Living (ADLs), mood and behaviors, or medical condition that will affect the care plan. The reported change may be an improvement or a decline in the client's condition. Always use the Significant Change assessment when assessing a client in-person, within the current plan period, even if there is no change in the client's condition. On the Assessment Main screen "Reason for Assessment" field, indicate the reason for the Significant Change assessment.

Significant Change assessments should be completed (moved to *Current*) no later than 30 calendar days from the date it is determined that there has been a change in the client's condition that warrants a new assessment. If the 30-day timeframe is exceeded, a reason must be documented in a Service Episode Record (SER).

AFH providers who submit a written request via fax, e-mail, or mail to the SSS/CM of a change in the client's condition that warrants a Significant Change assessment, may request a review from the department when the assessment results in an increased daily rate but was not completed within 30 *calendar* days of receipt of a fully completed Form "*AFH Resident Significant Change Assessment Request*" and updated Negotiated Care Plan. If a review is requested, and the department determines the assessment was not completed within 30 *calendar* days due to department error, the increased daily rate must be authorized starting the 31st day from receipt of the written request.

When all required information has been received, the SSS/CM will use the "**AFH Sig Change Request**" SER code in CARE and enter the date the complete written request was received. (CARE will then generate a tickler to send reminders on the 20th and 27th calendar day from the written request date to complete the assessment and move it to Current.)

In some HCS/AAA cases, completion of an in-person, Significant Change assessment can determine the date of the next annual reassessment. For example:

- You complete (move to *Current*) a client's Initial assessment on July 6, 2023, which means the Annual assessment must be completed on or before July 31, 2024.
- You complete an in-person, Significant Change assessment on October 15, 2023. This client's Annual assessment date could be changed and would need to be completed on or before October 31, 2024. Additionally, you must confirm that the client is financially eligible before extending services for 12 months.

In some cases, the change in the client's condition may be temporary. If the change appears to be temporary do not assume the next in-person assessment will be an Annual assessment. Depending on the client's situation you may need to reassess the client prior to a year for appropriate service planning.

When do I perform an Interim assessment?

Perform an Interim assessment (for in-office use only. Never use for in-person assessments) when:

1. Making changes to assessments that do not involve a reported change in the client's cognition, ADLs, mood and behaviors, or medical condition. This may be the result of:
    a. Additional information about the client that is **not** related to a change in the client's condition
    b. A change in the availability of an informal support, or
    c. A correction of coding, for example, as a result of a Quality Assurance (QA) or supervisory review.

2. Documenting changes to the client's condition that do not change the CARE Classification, and the client is <u>not</u> planning to discharge from a skilled nursing facility.
    a. Information may be gathered via phone by the nurse/CM/SSS from:
        i. the client or the client's representative,
        ii. medical professionals,
        iii. personal care providers, etc.
    b. Discuss and document the client's reported changes using the appropriate and consistent lookback periods.

NOTES on Interim assessments:

- The reason for the Interim assessment must be documented on the Assessment Main screen in the "Reason for Assessment" field. The assessor should remove outdated information in this section.
- Triggered Referrals screen:
    - Follow up on any indicators that are relevant to the documented change in client's condition (reason for the Interim).
    - Indicators may be marked "No" in the "Refer?" dropdown if the Triggered Referral screen was completed at the previous in-person assessment.
- Completing an Interim assessment will not restart the plan period, and an in-person assessment will need to be completed before the plan period expires. If an in-person Significant Change is completed, the plan period will restart and another in-person assessment will be due within 365 days.
- **IMPORTANT:** An in-person Significant Change assessment <u>must</u> be completed when the:
    - Interim assessment results in a **change in CARE Classification**. **<u>The Interim assessment must be moved to *History* and a Significant Change assessment completed in the client's residence unless the change in classification was due to a correction of coding after a supervisory or Quality Assurance (QA) review;</u>** or
    - Client plans to discharge from a skilled nursing facility.

<u>Can a nursing referral result in a Significant Change assessment?</u>

Yes. The nurse/CM/SSS may perform a Significant Change assessment as a result of the Skin Observation Protocol or a nursing referral when one or more Critical Indicators are triggered.

<u>Who uses the Veteran's Directed Care (VDC) assessment?</u>

AAA staff use the VDC assessment type for Veteran Directed Care program participants.

<u>What is an AAA/Non-Core assessment?</u>

An AAA/Non-Core assessment is used by AAA staff when assessing a client for non-Core services, under the Senior Citizens Services Act (SCSA), Older Americans Act (OAA), or under locally funded services when providing Aging Network case management.

Can I assess an individual who is in jail or prison?

Individuals in a jail or prison in Washington are considered residents of the State of Washington. Medicaid financial eligibility determinations can be initiated while an individual is in either a jail or prison facility. The individual, representative, or staff at the jail/prison can be provided with an Application for Benefits or directed to the online application. Applications should be submitted as soon as the individual knows of a potential release date.

Referrals for individuals in jails will follow the regular intake process. Social Service Specialists or nurses may go into jails or prisons to conduct assessments but will need to comply with the security requirements of the jail/prison facility. This may include submitting information for a background check, as well as making specific arrangements with the facility to bring a laptop computer into the jail/prison (this often requires specific security clearance).

Social Service Specialists or nurses should coordinate closely with the jail or prison facility staff to ensure access is provided to:

- the individual,
- staff who work with the individual (such as counselors or medical staff),
- and the individual's medical and behavioral records.

Note: If a client is receiving a Non-Core SCSA or OAA-funded service and then applies for Core ALTSA long-term care services, HCS staff may perform an assessment using the last assessment (via "copy & create" function) that was done by the Aging Network. This process builds upon the assessments that were previously completed and facilitates the exchange of information regarding the client's past functioning.

ADDING A CLIENT TO CARE

Once you receive a request for an assessment, you must perform an intake, assign the case, and follow-up with clients to schedule the assessment within the required timeframes.

TIMEFRAMES		
	For all applicants (except hospital):	**For applicants currently in an acute care/community psychiatric hospital:**
Intake	Enter applicants into CARE within 2 working days of receipt of referral.	Enter applicants within 1 working day.
Assignment	Intake Specialist will make 2 attempts to reach client by phone on 2 consecutive working days. If unable to reach client, Intake will mail 10-day letter to client. Assign a primary case manager within one working day of conducting the initial Intake phone interview. If no response after 10 days, case will be inactivated.	Assign the case so that the case manager has adequate time to make contact with the individual.
Contact	Case manager will make 2 attempts to reach client by phone within 3 working days of assignment. If unable to reach client, CM will mail 10-day letter to client. If no response after 10 days, case will be inactivated. However, priority must be given to those individuals in jeopardy of imminent harm or in a nursing facility.	Make contact within 2 working days of receipt of referral to schedule an assessment and review Long-Term Services and Supports (LTSS) options regardless of desired discharge setting.
Completion	• From date of intake: Complete the assessment (move to *Current* and authorize services) within 45 days after the date of intake. • From CARE assessment creation date: Once the assessment has been initiated, it must be finalized (moved to Current) within 30 days.	• Assessment start date must be seven days from the date of referral or from the date the client is stable and predictable. • Complete the assessment (move to Current and authorize services) within 30 days of the date of receipt of referral.
Exceptions *to this timeframe may occur when:* • *The client requests a longer response time;* • *The client is not available for an in-person contact;* • *There is difficulty in finding an appropriate and qualified provider;* • *Financial eligibility has not been completed; and/or* • *Coordination is needed with interpreter services.*		

When the required response time is not met, document the reason for the delay in a SER and describe what follow-up will occur.

How do I add a client to CARE?

Determine whether the client is already in CARE using a unique identifier such as a Social Security Number (SSN). This will prevent creation of a duplicate client in CARE. Having a duplicate client in CARE will create problems when linking the client to ProviderOne. If the client does not exist in CARE, add the client to the system and complete the following screens:

1. Client Details
2. Overview: Assign a primary case manager and supervisor.
3. Residence: select the client's Residence Type from the dropdown list and enter the client's residence address[1]. If the mailing address is the same, mark the appropriate checkbox. **Do not delete historical residence records. If the client has moved, create a new residence record.**
4. Client Contact: if the client's mailing address is different than their residence address, indicate the mailing address and contact phone numbers.
5. If the client uses email, enter the email address in the field provided.
6. Collateral Contacts: add all appropriate collateral contacts. If the client did not self-refer, identify the referent here.
7. Financial: Intake may obtain financial information, but the assessor must verify that the client is financially eligible at the time services are being authorized.
8. ProviderOne: link client to correct ProviderOne (P1) record. IMPORTANT: Use caution when linking CARE and P1 records. Compare the demographic information in CARE with ACES (Name, Date of Birth (DOB), SSN must match exactly)[2]. ACES is the primary source for this information when linking to P1.

   When attempting to link a record in CARE you may get a message that indicates there is no record, and you have the option to create a new record. Ensure all the information has been entered correctly into your search and in CARE before creating a new record in P1. This is very important to avoid payment problems.

   See the CARE Help File > Dashboard > Desk-Aid for Preventing Duplicate Client Record Creation in P1 for details and instructions related to linking clients in ProviderOne.

[1] If the client is experiencing homelessness, select "Homeless" as the Residence Type. Document known special instructions in the Comments box to assist staff in successfully contacting the client.
[2] Rarely, but sometimes, the information may be incorrect in ACES. When this happens, the CARE record still needs to match ACES to link correctly. When ACES information is incorrect, the client should work with their financial worker to correct it.

When do I inactivate a client record in CARE?

Inactivate a client record in CARE anytime a client has requested voluntary withdrawal from services or has been terminated because they are no longer eligible.

PERFORMING A CARE ASSESSMENT

The CARE tool is used for determining eligibility and benefit level, developing care plans, and authorizing services for individuals served by ALTSA and DDA. Please refer to the CARE Web Assessor's Manual (i.e., Help File) for detailed policy and procedure for completing an assessment in CARE. See Chapter 7/Intro to Medicaid, State Plan, and 1915c Waivers and its subsections of the Long-Term Care Manual for policy and eligibility criteria for specific services available for eligible clients.

Functional eligibility for programs assessed in CARE are based fundamentally, upon the assistance an individual receives with personal care tasks. Assistance with personal care means physical or verbal support with Activities of Daily Living because of the individual's functional limitations. This assistance is documented using the CARE tool.

Assistance with personal care tasks is typically provided in the client's residence but may also be provided while in the community if the client chooses. A common example of this would be a client wanting to attend a church or other organization but needs support with personal care while attending. This is supported in federal rules regarding person-centered care and community integration.

Steps in performing a CARE Assessment

1. Contact the client to introduce yourself, purpose of the appointment and assessment process, and schedule an appointment following the contact timeframes. The following are suggestions:
    a. If there is enough lead-time before the appointment, ask the client or their representative to have a letter from their healthcare provider listing their diagnoses.
    b. Ask the client who they would like to attend the assessment appointment with them. Offer suggestions for who may be helpful in providing useful information, such as an individual helping them, a paid provider, or a representative.
    c. Explain to the client that the assessment will take 2-3 hours. Assessment information will be requested from the client, agency provider(s) and/or Individual Provider(s), facility records/staff (if applicable), and other collateral contacts as appropriate. Check for staff and client availability before the assessment (for residential clients, facility activities may limit the time the client is available for the assessment).
    d. Let the client know you will be using a laptop or tablet and may need to work on a flat surface near an electrical outlet.
    e. In addition to information already gathered (e.g., on an Intake form), document relevant information that an assessor should be aware of prior to making a home visit such as, whether there are locked gates, unmarked roads, or other hazards (such as extreme weather conditions

or broken steps on stairways) that staff may encounter at the address, or if there is a lack of adequate cellular service.

- Ask the client if they or anyone in the home would have any concerns conducting a home visit to conduct their assessment. For instance, are there perfume or animal allergens to consider that the client, household member, or staff member must refrain from, are there animals in the home that must be restrained prior to the home visit, any recent illness exposures amongst household members, or any environmental concerns, such as mold, bed bug/cockroach infestations, or do any household members own have weapons, and are these secured?

f. On the day of the appointment, call to confirm and document the appointment confirmation in a SER.

NOTE: If the client's primary language is not English, follow the policy in Chapter 15A/ Communicating with Individuals with LEP & SD, Guidance for AAA Staff or Chapter 15B/ Communicating with Individuals with LEP & SD Guidance for ALTSA and DDA Staff for using an interpreter and translating documents.

2. Assess the client in an in-person interview and gather information related to the individual's functional abilities, goals, personal preferences, and any special instructions the caregiver may need to know to support the individual to complete tasks. At some point during the assessment request that the client speak with you privately in case they would like to share information for which they are not comfortable sharing in front of others. The assessment may be in pending status while you gather additional information to complete the assessment and care plan. During this time:

   a. Complete Consent Form DSHS 14-012. You must use this form to obtain, use, or share confidential information about a client in certain situations. Read the instructions on the Consent form carefully prior to assisting the client to complete the form and emphasize the information in the "notice to clients" section at the top of the form. Supplementing the consent form with the DSHS Notice of Privacy Practices (03-387) is required at an initial assessment and is suggested for subsequent assessments to enhance the client/representative's understanding of how and why information may be shared. Check the box "Other DSHS contracted providers." SSS/CM staff should write in "ALTSA paid providers," and CRM staff should write in "All DSHS Contracted Providers," to cover the need to share information on an as needed basis, with providers paid by ALTSA or DDA-only. If there are specific questions about sharing information, consent and privacy, please contact the DSHS or ALTSA Privacy Officer.

   b. Gather Information

      i. The client should be used as the primary source of information whenever possible.
      ii. Gather information from the client's legal representative or substitute decision-maker, as appropriate. If the client has a guardian or DPOA, get this paperwork and forward to the Hub Imaging Unit (HIU) for imaging into the client's electronic file.
      iii. Gather other information from collateral contacts if it is needed to complete the client's assessment.

c. Discuss Necessary Supplemental Accommodations (NSA). Individuals who have a mental, neurological, physical, or sensory impairment that prevents them from getting program benefits in the same way as those who are not impaired are considered in need of necessary supplemental accommodation. Read more about NSA.

   Review all brochures and forms with the client. Also follow the Self-Directed Care Checklist for clients who would like to self-direct their services.

d. Assess for informal support available to fully or partially meet tasks identified in the client's care plan.

e. Complete the "My Goals and Plans" section on the Profile screen in CARE: Documenting and assisting clients to identify goals is an important part of person-centered service planning. Goals can identify what motivates a person, what is important to the person, and what are their desired outcomes regarding their care.

f. For residential clients, document any modifications to client's rights in a SER and in the comments section on the appropriate corresponding CARE screen for which the modification relates. See Chapter 8/Residential Services for details.

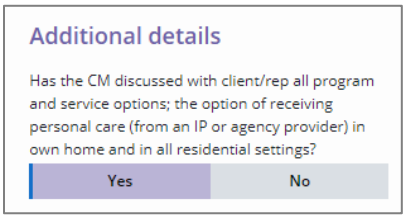
g. Review critical indicators from the Triggered Referrals screen. When possible, review while in the home with the client and/or representative as some have specific deadlines for follow-up. The following are some examples of when you would refer to or coordinate with nurses or make other referrals:
   i. Skin Observation Protocol has been triggered. NOTE: The ALTSA skin breakdown prevention plan will print on the client's assessment details when potential skin issues exist.
   ii. Other critical indicators have been triggered (e.g., nutritional status affecting the plan of care).
   iii. Depression, Drug/Alcohol Abuse, Suicide, or Pain has triggered consideration of referrals.

3. Verify and Determine Eligibility. **Financial and functional eligibility must be determined concurrently** for clients receiving Core services (e.g., CFC, COPES, MPC, New Freedom, etc.). Communicate with financial staff regularly on status of financial eligibility and confirm financial eligibility has been established, or complete Fast Track procedures as necessary. Document financial verification on the Financial screen in CARE or forward documents to HIU for imaging into the client's file before authorizing or re-authorizing services for a new plan period. Develop a proposed plan of care with input from the client and relevant parties and if appropriate, hold an interdisciplinary case staffing to discuss the proposed care plan given a client's particular situation.

4. Have a discussion with clients and present all the programs and services for which the client may benefit based on their needs, goals, and eligibility. Consider any assistive technology that may assist a client to be more independent with performing ADLs, IADLS, or health related tasks. Coordinate and plan for chosen services and supports and document in the client's plan of care. See relevant

Long Term Care Manual Chapters for policy and eligibility criteria for specific programs and services available for eligible clients.

5. Have a discussion with clients regarding their choices related to long-term care settings and in-home personal care provider types (an Individual Provider through the Consumer Directed Employer (CDE) or a Homecare Agency provider). Clients should receive enough information about the settings and provider types available to them to make an informed choice of providers.
6. Document the discussion from #4 and #5 above in the Care Plan screen in CARE.



7. Assist clients in identifying a qualified provider. If a client has a difficult time identifying a provider, assist the client to identify barriers preventing the selection of a provider and to resolve issues that may be preventing service delivery. Ensure the client is familiar with the CDE and can access Carina. Check in with the client regularly and assist as needed. If a client is having challenges but is actively seeking a provider, do not terminate a client for the reason of not having a qualified provider.
8. If requested by client/representative, review the plan of care with potential providers.
9. If a client has chosen to have an assessment in a setting other than their home or residence where services are being provided, a visit must be made to the client's residence before the assessment is moved to Current, or within 30 days of the assessment being moved to Current when extenuating circumstances are noted in a SER.

Behavior Screen indicator related to Community Behavioral Health Support (CBHS) Services/ 1915i (effective 7/2024)

These services are currently available to clients in Adult Family Homes, Adult Residential Care Facilities, Enhanced Adult Residential Care Facilities, Assisted Living Facilities and Enhanced Service Facilities. For clients residing/seeking services in these settings:

During the CARE assessment, while providing the client with Home and Community Based Services (HCBS) and options, also provide the client with the CBHS brochure (HCA Form 19-0087). Based on selected diagnoses, a client may be eligible for Community Behavioral Health Support Services. If your client is interested in these services, the SSS/CM will review the assessment and for potential CBHS eligibility. If it seems the client is eligible on the Behavior Screen in CARE, update the question "Was a referral made for CBHS/1915i eligibility?" to "Yes". See Chapter 22a/Apple Health Managed Care and Apple Health Medicare Connect (D-SNP) of the LTC Manual for more information on Community Behavioral Health Support (CBHS) services.

In-person vs. Telephonic Assessments

Clients must be provided the opportunity for an in-person assessment, as in-person assessments remain the requirement. Telephonic or other technological media options may be used only when the in-person option is not available, due to circumstances or conditions, such as health and safety of client and/or provider, inclement weather, or critical staffing crisis.

Remote assessment delivery through telephone or other technology will be in accordance with State, Federal, and Health Insurance Portability and Accountability Act (HIPAA) requirements. Other technology means any two-way, real-time communication technology that meets HIPAA requirements.

Performing a Telephonic or Other Technology Media-Type Assessment

1. When there is concern that the in-person assessment cannot be done due to a circumstance such as health and safety of client and/or provider, inclement weather, or critical staffing crisis, consult and obtain approval from Regional Leadership/AAA Case Management Director or their designee. Local HCS or AAA offices should use their professional judgement to decide of how to respond, balancing health and safety of the client, the worker, and workforce capacity.

2. A SER note should briefly document:
    a. Any known information about the circumstance or condition;
    b. Action plan as a result of consultation with Regional Leadership/AAA Case Management Director or their designee
3. Prior to initiating a telephonic or other technology media-type assessment, a private setting must be used to maintain the client's privacy. Verify the client's identity before conducting the assessment; ask the client/formally appointed representative to confirm the client's legal name and date of birth.
4. During the telephonic or other technology media-type assessment, schedule a date for an in-person home visit with the client.
5. CARE MMSE Instructions: For all CARE assessment types, accurately complete the parts of the MMSE that do not require in-person interaction. For the sections that require in-person interaction (Language and Commands sections), select 'no' and note in the "Other factors" text box that the Language and Command sections were not completed because the assessment was completed telephonically or through other technology media. The sections that can be completed telephonically or through other technology media will total 22 MMSE points instead of 30.

Not eligible for Core services?

If a potential client is found to be ineligible for Core services:

a) For clients who may benefit from Family Caregiver Support Services, refer them to the local AAA

b) For clients over 60, consider a referral to the local AAA office or their partners for Community Living Connections (formerly Senior Information & Assistance)
c) Move the assessment to history
d) Send a Planned Action Notice and
e) Inactivate the client within 14 days unless an administrative hearing is requested

Limited English Proficient Persons

Use the Demographics screen in the Client Details section in CARE to document the client's language details. See Chapter 15A/ Communicating with Individuals with LEP & SD, Guidance for AAA Staff or Chapter 15B/ Communicating with Individuals with LEP & SD Guidance for ALTSA and DDA Staff for specific details related to clients who have limited English proficiency.

Assessing Status (Informal Supports)

Background

As part of the waiver approval process and Code of Federal Regulations (CFR) related to person-centered planning, the Centers for Medicare and Medicaid Services (CMS) require the state to not replace naturally occurring supports with federal funds. One of the purposes of the assessment is to determine availability of informal supports and other non-department paid resources and community resources. Identified informal supports are based on voluntary action and are available so long as the source is willing and able to continue them. The state will inform clients, families, and support systems of options to address needs a client may have for unscheduled tasks and/or supervision beyond the number of hours authorized in an in-home care plan, including residential or nursing facility care (if applicable).

As the employer, the client/representative should determine the provider's schedule, which is then documented by the case manager. When requested by the client or their representative, the schedule may be facilitated by the case manager with input from the client, formal and informal decision makers. The department is obligated to pay for hours worked up to the maximum number authorized in the plan of care.

What are examples of informal supports?

Informal supports are any resources available to fully or partially complete individual ADL and IADL tasks identified in the client's care plan. Examples of informal support resources may include family members, friends, church groups, neighbors, Adult Day Health or Adult Day Care (because it is paid through a different DSHS funding source), hospice services, doctor's office services for certain treatments/foot care, home health, congregate meals (served at senior centers, tribal centers, community center), etc.

Process of Determining Status

For each task, status indicates the degree of unmet need (anticipated informal/non-ALTSA/DDA paid support) looking forward, regardless of what the status was in the past.

Coding of informal supports are based on an individualized assessment of each ADL/IADL, considering any informal support that is willing and able regardless of the client's living arrangement. No assumptions must be made about informal supports. Determinations are based on an individualized assessment of each client.

Special Considerations

- An Individual Provider (IP), who is paid by the Consumer Directed Employer to provide care to an ALTSA/DDA client, may not be considered a source of informal support.
- If an individual requires two-person assistance every time the ADL is performed and only one informal support is available, then the status would be unmet.
- Consideration may include whether the client has unusually high needs for assistance with tasks that may offset a deduction to *Status* if some informal support is available Do not consider assistance with ADLs that will occur less than weekly, except for *Locomotion Outside of Room*.
- Do not consider assistance that will be provided by children under the age of 18.

When is the status "met"?

If the informal support(s) is willing and able to fully complete an activity (ADL or IADL) identified in the care plan on an ongoing basis, the status is considered "met."

When is the status "partially met"?

If the informal support is willing and able to provide some, but not all assistance with an activity (ADL or IADL) identified in the care plan on an ongoing basis, the status is considered "partially met." If partially met is chosen, the assessor will need to identify the level of assistance available. Use the Assistance Available chart to determine the percentage.

When is the status "unmet"?

When there is no informal support available to assist with the activity (ADL or IADL), the status is considered "unmet".

Note: If the client uses Paratransit or other public transportation but also requires an ALTSA-paid caregiver to assist with transfers, locomotion outside of room, and/or cognitive needs, the status may be "unmet" for Transportation. If the client does not need an escort, code Status based on provision of the transportation only.
Medicaid brokerage services must be considered when determining whether or not to assign transportation to a personal care provider.

Assistance Available

Use this chart to determine what portion of a task is "partially met" by an informal support:

- Less than ¼ of the time
- ¼ to ½ of the time
- ½ to ¾ of the time
- More than ¾ of the time

NUMBER OF TIMES/HOURS TASK IS REQUIRED	NUMBER OF TIMES/HOURS TASK IS MET INFORMALLY																			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1	100%																			
2	50%	100%																		
3	33%	67%	100%																	
4	25%	50%	75%	100%																
5	20%	40%	60%	80%	100%															
6	17%	33%	50%	67%	83%	100%														
7	14%	29%	43%	57%	71%	86%	100%													
8	13%	25%	38%	50%	63%	75%	88%	100%												
9	11%	22%	33%	44%	56%	67%	78%	89%	100%											
10	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%										
11	9%	18%	27%	36%	45%	55%	64%	73%	82%	91%	100%									
12	8%	17%	25%	33%	42%	50%	58%	67%	75%	83%	92%	100%								
13	8%	15%	23%	31%	38%	46%	54%	62%	69%	77%	85%	92%	100%							
14	7%	14%	21%	29%	36%	43%	50%	57%	64%	71%	79%	86%	93%	100%						
15	7%	13%	20%	27%	33%	40%	47%	53%	60%	67%	73%	80%	87%	93%	100%					
16	6%	13%	19%	25%	31%	38%	44%	50%	56%	63%	69%	75%	81%	88%	94%	100%				
17	6%	12%	18%	24%	29%	35%	41%	47%	53%	59%	65%	71%	76%	82%	88%	94%	100%			
18	6%	11%	17%	22%	28%	33%	39%	44%	50%	56%	61%	67%	72%	78%	83%	89%	94%	100%		
19	5%	11%	16%	21%	26%	32%	37%	42%	47%	53%	58%	63%	68%	74%	79%	84%	89%	95%	100%	
20	5%	10%	15%	20%	25%	30%	35%	40%	45%	50%	55%	60%	65%	70%	75%	80%	85%	90%	95%	100%

How do I know when I'm ready to complete CARE?
Does your assessment meet the minimum standards requirements? If yes, you are now ready to complete your CARE assessment.

Finalizing a CARE Assessment – Developing the Plan of Care

Background

Clients can choose from options for personal and healthcare services that are governed by eligibility criteria, payment source requirements, coverage options, and provider qualifications. Twenty-four-hour, paid care is available only in residential or medical facility settings, so case managers must work with clients to maximize all available resources, both paid and unpaid, to develop a plan of care that addresses the health and safety needs of the client. The state identifies the essential tasks to be performed by formal providers in the care plan within program limits. How and when they are performed is determined by the client.

The state has an obligation to educate clients, family members, support systems, and other service providers, informing them that a plan of care is developed based on the resources available and that meeting all needs and providing all services is an expectation that neither the client, family, support system, or case manager may be able to achieve.

How do I get approval on the plan of care from the client?

Before authorizing services, you must obtain the client's approval on the plan of care and finalize the assessment by moving it to Current status.

How do I distribute the plan of care to the client/representative?

Distribute the Service Summary to the client along with a Planned Action Notice (PAN) found in CARE. The Personal Care Results (PCR) or Personal Care Results Comparison (PCRC) will be attached to the PAN. If the PCR or PCRC does not print, attach the CARE Results. Distribute Assessment Details if requested by the client/representative.

Follow instructions for translating CARE documents in Chapter 15A/ Communicating with Individuals with LEP & SD, Guidance for AAA Staff or Chapter 15B/ Communicating with Individuals with LEP & SD Guidance for ALTSA and DDA Staff when the client has a written language identified in CARE other than English.

How and when do I distribute the plan of care to the provider(s)?

Mail, fax, or securely email the Service Summary and Assessment Details prior to authorizing/extending services and document the action taken in the SER. Distribute the Service Summary and Assessment Details to:

- Consumer Directed Employer (through CARE)
- Agency providers
- Nursing services staff, if applicable
- Residential providers
- The nursing facility, for those residents who are seeking Home and Community Based Services
- Hospital Discharge Planners for those patients who are seeking Home and Community Based Services
- Adult Day Services providers
- Nurse delegators
- Supportive housing providers
- Community Choice Guides
- Client Training Providers

Document in a SER when you have distributed the documents and to whom.

Documenting potential risk in the Plan of Care

1. Document any potential client/provider risks not otherwise documented in CARE using the 'General comments' section on the 'Comments' screen in CARE Web.
    - Document a client's registered sex offender status under "Legal issues" in the Safety screen

Each of these sections will print in the Assessment Details for the provider's awareness.

2. Document in the SER that the specific issue that may be a potential risk to a provider (or other residents in a residential setting) was discussed with the provider.

Plans of care that include Individual Providers (IPs) through the CDE

- If the client does not have an IP identified, have the client/rep contact Consumer Direct of Washington (CDWA) for assistance with Carina
- If the client does have an IP identified, have the client/rep refer the potential IP to CDWA to begin the hiring process
- Ensure CDWA is added to the Supports screen in CARE and has all relevant tasks assigned. (CMs do not need to wait until an IP is fully hired with CDWA to move the assessment to Current.)
- Except when there is an urgent personal care need, CDWA must have an open authorization before they can begin working with clients.
- CARE notifications from CDWA will let the CM know when an IP has been hired.
- Clients will work with CDWA to assign the hours to an IP(s).
- As the managing employer of IPs, the client/representative should determine the service plan schedule and communicate their preference to the CDE.
- When requested by the client or their representative, the schedule may be facilitated by the case manager with input from formal and informal decision-makers.
- IPs have a work week limit (WWL) managed by the CDE.
- Supervision of the IP must be performed by the client or their representative. When a client or client representative is unable to supervise their employee, a plan for increased monitoring is documented on the Cognitive Performance screen in CARE by the case manager.
- It is the client/representative's responsibility as a managing employer to review the plan of care with the IP. The client may use the IP's copy provided by CDWA, or request a copy from the CM.
- HCS/AAA staff do not complete Character, Competence, and Suitability (CC&S) reviews for IPs. If a CM has a concern about a current or potential IP/Client pairing, this information may be shared with the CDWA by using the CDWA CM Hotline at 866-932-6468 or by sending an email to the appropriate CDWA supervisor, based on their contact list for CMs. All emails should be specific in their subject line. **For example:** Subject: Concerns with IP/Client pairing. CC&S may be needed.

Getting Approval on the Plan of Care

To authorize services, the assessment must be in Current status following the client's approval of the plan of care. The client's approval verifies their participation in the development of the plan and consent to services outlined in the plan. You must have documentation of approval from the client or duly appointed representative.[3] Clients are considered legally competent unless deemed incompetent by a

[3] Durable Power of Attorney (DPOA) and Guardian are examples of duly appointed representatives. A DPOA (as a type of Power of Attorney) is the only one that can be used when the client becomes

court of law. A reasonable effort must be made to have the client's approval and signature on documents if there is no court order deeming them incompetent.

Even if client has an active DPOA or guardian, look to the client directly to make choices about Medicaid services, to the extent possible based on authorities and rights restrictions imposed in the orders or documentation. A client may also choose a representative who is not a DPOA or guardian, to act on their behalf to make decisions about Medicaid services and supports. If the client can indicate their free choice to authorize a representative, the representative may be allowed to make decisions about the client's Medicaid services. Identify the representative or DPOA/Guardian in the Collateral Contact Screen in the Contact Details screen in CARE Web. If the client has sufficient capacity to choose a representative, the SSS/CM should provide resources for DPOA execution to the client to assist the client with future care planning needs if the time comes the client is no longer able to choose a representative. This is because representatives must be appointed at each annual and significant change assessment, whereas a DPOA can be activated at any time after the client is unable to make decisions for themselves.

If an individual's representative, is also the client's paid caregiver, that representative can sign the Service Summary on behalf of the client, however, another person must assist the client as their representative for the purpose of care planning. In rare circumstances when there is no other option, the SSS/CM may assist the client for the purposes of care planning only. When the SSS/CM is assisting the client for the purpose of care planning, the SSS/CM will indicate this in the client's SER in CARE. This is different than plan of care supervision, the SSS/CM must never identify themselves as responsible for supervising the plan of care on the Cognitive Performance screen in CARE.

Determinations of capacity are very fact-specific, and the necessary level of "capacity" may depend on the type of decision that is being made. There may be situations when a doctor has determined that a particular client does not have the ability to consent for purposes of a particular medical decision. But that client may still have sufficient capacity to participate in the person-centered planning process or designate a representative to help them with the process (and subsequent decisions about their Medicaid services)

If while during the assessment there is reason to believe that the client's ability to participate in the assessment is significantly impacted, the SSS/CM should be cautious about accepting the client's approval and signature. The SSS/CM should document in a SER, the basis for accepting the client's approval or signature, including objective facts and observations to support that the client was engaged in the activity and understood what they were signing. It may be appropriate in these situations to staff the case with a supervisor, submit an inquiry to the ALTSA escalation pathway, and to consider consulting with your agency's attorney.

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incapacitated. A copy of the relevant POA document is to be maintained in the electronic case record as needed and updated as required. A legally appointed guardian must have guardianship papers, and an unexpired copy must be kept in the electronic case record.

Obtaining signatures on the CARE Service Summary portion of the client's plan of care

42 CFR 441.540(b)(9) requires all person-centered service plans to "be finalized and agreed to in writing by the individual and signed by all individuals and providers responsible for its implementation." The Service Summary page in the plan of care within CARE is the document used by HCS and AAA to comply with federal person-centered service plan signature requirements.

Once a client's CARE assessment has been completed and moved to Current, the SSS/CMs must sign and obtain signatures of the client or their representative agent or guardian and the personal care service providers who are assigned tasks in the plan of care on the CARE Service Summary. The client or their representative agent or guardian and provider may only sign a Current Service Summary. It must not be in Pending or History Status (unless required to remediate a QA finding).

Client Signature

SSS/CMs must obtain the client's or their representative agent's or guardian's signature on the CARE Service Summary for Initial, Initial/Re-apply, Significant Change and Annual assessments. **For Interim assessments**, follow the steps for getting approval on the plan of care:

- when there is a change in CARE generated hours or classification,
- program change,
- addition/deletion of a service, and/or
- provider change.

***See attachment 'Chart of Scenarios for Service Summary Signatures' for full details of when a Client, Provider or Case Manager signature is required.**

SSS/CMs may continue to authorize services for a completed assessment using the client's **verbal approval** until the client's signature can be obtained, and the client's physical, electronic, or voice signature must be obtained at the earlier date of 90 days from the assessment *completion* date, or before case transfer; however, verbal approval may not substitute for the client's physical, electronic, or voice signature.

CMS requires a **person-centered approach** to work with the client to obtain their signature. **Examples of methods that may be offered include, but are not limited to:**

- Completing and moving the assessment to current in the home and obtaining the client's signature electronically in a PDF document using your touch pad, mouse, or touchscreen.
- Using the e-signature feature in CARE supported by Adobe.
- Using the voice signature feature in CARE supported by AmazonConnect. (See voice signature instructions and script in the Attachments section).
- Making an in-person visit once the assessment is completed and moved to Current.
- Obtaining the signature by mail (See instructions in the Attachments section for setting up ticklers in Barcode).

- Utilizing supports identified by the client to assist them with reminders to return the signed form.

The client may agree to initiate or continue services without agreeing with the hours/daily rate. Document this in a SER and move the assessment to Current.

For LTSS in-home assessments, if a client requests fewer hours to be authorized than are indicated on the Care Plan screen, document this in a SER. Use the In-home *Personal care adjustments* field in the Care Plan screen in CARE to document the number of monthly hours the client is choosing not to utilize. Select, *Client voluntarily hour reduction* from the *Reason* dropdown. This will result in the adjusted number of monthly hours to print on the Service Summary.

For LTSS in-home assessments, indicate adjustments for waiver services and/or HQ approved personal care ETRs using the In-home *Personal care adjustments* field in the Care Plan screen in CARE. This will result in the adjustment to total hours to print on the client's Service Summary. (For details about waiver deductions see Chapter 7)

If the client has chosen a signature method other than e-signature, send the client a copy of the Current Service Summary with the SSS/CM's signature and a Planned Action Notice (PAN). The Personal Care Results (PCR) or Personal Care Results Comparison (PCRC) will be attached to the PAN.

If a client chooses electronic communication outside of the e-signature feature in CARE, a faxed or electronic scanned signature is acceptable. If the client prefers, use encrypted email to send the client a PDF version of the Service Summary and PAN/PCR/PCRC. As necessary or requested by the client via a signed *Notice and Consent of Communication via Text or Unencrypted Email* (DSHS Form #27-156) on file, the client may consent to receiving unencrypted email messages.

If the client chooses mail delivery as the method to obtain their signature, include an extra Service Summary with a cover letter and self-addressed, stamped envelope, so that the client can sign, date, and return the signed Service Summary.

If the client chooses voice signature, the CM/SSS may call the client using the Amazon Connect feature in CARE, to review the contents of the plan verbally and obtain the voice signature by phone. CARE will allow the assessment to be moved to Current while connected to a call. This would replace the need to obtain verbal approval prior to obtaining the signature. Upon completion of the assessment (assessment is moved from *Pending* to *Current* status), SSS/CMs need to send a copy of the SS to all clients, regardless of whether the client/representative chose to sign the SS via voice signature, and when needed, include the translated version of the SS to the client. Service Summaries for individuals whose signatures were obtained by voice signature, are typically not sent to the HIU for imaging. For LEP

clients, the signed SS signature page *(in the translated version only*) should be sent to HIU. For detailed information and the script for obtaining voice signatures, see the instructions in the Attachments section.

Document relevant approval/signature steps in the SER.

If it is not possible to obtain the client's signature prior to authorizing/extending services:

1. Call the client to review the contents of the plan verbally and obtain verbal consent to receive the services that are documented in their plan of care.
    a. Document this conversation via CARE > Service Episode Record (SER) > *Plan Approval* purpose code; and
    b. Document that the client has participated in the development of the plan and verbally consents to the services.

Once the client has given verbal consent of the completed plan, work with the client to determine the best way to obtain their signature on the CARE Service Summary.

If a client does not return the signed Service Summary or refuses to sign the Service Summary:

Re-evaluate the person-centered approach used and work with the client/representative to obtain their signature. The approach used will depend on the individual and it may help to understand the reason for their resistance.

In some cases, a client may disagree with items identified in the plan or how they are worded and will not sign the plan. If this occurs, adjust the plan contents or wording. Clients may choose to delete certain information; however, if the information is determined to be necessary to address the health and welfare of either the client or the provider, discuss with the client and explain that unless the provider has this information, you may not be able to authorize services.

Do not:

- Include services on the plan for which the client is not eligible;
- Omit information that a caregiver must be aware of to determine that they can meet the client's needs or provide care; or
- Omit information that could impact the health or safety of the client or provider.

If the SSS/CM is unable to obtain the client's signature despite exhausting documented person-centered efforts, provide the following documentation in the SER in CARE:

1. The reason why the signature could not be obtained;
2. The person-centered approach and steps that were taken to obtain the client's the signature;
3. A statement of the client's verbal plan approval; and
4. What, if any, follow up will occur?

What to do when the client cannot sign

1. If the client appears to have capacity but physically cannot sign documents, the reason should be documented in a SER. Signing with an "X" or comparable mark is acceptable if it is witnessed by the CRM/CM/SSS or another party who has verified the client's identity and has witnessed them signing the document.
2. If the client appears to not have capacity but there is no DPOA or Guardian in place, the CRM/CM/SSS should state this in a SER. An APS referral for Self-Neglect should be made and a referral to the ALTSA escalation pathway should be made. A guardianship may need to be considered for establishment of a formal decision maker for signing and consent purposes. An email may be sent to ALTSAAcuteHospitalGuardianshipCaseStaffing@dshs.wa.gov

If the client does not appear to have capacity and there is a DPOA or guardian in place, all documents should be signed by the client's decision maker and noted in a SER that the information was discussed with both the client and the client's decision maker while identifying the decision maker in the Collateral Contacts screen.

Provider Signature(s)

1. SSS/CMs must obtain signatures on the CARE Service Summary from all providers who are authorized to provide personal care, at the earlier date of 90 days from the assessment *completion* date or before case transfer. The following personal care service provider types must sign the CARE Service Summary that is in Current status when the provider is added to the plan of care:
    - Consumer Directed Employer
    - Home Care Agency
    - Adult Family Home
    - Assisted Living Facilities
    - Enhanced Services Facilities
2. SSS/CM must also obtain the provider's signature when there is a change in their task assignment. For changes in providers during the plan period, SSS/CMs should obtain signatures at the earlier date of 90 days from the *authorization start date* or before case transfer.
3. Plans of care must continue to be sent to the provider prior to authorizing services.
4. All providers listed in #1 of this section are required to sign the Service Summary of the plan of care as required by CFR. Providers must return the signed Service Summary to the SSS/CM as soon as possible, using a method that protects the client's protected health information (e.g. secure email, fax, mail etc.).

More about signatures

1. When the ONLY change to a client's care plan is a change of a paid or unpaid provider:
    a. A new assessment may not be required

b. A new client signature is not required
c. A personal care provider signature may be required if there is a change in the paid task assignment
d. The Service Summary in CARE must be updated and the updated version filed in the client's electronic case record (ECR) via the HCS Imaging Unit (HIU). If the changes made do not require a signature, on the signature line, write "signature not required".
e. Print/send the Service Summary to the client and the provider and document the client's request and consent for these changes in the SER.

2. Client and provider signatures must be obtained on Current assessments only. Signatures on plans of care that are in *Pending* or *History* are not valid approvals of the plan of care.
3. Obtain all required signatures prior to transferring a client's case to another office.
   There may be extenuating circumstances which prevent the SSS/CM from obtaining required signatures. In these rare situations, the local office must exhaust and document person centered approaches to obtain the required signatures and then discuss the matter with the receiving office directly, before transferring the case.
4. If there is more than one provider in the plan, it is acceptable to have the provider(s) sign in the blank space below the signature lines if they are signing the same copy.
5. Although it is ideal for all required signatures to be on one document, or as few documents as possible for the purposes of records management in the HIU, obtaining all required signatures is the most important priority. It is acceptable to have required signatures on separate Service Summaries stored in the HIU. If the complete Service Summary is sent to HIU prior to obtaining client and provider signatures and then the client or provider subsequently returns the signature page, staff do not need to send the entire Service Summary to HIU again. In this scenario only the additional signature pages would need to be uploaded to HIU.
6. Signatures may be in any format (e.g. written, electronic, stamp, typed, etc.) that denotes the signatory agrees to the plan of care. Signature means at least the signatory's first and last name, but the CFR does not require a date or title. See instructions in the Attachments section on using electronic signatures. Obtaining an electronic signature in the client's residence has many advantages including:
   - reduced or no ongoing tracking required
   - in-person, person-centered review of the assessment with the client and/or provider to enhance understanding of the contents
7. Staff using the DSHS network can upload signed Service Summaries to HIU electronically and the document will be visible in the ECR within 24 hours. Local HCS and AAA offices will need to develop methods for monitoring and measuring the outcomes of the client and provider signature policy.

Assessment Completion Timeframes

For all assessment types, the assessment must be moved to Current status by the 30th calendar day from the date the assessment was created in CARE.

If an assessment cannot be moved to Current within 30 days of the date it was created, document the reason in the SER. The Plan Period end date will automatically calculate using the last day of the month that the in-person assessment occurred. For example, if an assessment was created on 1/20/2022 and was moved to Current on 3/4/2022, 1/31/2023 will be automatically calculated as the Plan Period end date on the *Assessment Main* screen.

For Initial and Initial/Reapply assessments, CARE will require a delay reason be selected when the assessment is moved to Current after the 30th day.

These delay reason codes will be used in assessment timeliness reports and by ALTSA HQ to identify justifiable reasons that assessment completion may be delayed. When evaluating timeliness in reporting for ALTSA's strategic measure, delay reasons will be considered.

CARE Delay Reason Codes for Initial and Initial/Reapply Assessments		
Code	**Description**	**Examples**
CR	Client specific reason/request	• Difficulty reaching client for verbal approval after multiple attempts • Client changing mind about desired care plan • Client requesting more time
FE	Financial eligibility	• Financial eligibility not yet determined and fast track is not an option
DO	Awaiting documentation	• Awaiting medical records and/or treatment documents to complete assessment
IP	Individual provider	• Unable to identify qualified IP • Awaiting completion of IP hiring process through CDE
AP	Home Care Agency provider	• Awaiting homecare agency staffing
RP	Residential provider	• Difficulty locating and securing move to a residential setting
TH	Temporary hospitalization/SNF admit	• The client was temporarily admitted to a hospital or SNF and you are awaiting transition planning and/or plan approval.
NR	No other reason	• No other applicable reason noted here for assessment remaining in pending status

Significant Change Assessment by a Nurse

A nurse may conduct a home visit or consultation when a critical indicator or Skin Observation Protocol is triggered. Nurses will document concerns and recommendations via CARE > Nurse Comments, or a paper form, if they do not have access to CARE.

If the case is referred to the nurse and the assessment is in:

Pending status: the nurse can complete any screen using the original look-back periods for assessment data. The nurse would then consult with the CM/SSS regarding the assessment and/or recommendations.

Current status: The CM/SSS must decide who should initiate the pending assessment. If:

- The nurse creates a pending Significant Change assessment and completes applicable screens, after consulting with the nurse, the CM/SSS can complete the remaining screens with a client visit.
- The CM/SSS will create a pending assessment, initiate the assessment, then refer to the nurse for a visit and completion of the appropriate screens.
- Regardless of the nurse's changes, the CM/SSS is responsible for moving the assessment from *Pending* to *Current* status.
- If the nurse wants a record of their changes, the nurse may print out the pending assessment after making changes or adding new information before returning the case to the CM/SSS.

Significant Change Request by an Adult Family Home (AFH)

When a written request from an AFH provider demonstrates that there has been a change in a client's condition that warrants a Significant Change assessment, the Department must complete the assessment within thirty (30) ***calendar*** days of receipt of a fully completed Form 15-558 (AFH Resident Significant Change Assessment Request) and updated Negotiated Care Plan.

An AFH provider may request a significant change assessment by:

- Completing DSHS 15-558 *Adult Family Home Resident Significant Change Assessment Request* by providing complete and detailed information about the resulting change in the client's condition and the care provided*;*
- Updating the Negotiated Care Plan with the changes noted; **and**
- Submitting the *Adult Family Home Resident Significant Change Assessment Request* **and** the updated Negotiated Care Plan to the Case Manager.

When the CM/SSS receives the written request and updated Negotiated Care Plan, the CM/SSS must:

- Review the request to determine if the changes meet the criteria of a Significant Change as defined in WAC 388-76-10000.
- If the request does not meet the criteria in WAC, document the reason(s) in a SER and notify the AFH provider.
- If the request is not complete or lacks sufficient detail to determine if a Significant Change Assessment is warranted, the SSS/CRM will contact the AFH provider and request additional information.

- The SSS/CRM will enter a Service Episode Record (SER) when the request is received and for each interaction with the provider to obtain the information needed.
- When all required information has been received, the SSS/CRM will use the *AFH Sig Change Request* SER Purpose Code in CARE and enter the date the complete written request was received. (CARE will then generate a tickler to send reminders on the 20th and 27th calendar day from the written request date to complete the assessment and move it to current.)
- Complete the significant change assessment and move it to current no later than 30 calendar days from the date the complete written request was received.

If the assessment results in an increase to the daily rate and the 30-calendar day timeframe is exceeded, the AFH provider may request a review by the department. If the AFH provider requests a review, the Field Services Administrator (FSA) or designee will:

- Review the assessment to determine if it was not completed within 30 calendar days due to department error, and
- If due to department error, instruct the CM/SSS to authorize the increase to the daily rate starting on the 31st calendar day from the date of the *complete* written request.
- Keep a record of the number of reviews completed and the results of each review.

Authorization of Services

Prior to authorizing payment for any long-term service or support, the following must be completed:

1. Program Eligibility - the CM/SSS has determined financial eligibility and functional program eligibility as determined by a *Current* CARE assessment
2. The client has chosen the program/services from which they are eligible:
   - All services (paid through ALTSA or not) must be indicated on the plan of care
   - Do not delay implementation of other identified services for which the client is eligible as indicated by their Current assessment, if a personal care provider has not yet been identified. For example, community transition items may need to be purchased or the authorization of a Community Choice Guide (CCG) to assist with hiring a caregiver
3. The client has approved the plan of care and given consent for services
4. The client has chosen a qualified provider(s)
5. Qualified provider(s) are selected from the ProviderOne database in CARE > *Supports* screen
6. Tasks are assigned to qualified provider(s) in CARE > *Supports* screen; and
7. Verification of any client responsibility and/or room & board
8. Complete all authorizations in CARE. See Social Service Authorization Manual (SSAM) for detailed instructions on authorization of services.

9. Complete electronic form DSHS 14-443 in Barcode. A 14-443 should only be sent for a MAGI client when they need to be transitioned to S02 and are losing MAGI coverage.

Payment for most services cannot occur while the client is an institutional setting (hospital, nursing facility or jail). State-only exceptions may exist. See policy chapter for specific service in question. Payment authorizations for personal care services must be adjusted or ended during the time client is in an institutional setting.

When do I transfer the case?

Transfer the active case to the appropriate AAA office or HCS residential SSS when the assessment has been moved to *Current*, SSS/CM has confirmed that at minimum one paid service is authorized, and you have a signed/dated Service Summary returned from the client. Refer to Transfer Protocol in Chapter 5.

When do I move an assessment to Current?

Move the assessment to *Current* status:

- After the client has provided verbal plan approval (consented) to the services identified in the assessment and plan of care; and
- Prior to sending a Planned Action Notice for services.

When do I move an assessment to History?

- The assessment will automatically be moved to *History* once a newly created/pending assessment is moved to *Current*.
- You may manually move an assessment into *History:*
  - When the client is no longer receiving services due to ineligibility;
  - When the client declined services;
  - Before sending the Planned Action Notice, if the client has requested an Administrative Hearing, after being found functionally ineligible; or
  - When a *Pending* assessment has been created and is no longer valid or cannot be completed, due to reasons such as the client moves out of state, declines assessment, etc. Document the reason in *Reason for assessment on the Assessment Main screen* and/or via a SER note.

Exception to Rule (ETR) Process

Before authorizing any exceptions to rule (ETR), you will need to get local or headquarters (HQ) approval, depending on the type of request.

Local ETRs

The local, regional/AAA level must review and render decisions for the following ETR requests where services/rate exceeds program limits *before* they can be authorized:

- The maximum allowed for environmental modifications;
- The maximum allowed for specialized medical equipment and supplies;
- The rate for COPES transportation services;
- The maximum units allowed for COPES client training;
- The maximum units allowed for Community Choice Guide (CCG);
- The maximum allowed for COPES Community Support: Goods and Services;
- The maximum allowed for Community Transition and Sustainability Service (CTSS); or
- Requests to exceed Residential Social Leave.

For HCS/AAA: At a minimum, a Field Approver must render a decision on a local ETR request. Field Review is optional based on local agency policy.

HQ ETRs

HQ must review and render decisions for the following ETR requests before they can be authorized:

- Any requests to authorize personal care services beyond the maximum hours/budget/daily rate generated by CARE. A new request must be submitted for each subsequent Annual, Significant Change or Initial Re/Apply assessment.
- Any request to authorize a combination of personal care, home-delivered meals (including Older American's Act), and/or Adult Day Care services beyond the maximum number of hours or daily rate generated by CARE.
- COPES skilled nursing services requests. See Chapter 7d for information about when an ETR is required.
- All requests related to CHORE such as requests to pay a spouse provider an amount in excess of Medical Care Services (MCS), requests to exceed program maximum hours/month of 116, and requests to remain on the program in order to keep spouse provider when client becomes financially eligible for MPC or CFC.
- PDN requests that exceed 16 hours/day of PDN services.
- PDN requests to authorize PDN and in-home personal care that, in total, exceed the maximum hours generated by CARE.
- CFC Community Transition Services (CTS) requests that exceed the limit.
- CFC Assistive Technology (AT) and/or Skills Acquisition Training (SAT) purchases/services in excess of the CFC state fiscal year (SFY) annual limit.
- All bathroom equipment authorized using SA875 (excludes urinals, transfer poles and handheld showers which are authorized using SA421). See *Bathroom Equipment ETR training* found here.

- Lift Chairs when furniture portion exceeds rate maximum of $1800 (typically necessary solely for double or triple width chairs). See *Service Code Data Sheet* for SA419 for more information.
- Durable Medical Equipment (DME) for the following situations:
  - An item is covered by insurance, but the client does not meet the medical criteria for the item to be paid for by insurance (example: client *needs* a heavy-duty hospital bed to live successfully in a community setting but does not meet the weight criteria for coverage by medical insurance).
  - The item is never covered by insurance, but it may be *necessary* for a client to live successfully in the community [example: fully electric bed is *needed (*not just for convenience), but insurance only covers a semi-electric bed].

Personal care ETRs are always attached to a specific assessment. When an assessment is moved to history, any attached ETR automatically moves to history; however, Interim assessments do not move an ETR to history. The ETR will attach itself to the new Interim assessment. If the Interim assessment did not result in a change in classification, in-home hours, or residential rate, you may rely on the current ETR until its end date. If the Interim assessment changed the classification, in-home hours, or residential daily rate, then it must be resubmitted to HQ for review.

Who can request a personal care ETR?

A client may request an ETR or a CM/SSS/CRM may request an ETR on the client's behalf. After a review by the local office, the ETR committee at HQ makes the final decision and takes into consideration the following:

1. The exception would not contradict a specific provision of federal law or state statute; and
2. The client's situation differs from the majority; and
3. It is in the interest of overall economy and the client's welfare; and either
   a. It increases opportunities for the client to function effectively; or
   b. A client has impairment or limitation that significantly interferes with the usual procedures required to determine eligibility and payment and/or the client is at serious risk of institutionalization.

In-Home Client Request

1. If a client requests additional in-home personal care hours/budget above the CARE generated amount, the CM/SSS/CRM must have a conversation with the client and/or client representative to discuss the request and to identify how the frequency and duration of the assistance with personal care tasks differs from the majority. CM/SSS/CRM will use their professional judgment to determine if an ETR is appropriate or provide case management services to see if other options are more appropriate (e.g., using split shifts to maximize coverage when appropriate, informal supports, or other waiver and/or CFC options such as Home Delivered Meals, Adult Day Health, Adult Day Care, PERS, Assistive Technology, etc.)

2. If the client's initial request for an ETR is denied at the field level either verbally by the CM/SSS/CRM or in CARE by the Field Reviewer, a Notice of Decision on Request for an In-Home Personal Care Exception to Rule (DSHS Form 15-429) via CARE > *Notices* screen, must be sent to the client. Clients do not have administrative hearing rights for initial ETR request decisions. If the ETR request is denied at the field level the client may request a review by the HQ ETR committee. The client may ask for a review by contacting the CM/SSS/CRM or by writing the ETR committee directly. These instructions are indicated on the 15-429 form mailed to the client. CM/SSS/CRM will submit the requests for HQ review through CARE using the standard ETR Categories and Types and indicate the client's request by checking the *Client requested ETR HQ review* checkbox. **Only use this checkbox if the initial request was denied locally and the client has requested a review by HQ**.

3. **If the client directly contacts the ETR committee at HQ requesting review of an initially denied ETR, the ETR Program Coordinator will**:
   - Notify the field reviewer, field approver, or supervisor of the client's assigned office of the request for review; and
   - Forward any communication sent to the ETR committee by the client/client representative to the field office.

   The field office will:
   - Contact the client regarding the client's request for review if the communication received by the client contains new or additional information that was not reported in the initial request.
   - Submit a new ETR request to the HQ ETR Committee through CARE using the standard ETR Categories and Types and indicate the client's request by checking the *Client requested ETR HQ review* checkbox.

4. The HQ ETR committee will make an individualized determination to approve, partially approve or deny the ETR request based on WAC 388-440-0001.

What is the process for submitting an ETR request to the HQ ETR Committee?

ETR Requests for in-home clients

1. **For In-Home Personal Care ETRs**

   Create an ETR within CARE utilizing the appropriate Category and Type for all ETRs. See the ETR chart for types and approval authority. To complete the ETR request in CARE:

   a. Use the *Date Range* dropdown to select either Plan Period or Custom. Use custom only for short-term or time specific requests.

   b. Use the *Hours* field to indicate the number of ADDITIONAL hours requested above the CARE generated hours.

   c. In the *Request Description* tab, note the CARE-generated personal care hours, the additional amount requested by the assessor or client, and the proposed schedule.

Include any specific information about how personal care needs are addressed by formal and informal supports and any gaps in service you are proposing to address through the ETR request.

d. In the *Justification for Request* tab, list the clinical characteristics and outline the specific personal care tasks performed that support the request. This information should describe how the client's situation differs from the majority.

e. In the *Alternatives Explored* tab, detail other options that have been attempted or explored (e.g., split shifts, community supports, waiver and/or CFC services, etc.)

f. Process for Field Review or Field Approval depending on local office policy. The ETR must have Field Approval before processing to HQ.

g. HQ will review and finalize Personal Care ETR requests within 7 business days of receipt.

h. HQ will review and finalize Personal Care ETR requests within 3 business days when the processing comments of the request indicate the client is awaiting discharge from an Acute Care Hospital.

i. Once the ETR decision has been finalized the primary CM will receive notification via a CARE tickler. The CM must review the ETR outcome decision to confirm whether the request was approved, partially approved, or denied and to confirm the begin/end dates of an approved ETR as the dates may be something other than "plan period".

When an ETR request has been approved for the plan period, the ETR Committee Decision Date is always the effective date of the ETR and the effective date of the authorization of payment.

2. **For initial personal care ETR requests that are:**

   a. **Approved/Partially Approved**, include the additional hours via CARE > *Care Plan* screen > *Personal care adjustments* > *HQ Approved Personal Care ETR*. This will result in the adjustment to total hours to print on the client's Service Summary, to send to the client for signature. Authorize CARE generated benefit and approved ETR amount in the payment system (see *Authorizing Personal Care ETRs in CARE* section below).

   b. **Approved/Partially Approved, or Denied**, send a Notice of Decision on Request for an In-Home Personal Care Exception to Rule (DSHS Form 15-429) via CARE > *Notices* screen, to the client. Clients do not have administrative hearing rights for initial ETR request decisions.

3. **For ETR requests that were approved in the previous plan period, or are being requested to extend a custom date range:**

   a. **Approved/Partially Approved, denied, reduced, or terminated**, note any approved hours via CARE > *Care Plan* screen > *Personal care adjustments* > *HQ Approved Personal Care ETR*. This will result in the adjustment to total hours to print on the client's Service Summary, to send to the client for signature. Send a services PAN to the client indicating the approval, denial, or reduction in hours. The client has an administrative

hearing right for ETRs authorized in the plan period that immediately precedes the new ETR request. Authorize CARE generated benefit and approved ETR amount in the payment system (see *Authorizing Personal Care ETRs in CARE* section below).

Example:

- A client's 2022 CARE assessment resulted in 158 hours of personal care. The CM submitted an ETR request for 100 additional hours and it was approved. The total number of hours approved and authorized in 2022 was 258 hours. This client's 2023 CARE assessment also resulted in 158 hours, and the CM submitted an ETR request for 125 additional hours. If the ETR request is partially approved for 100 hours, the total number of hours for which the client is eligible is still 258. Send a services PAN for the 258 hours. Send a **Notice of Decision on Request for an In-Home Personal Care Exception to Rule** (in CARE > Notices screen**)** for the additional 25 hours that was requested but not approved.

4. **When a client's total in-home personal care hours/budget including an ETR are reduced or terminated, send a PAN to the client.**

   Example:

   A client's 2022 CARE assessment resulted in 158 hours of personal care. The CM submitted an ETR request for 100 additional hours and it was approved. The total number of hours approved and authorized in 2022 was 258 hours. This client's 2023 CARE assessment resulted in 115 hours and the CM submitted an ETR request for 100 hours that was approved. The total number of hours for which the client is eligible is 215. Send a services PAN indicating a reduction from 258 hours to 215 hours.

5. If an ETR was approved and authorized in the plan period preceding a new request and the new ETR requests personal care hours/budget above the amount of the previous ETR request, the additional amount is considered an initial request. Based on the decision for the additional amount by the ETR committee, follow the policy above for initial requests.

ETR requests for residential clients

An Exception to Rule to the published daily rate of a residential setting may be appropriate in situations where a client may have exceptional needs that differ from the majority and meet additional criteria as described in WAC 388-440-0001. ETRs are reviewed and decided based upon individualized needs for assistance with personal care or skilled care, how those differ from the majority of clients in the same classification group, and any specific information provided by the Social Service Specialist and the provider.

Except for specific rates bargained in the Collective Bargaining Agreement (CBA) and relevant Memorandums of Understanding (MOUs), there is no standard rate (hourly or daily) used in determining the amount of an ETR. Unless specific rates are called out in the CBA, do not

communicate that there are standard methodologies or rates used in the ETR process as it conflicts with the intent of ETRs.

The focus of conversations about whether a provider will admit a client should be based upon the needs of the client as documented in the assessment and plan of care. Similarly, any conversation around an ETR with a provider should focus on the personal care needs of the client and, how those needs differ from the majority.

ETR approvals are at the sole discretion of the department and are reviewed based upon the individualized circumstances presented. It is an expectation that when an ETR is submitted by an SSS/NCC that they understand and can articulate why the request is being made. If the SSS/NCC does not agree that an ETR is necessary, the request can and should be denied at the local level. AFH providers can request that an ETR be reviewed by the HQ ETR committee when it is not initiated by the local office.

Because AFHs are authorized using a daily rate, when an ETR is requested, the daily amount being requested must be identified. The ETR Committee will review, considering the individualized needs of each client, and make a final determination based on the assessment, plan of care, and the ETR documentation. The amount approved by the ETR Committee will be added to the CARE generated daily rate based on the conclusion that the client's needs look different from the majority of others in the same classification group. Per WAC 388-76-10195, it is the responsibility of the AFH to ensure enough staff are available in the home to meet the needs of each resident. Unless required under a specialized contract, it is not the responsibility of HCS to determine staffing levels. The needs of the individual should be clearly documented in the assessment and plan of care.

AFH provider notices about ETR requests:
The Adult Family Home Council Collective Bargaining Agreement (CBA) requires the state to provide a written notice to an AFH provider who's current or referred client's level of care is being considered through the ETR process during the initial discussion with an AFH provider.

Provider notices will only be sent electronically, and be in the form of postcards, which must be provided to the AFH provider(s) by field staff during initial discussion with an AFH provider of a potential ETR request for current or referred client.

For residential personal care ETRs:

1. Use the *Date Range* dropdown to select either Plan Period or Custom. Use custom only for short-term or time specific requests.
2. Use the *Rate* field to indicate the ADDITIONAL rate requested above the CARE generated rate.
3. In the *Request Description* tab, note the CARE Classification and daily rate generated by CARE (including any add-on outside of CARE e.g., SBS or ECS) and the additional amount requested by the assessor.

4. In the *Justification for Request* tab, list the clinical characteristics and outline the specific personal care tasks performed that support the request. This information should describe how the client's situation differs from the majority.
5. In the *Alternatives Explored* tab, detail other options that have been attempted or explored (e.g. assistive devices that have been considered or utilized, community and behavior supports, waiver and CFC services, etc.).
6. Process for Field Review or Field Approval depending on local office policy. The ETR must have Field Approval before processing to HQ.
7. HQ will review and finalize residential personal care ETR requests within 7 business days of receipt.
8. HQ will review and finalize Personal Care ETR requests within 3 business days when the processing comments of the request indicate the client is awaiting discharge from an Acute Care Hospital.
9. Once the ETR has been finalized, the primary CM will receive notification via the CARE tickler. It is important to review the ETR outcome decision to confirm if the request was approved, partially approved, or denied, and to confirm the start/end dates of the approved ETR, as they may be something other than "plan period."

    a. For initial residential personal care ETR requests that are:

        i. **Approved/Partially Approved**, note the additional rate on the Service Summary, initial and date, and send to the client for signature. Authorize CARE generated benefit and approved ETR amount in the payment system (see *Authorizing Personal Care ETRs in CARE* section below).

        ii. **Initiated, Not initiated, Approved, or Denied**, send a Notice of Action Exception to Rule (CARE > Notices screen) to the client. For Adult Family Home requests, use Notice of Action Exception to Rule for AFH Daily Rates (CARE > Notices screen), and send a copy of this completed form to the client and the AFH provider. For all other residential settings, (e.g., Assisted Living, Adult Residential Facility, etc.) use Notice of Action Exception to Rule (excluding AFH, via the CARE > Notices screen). If the ETR is approved or partially approved, include, and confirm in CARE, the approved time period. The start date must not be prior to the HQ ETR Committee decision date. The end date cannot exceed the end date of the plan period. Clients do not have administrative hearing rights for initial ETR request decisions.

    b. For residential ETR requests that were approved in the previous plan period or are being requested to extend a custom date range:

        1. **Approved/Partially approved, reduced, or terminated,** note any approved rate on the Service Summary, initial and date, and send to the client for signature. Send a services PAN to the client indicating the approval, denial, or reduction in rate. The client has an administrative hearing right for ETRs authorized in the plan that precede the new request. Authorize CARE generated benefit and approved ETR

amount in the payment system (see *Authorizing Personal Care ETRs in CARE* section below).

d. If an ETR was approved and authorized in the plan period preceding a new request and the new ETR requests personal care rate above the amount of the previous ETR request, the additional amount is considered an initial request. Based on the decision for the additional amount by the ETR committee, follow the policy above for initial requests.

NOTE for all in-home and residential personal CARE ETR decisions: If an ETR request was approved/partially approved for hours/budget/rate and the CM makes a change that effects the classification or the hours/budget/rate, the CM must submit a new request if it is still warranted.

WHAT NOTICE TO USE FOR ETR REQUESTS AND DECISIONS

ETR Request Types	Planned Action Notice Should Include:	-In-Home ONLY- Notice of Decision for ETR (15-429)	-AFH ONLY - Notice of Action ETR AFH (05-256)	-AL/ARC/EARC ONLY - Notice of Action ETR (05-246)
ETR rate/hours are requested for the first time *Client did not have this ETR in the preceding plan period.*	Only CARE generated rate/hours	Based on setting, use appropriate Notice of Decision/Action Form through CARE > Notices screen, to communicate the outcome of the initial ETR request.		
ETR continuation requested and approved *Client had the same ETR in the preceding plan period.*	Combine CARE generated rate/hours + ETR rate/hours	Do not use Notice of Decision/Action.		
ETR continuation AND an additional amount requested *Client had some of the ETR rate/hours in the proceeding plan period, but more is requested this time.*	CARE generated rate/hours + only ETR rate/hours that were approved in the preceding plan period	Based on setting, use appropriate Notice of Decision/Action Form through CARE > Notices screen, to communicate the outcome of the NEWLY requested amount.		
ETR continuation requested but denied. *Client had the same ETR rate/hours in the preceding plan period, but the request was denied this time.*	Communicate this information as part of the PAN whether the total rate/hours increased, decreased, or stayed the same.	Do not use Notice of Decision/Action.		

HCS/AAA Complaint Procedure

When a client does not have an administrative hearing right on an initial ETR decision, they have the right to make a complaint to the Department. Complaints related to initial ETR decisions made at the field level (e.g., COPES waiver services such as environmental modifications, specialized medical equipment, client training, etc.) will be reviewed as follows:

For local Initial ETR decisions made by HCS:

1. The client may make a complaint in writing to the Field Services Administrator (FSA). The FSA will make a decision about the complaint within ten days of the date it was received, send a letter informing the client of the decision, and that the decision may be reviewed by the Regional Administrator (RA) at the client's request.
2. If the client makes a written request asking the RA to review the FSA's decision, the RA will make a decision about the complaint within ten days of the date it was received and send a letter informing the client of the final decision.

For local Initial ETR decisions made by AAA:

1. The client may make a complaint in writing to the AAA Case Management Director/Program Manager. The AAA Case Management Director/Program Manager will make a decision about the complaint within ten days of the date it was received, send a letter informing the client of the decision, and that the decision may be reviewed by the AAA Director at the client's request.
2. If the client makes a written request asking the AAA Director to review the Program Manager's decision, the AAA Director will make a decision about the complaint within ten days of the date it was received and send a letter informing the client of the final decision.

For Initial ETR decisions made by Headquarters:

1. The client may make a complaint in writing to the HCS State Unit on Aging (SUA) Office Chief. The Office Chief will make a decision about the written complaint within ten days of the date it was received, send a letter informing the client of the decision, and that the decision may be reviewed by the HCS Director at the client's request.
2. If the client makes a written request asking the HCS Director to review the Office Chief's decision, the Director will make a decision about the complaint within ten days of the date it was received and send a letter informing the client of the final decision.

When responding to a complaint it is important to address, at a minimum, the specific concern perceived by the client and explain how all the information was reviewed (such as the CARE assessment, any additional information provided in the complaint, or information from other relevant sources) to make a decision. The CM/SSS may want to discuss the care plan with the client to identify service gaps that may be addressed using other available resources. ***If you must respond to a complaint that relates to an initial denial of a personal care ETR, please consult with the HCS CARE Program Manager.***

Authorizing Personal Care ETRs in CARE

When an ETR is approved for the Plan Period:

Authorize the total amount (CARE-generated hours/rate generated + the approved ETR amount) on one service line.

1. Authorization start date: the begin date on the authorization service line must match the ETR Committee Decision Date. ETR approvals cannot be backdated. The authorization start date must never be prior to the ETR Committee Decision Date.

2. Authorization end date: the end date on the authorization service line must match the plan period end date, via CARE Assessment Main Screen > Plan Period > End Date.

When an ETR is approved for a custom date range:

Authorize the total amount (CARE-generated hours/rate generated + the approved ETR amount) on one service line.

1. Authorization start date: the begin date on the authorization service line must match the Custom Start Date on the ETR screen entered by the ETR Committee. ETR approvals cannot be backdated. The authorization start date must never be prior to the ETR Committee Decision Date.
2. Authorization end date: the end date on the service line must match the Custom End Date in the ETR decision screen. **You may not extend the end date without approval of a new ETR request by the ETR Committee at Headquarters.**

When the MCO funds BHWS or CBHS for an in-home or residential client:

For information and instructions on MCO Behavioral Health Wraparound Support (BHWS) for in-home clients or Community Behavioral Health Support (CBHS) services for residential clients, please see LTC Chapter 22a.

Termination of Services

Terminate services when:

- The client is no longer financially eligible.
- The client is no longer functionally eligible based on their CARE assessment.
- A client chooses to decline *all* services for which they are eligible. Consider that many clients have other services in addition to personal care.
- The *Challenging Cases Protocol* (see Chapter 5) has been exhausted.
- The client is deceased. When the client had been receiving services through MPC or was eligible through MAGI, send Condolence Termination Letter (DSHS Form #07-099) to the client's representative/estate.
    - If you are an SSS/CM/CRM inside the DSHS firewall, you may access the Condolence Termination Letter via Forms Picker: DSHS Form #07-099
    - For public access (or you are an CM outside the DSHS firewall), you may access via imaged icon below:

DSHS Form #07-099

Steps to take when a client no longer meets program eligibility:

- Termination Planning (See Chapter 5 > *Goals / Functions* section)
- A Planned Action Notice (in CARE) is required anytime there is an approval, increase, denial, reduction, or termination of a service (see Chapter 5).

- Notify the Public Benefits Specialist (PBS) of a client's ineligibility using form 14-443 in Barcode (except for MAGI clients whose cases are not handled by PBSs). The PBS will determine Medicaid financial eligibility for other programs.

Note: MPC and CFC clients receiving SSI would continue to receive a Medicaid Services Card for Apple Health regardless of the receipt of personal care services.

RESOURCES

Related WACs and RCWs

42 CFR 441.540(b)(9)	Person-centered Service Plan
RCW 7.70.065	Informed consent—Persons authorized to provide for patients who are not competent *This RCW applies in hospital and SNF settings only.
RCW 74.39A.525	Overtime Criteria
RCW 74.39.050	Individuals with functional disabilities-Self-directed Care
WAC 388-106-0010	What definitions apply to this chapter?
WAC 388-106-0050	What is an assessment?
WAC 388-106-0055	What is the purpose of an assessment?
WAC 388-106-0060	Who must perform the assessment?
WAC 388-106-0065	What is the process for conducting an assessment?
WAC 388-106-0070	Will I be assessed in CARE?
WAC 388-106-0075	How is my need for personal care services assessed in CARE?
WAC 388-106-0080 TO 0145	CARE Classifications
WAC 388-472-0020	How does the department decide if I am eligible for NSA services?
WAC 388-115-05640	Self-directed care — Who must direct self-directed care?
WAC 388-440	Exception to Rule
WAC 388-472-0020	Necessary Supplemental Accommodations

Acronyms

A complete list of WA. State DSHS acronyms can be found here.

AAA	Area Agency on Aging	IADL	Instrumental Activities of Daily Living
ACP	Address Confidentiality Program	IP	Individual Provider
ACRS	Asian Counseling and Referral Service	LEP	Limited English Proficient
ADA	Americans with Disabilities Act	LTSS	Long-Term Services and Supports

ADL	Activities of daily living	MCO	Managed Care Organization
AFH	Adult Family Home	MMSE	Mini-Mental State Examination
AH	Apple Health (Medicaid)	MPC	Medicaid Personal Care
ALF	Assisted Living Facility	NCC	Nurse Care Consultant
ALTSA	Aging and Long-Term Support Administration	NFLOC	Nursing Facility Level of Care
APS	Adult Protective Services	NGMA	Non-Grant Medical Assistance
ARC	Adult Residential Care	NSA	Necessary Supplemental Accommodations
AREP	Authorized Representative	NSA/CP	Negotiated Service Agreement/ Care Plan
AT	Assistive Technology	OAA	Older American's Act
CARE	Comprehensive Assessment Reporting Evaluation	P1	ProviderOne
CCG	Community Choice Guide	PAN	Planned Action Notice
CDE	Consumer Directed Employer	PBS	Public Benefits Specialist
CFC	Community First Choice	PCRC	Personal Care Results Comparison
CFR	Code of Federal Regulation	PCR	Personal Care Results
CISC	Chinese Information and Service Center	PDN	Private Duty Nursing
CM	Case manager	PERS	Personal Emergency Response Systems
CMS	Centers for Medicare and Medicaid Services	QA	Quality Assurance
COPES	Community Options Program Entry System	RA	Regional Administrator
CRM	Case Resource Manager (DDA)	RCL	Roads to Community Living
CTS	Community Transition Services	RCW	Revised Code of Washington
DDA	Developmental Disability Administration	RSW	Residential Support Waiver
DES	Department of Enterprise Services	SAT	Skills Acquisition Training
DME	Durable Medical Equipment	SBS	Specialized Behavior Support
DMS	Document Management System	SCSA	Senior Citizens Services Act
D/POA	Durable/Power of Attorney	SDC	Self-directed Care
DSHS	Department of Social and Health Services	SER	Service Episode Record
EARC	Enhanced Adult Residential Care	SES	Specialized Equipment and Supplies
ECR	Electronic Case Record	SNF	Skilled Nursing Facility
ECS	Expanded Community Services	SOP	Skin Observation Protocol
ESA	Economic Services Administration	SS	Social Services
ESF	Enhanced Services Facility	SSAM	Social Service Authorization Manual
ETR	Exception to Rule	SSN	Social Security Number
FSA	Field Services Administrator	SSS	Social service specialist
HCA	Health Care Authority	VDC	Veteran's Directed Care
HCS	Home and Community Services	WAC	Washington Administrative Code
HIU	HCS Imaging Unit	WWL	Work Week Limit
HQ	Headquarters		

REVISION HISTORY

Date	Made by	Change(s)	MB #
6/2020	Debbie Blackner	Added additional situations when an HQ ETR is required (bathroom equipment, lift chair that exceeds furniture maximum and when specific DME scenarios).	
6/2020	Debbie Blackner	Added COPES services CCG and Community Supports: Goods and Services to the Minimum Standards table	
6/2020	Debbie Blackner	Bed rail policy added	
6/2020	Rachelle Ames	Updated Case File Standards to include: • updated list of documents to be scanned to the ECR • removal of language related to paper files • update translated documents section to be consistent with Chapter 15	
6/2020	Rachelle Ames	Updated Timeframes table included in the "Adding a Client to CARE" section	
12/2020	Rachelle Ames	Removed incorrect RCW reference from "What to do when a client cannot sign" section	
12/2020	Rachelle Ames	Updated Minimum Standards "Supports screen" section to reflect current CARE functionality	
12/2020	Rachelle Ames	Removed "BHO" from MCO references to accurately reflect current terminology	
12/2020	Rachelle Ames	Updated "Forms/Brochures" table with updated DSHS 14-225 form instructions	H21-013
1/2021	Rachelle Ames	Updated procedure related to ETRs and Interim assessments to be consistent with updated CARE functionality	
1/2021	Rachelle Ames	Added clarification about consent form and who to contact with questions about privacy	
1/2021	Rachelle Ames	Updated "What notice to use…" in ETR Section	
3/2021	Rachelle Ames	Eliminated policy to assess shared benefit and added policy to include IP Informal Support Attestation	H21-002
9/2021	Rachelle Ames	Updated Minimum Standards table related to emergency plan to be consistent with CARE Web	
9/2021	Rachelle Ames	Added ETR FAQ Document attachments developed as part of an HCS statewide workgroup	
9/2021	Rachelle Ames	Added 72-hour ETR turnaround timeframe when client is in an acute care hospital	
9/2021	Rachelle Ames	Updated link to SDC publication	

Date	Made by	Change(s)	MB #
9/2021	Rachelle Ames	Updated reference to 14-443 and MAGI clients when the client is no longer MAGI	
9/2021	Rachelle Ames	Updated ETR Approval/Authority table to current field practice	
9/2021	Rachelle Ames	Updated how to document potential risk in the plan of care with updated CARE Web screen locations	
9/2021	Rachelle Ames	Clarified decision-making authority in "Getting Approval on the Plan of Care" section	
9/2021	Rachelle Ames	Updated Significant Change Request by an AFH section	H21-061
12/2021	Rachelle Ames	Updated "Brief" assessment type to "VDC" assessment type	H21-087 H21-047
12/2021	Rachelle Ames	Clarified "When to inactive a client record in CARE" section	
12/2021	Victoria Nuesca	Added updated "Care Planning Advocate" flow chart to "Attachments" section	H15-054
6/2022	Rachelle Ames	Edits related to IPs becoming employed by the CDE	H21-083 H22-027
9/2022	Victoria Nuesca	Updated language from provider to "caregiver" to not exclude IPs hired by CDWA	H15-054
9/2022	Rachelle Ames	Addition of Voice Signature option and Script Attachment	
5/2023	Dru Aubert	• Updated how to document the number of monthly hours the client is choosing not to utilize, and adjustments for waiver services and/or HQ approved personal care ETRs. • Updated the AAA CM or nurse completes VDC assessment types for participants in the VDC program.	H22-046
8/2023	Dru Aubert	• Updated Voice Signature attachment>FAQs in "Appendix" section. • Added timeframe Service Summary signatures must be obtained. • Updated "ETR requests for residential clients" section. • Added when to include the IP Informal Support Attestation form under "Special Considerations" section.	H21-002
12/2023	Dru Aubert	• Removed PACE from LTSS ETR Types and Approval Authority section. • Added assessment policy update to assess Adult Day Care (ADC) as Informal Support (WAC 388-106-0010). • Updated Voice Signature attachment>FAQs in "Appendix" section, related to HIU submission. • Specified DSHS contracted providers should be added to the written Consent Form (DDA-only).	H23-078

Date	Made by	Change(s)	MB #
2/2024	Dru Aubert	• Updated *Assessment Location Grid* to state hospital assessments need to be within 7 days from the date of referral. • Included Community Psychiatric Hospital Setting into *Timeframes* table • Updated Voice Signature attachment>FAQs in "Appendix" section. • Added combined *Notice of Consent of Communication via Text or Unencrypted Email* (DSHS Form 27-156).	
6/2024	Dru Aubert	Eliminated policy to assess IP as a source of informal support (SUBSTITUTE HOUSE BILL 1942) and retire DSHS Form 27-203 "Individual Provider (IP) Attestation of Informal Support".	H24-025 H21-002 *(amended 6/6/24)*
7/2024	Dru Aubert	• Updated "How and when do I distribute the plan of care to the provider(s)?" section to add hospital discharge planners (for those patients who are seeking Home and Community Based Services), Community Choice Guides, and Client Training Providers. • Clarified "More about signatures" section that a signature may be in any format that denotes the signatory agrees to the plan of care, including *typed*. • Removed duplicative "IP Overtime" section, that can be found in Chapter 11, Working with the Consumer Directed Employer. • Updated "Minimum Standards" section to describe the process and expectations of developing and completing a care plan, post assessment interview completion, to be used when transferring a case from one office to another. • Added to "Steps in performing a CARE Assessment" to include Community Behavioral Health Support (CBHS) Services/1915i (effective 7/2024). • Added 'Individuals on Hospice' to priority list of assessment eligibility.	
10/2024	Dru Aubert	• Updated *Forms and Brochures* section > *Consent Form* > *Information Included* section to clarify the most recently signed form by the client/representative replaces a previously signed form, and that clients must indicate what records are covered by the consent. • Added to "Steps in performing a CARE Assessment" to include screening for any relevant information that an assessor should be aware of prior to making a home visit.	H24-050

Date	Made by	Change(s)	MB #
		• Added clarity to linked DSHS forms to differentiate if the SSS/CM/CRM is inside the DSHS firewall, they may access some linked DSHS forms in chapter via Forms Picker, and for public access (or an CM outside the DSHS firewall), they may access via embedded icons, provided below the linked options throughout chapter. • Clarified "Getting Approval on the Plan of Care" that, if an individual's representative, is also the client's paid caregiver, that representative can sign the Service Summary on behalf of the client, however, another person must assist the client as their representative for the purpose of care planning. • To receive updates related to ACES.Online, Barcode, or Washington Connection (WACONN), social services and case management staff and Public Benefits Specialist and Regional financial program staff that use ACES.Online and/or Barcode should subscribe to IT Solutions topics available in GovDelivery.	

04/2025	Anna Mitchell	• Added policy related to Telephonic and Virtual assessments from MB H23-053.
		• Clarified "Getting Approval on the Plan of Care" related to utilizing a representative agent or guardian for approval and escalation pathways.
		• Updated information related to MCO funded ETRs.
		• Clarified 14-225 is required for clients on RCL.
		• Updated version of DSHS Privacy Practices to 03-387 which removes the signature page as it is not required.
		• Clarified policy related to the Consent form 14-012.
		  ○ Added reference to RCWs 70.02.230, 70.02.050 and 70.02.220.
		  ○ Added The 14-012 includes the following phrase on page 1: "DSHS may still share information about you to the extent allowed by law."	

APPENDIX

Bed Rail Policy

Bed rails (also called side rails or safety rails) are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of shapes and sizes. Full and half bed rails are covered by Apple Health (AH) with no prior authorization. Medicare does not pay for bed rails of any length.

One-quarter and one-eighth length bed rails are never covered by AH or Medicare. These are frequently referred to as mobility bars/rails, bed support handles, standing bars and bed canes. Some ¼ and ⅛ length bed rails were recalled in December 2021 (see MB H22-010).

Although bed rails have potential benefits for some individuals, potential risks of bed rails include:

- Strangulation, suffocation, bodily injury or death because an individual is caught between rails or between the bed rails and the mattress.
- Skin bruising, cuts, and scrapes.
- A higher risk of serious injuries from falls because sometimes individuals fall while trying to climb over bed rails. When that happens, the individual is often more seriously injured than if the person had fallen out of a bed without rails.
- Feeling agitated, isolated or unnecessarily restricted because the bed rails prevent individuals from moving freely.
- Loss of the ability to independently perform routine activities such as going to the bathroom or retrieving something from a closet because the individual is prevented from getting out of bed.

The use of any type of bed rail poses a potential safety risk regardless of care setting. The best way to prevent trapping or harming clients is to refrain from using bed rails and to encourage the use of safer alternatives. Bed rails must not be used as a restraint.

Bed rails are sometimes requested by a client who receives long-term services and supports (LTSS). At times, a new or reapplying client already has and uses a bed rail. The Bed Rail Policy must be followed in its entirety (Steps 1-10) for bed rails of any length in each of the following scenarios:

- For all DSHS clients receiving paid services in a community residential setting, including when:
  i. The residential provider will supply the bed rail.
  ii. When insurance will pay for the bed rail (such as Apple Health).
  iii. If the client is admitting to a residential setting with bed rails they already have/use, unless a bed rail evaluation (DSHS Form 13-906) is on file and there has not been a significant change in condition that impacts the client's ability to safely use the bed rail.
- When a bed rail will be purchased through a social services (SS) authorization, regardless of client's setting (residential or in-home).

A bed rail evaluation is recommended in all other situations, including when:

- Apple Health will pay for the bed rail for a client receiving LTSS in an in-home setting.
- The client has a completed bed rail evaluation (DSHS Form 13-906) in their electronic case record or file, but there has been a significant change in cognitive or physical condition that may impact the client's ability to safely use the bed rail.
- For new or reapplying in-home clients who already have and use a bed rail, unless a bed rail evaluation is on file and there has not been a significant change in condition that impacts the client's ability to safely use the bed rail.
- At a minimum, Steps 1 and 2 below should be completed and documented in a SER or a Progress Note in GetCare (MAC/TSOA).

Requests for New or Replacement Bed Rail of Any Length (including if an item has been recalled)

1. Provide the client a copy of the FDA brochure *"A Guide to Bed Safety"*. The brochure is focused on institutional settings, but the information applies to any home and community-based setting.
2. Discuss with the client, their representative (if applicable) and providers:
    a. The risks of entrapment, injury and death from bed rails per *"A Guide to Bed Safety*."
    b. Explain to the client and/or representative that there are alternatives to bed rails and that a specialist can help the client determine what alternatives are best through an individualized evaluation. Alternatives may include roll guards, foam bumpers, low beds, a trapeze or standing transfer poles. Other alternatives may be recommended as part of the evaluation.
    c. Document the date the bed rail discussion occurred with the client and representative (if applicable) and the requirement for the individualized bed rail evaluation in a SER in CARE or a Progress Note in GetCare.
    d. The client can choose not to participate in the evaluation; however, without a completed evaluation:
        i. A bed rail cannot be used in a residential setting for a DSHS LTSS client.
        ii. A SS authorization cannot be used to purchase a bed rail, regardless of size or service code used: SA878 (full or half-length bed rail) or SA421 (¼ or ⅛ length rails).
3. The client requests a referral from their primary care provider (PCP) for a bed rail evaluation from a physical therapist (PT) or occupational therapist (OT):
    a. The bed rail assessment is paid for by the client's AH medical plan. COPES Client Training cannot be authorized for this evaluation. Exception: if the client's item has been recalled and there is an emergent need.
    b. The client must be referred to a PT or OT that is in their AH provider network (managed care) or a provider with a Core Provider Agreement (fee for service).
    c. The therapist may be employed or contracted by agencies such as home health or outpatient therapy clinics. For a client transitioning from a skilled nursing facility, this could be a SNF therapist.
    d. Following established procedures, the therapist requests an expedited prior authorization (EPA) from the client's AH plan prior to completing the assessment.
    e. Step 3 is not necessary if:
        i. A SNF therapist will complete the assessment.
        ii. If the evaluation is performed in conjunction with another task the provider is authorized to complete, and the provider will not claim the AH procedure code for bed rail assessment (97165/modifier: GO).
4. The SSS/CM requests the therapist's contact information from either the PCP or client.
5. The SSS/CM completes Section 1 of DSHS form 13-906 and emails it to the therapist who will perform the assessment (note: Please make sure to use the most updated version).

6. The PT or OT:
    a. Completes the evaluation using generally accepted standards of practice and documents their recommendation(s) regarding the safe use of bed rails or alternative devices in Sections 2 and 3 on DSHS form 13-906 provided by the SSS/CM.
    b. Returns the completed form to the SSS/CM and sends a copy to the client's primary healthcare provider.
    c. If unsure the intent of the bed rail recommendation, the case worker should clarify the results with the OT/PT.
7. The CARE SSS/CM:
    a. Documents the results of the evaluation in the "Comments" section on the *Bed Mobility* screen.
    b. Discusses the results with the client, provider, and representative (if applicable).
    c. Provides the residential provider a copy of the form (if applicable).
    d. Submits the completed form with a Packet Cover Sheet - Social Services (DSHS Form 02-615) to HIU via Hotmail.
        - If you are an SSS/CM/CRM inside the DSHS firewall, you may access the Packet Cover Sheet - Social Services (DSHS Form 02-615) via Forms Picker: DSHS Form #02-615
        - For public access (or you are an CM outside the DSHS firewall), you may access via imaged icon below:

DSHS Form #02-615.docx

8. The GetCare SSS/CM:
    a. If unsure the intent of the bed rail recommendation, the SSS/CM should clarify the results with the OT/PT.
    b. Discusses the results with the client and provider(s).
    c. Documents the results of the evaluation and the discussion with the client and provider(s) in a Progress Note.
    d. Uploads the completed DSHS Form #13-906 into the client/care receiver's electronic file cabinet in GetCare.
9. Based on the results of the evaluation documented in the completed DSHS Form #13-906, and the informed decision by client and/or representative, complete one of the steps below.

    a. **Recommendation is an alternative device:** depending on the item, follow all established procedures for either AH durable medical equipment (DME) or specialized equipment and supplies (SES) to assist the client with obtaining the recommended item(s).

    b. **Recommendation is full or half-length bed rail(s):** client/vendor follows established AH DME procedures (with SSS/CM assisting, as necessary). Note:

        i. AH pays for one pair of full or half bed rails every 10 years *with no prior authorization*. The client provides a prescription from their healthcare provider to a DME provider who will dispense the bed rail.

ii. If a client has damaged their full or half bed rails or they have been lost before the 10-year limit has expired, the DME vendor should request a limitation extension (LE) from the client's AH plan.

iii. If the LE is denied and the client is enrolled in a LTSS program that includes DME, a SS authorization can be created in *Reviewing* status using blanket code **SA878**. Upon confirmation the client has received the item, the authorization is changed to *Approved* status and the DME vendor will be able to claim using the product's HCPCS in the SS medical portal in ProviderOne.

c. **Recommendation is one-fourth or one-eight length bed rail (also known as bed canes, mobility bars/rails, bed support handles, standing bars, and many other names):** a SS authorization is appropriate if client desires to use the item, and the client is enrolled in a program that includes SES.

- **Best Practice:** Utilize a *DME* vendor with the SES contract to authorize ¼ or ⅛ length bed rails. When requesting the quote, verify the item has not been recalled and that it meets the ASTM standard for adult portable bed rails.
- Create the authorization in Reviewing status using **SA421** after completing all other steps. Upon confirmation the client has received the item, the authorization is changed to Approved status and the DME vendor will be able to claim in the SS portal.

d. **Use of a bed rail is NOT recommended** due to concerns about the client's ability to safely use it:

i. If the client resides in (or is transitioning to) a residential setting, the client will not be able to use a bed rail, per policy. Alternative devices or equipment can be requested by the client, if recommended in the evaluation.

ii. If the client resides in (or is transitioning to) an in-home setting:

- If the bed rail is being paid for by the client's AH plan and the client/representative is making an informed decision based on the results of the evaluation, the client can request a prescription for a bed rail from the PCP and follow up with a DME vendor. Document informed decision in a CARE SER or GetCare Progress Note.
- A SS authorization cannot be used to purchase a bed rail, regardless of length.

10. If a client is not enrolled in Apple Health:

a. For clients enrolled in TSOA: if client's private insurance does not pay for the evaluation, TSOA funds can be used to pay for it.

b. If a full or half-length bed rail is recommended following the evaluation, a SS authorization can be created in *Reviewing* status using blanket code **SA878**. Upon confirmation the client has received the item, the authorization is changed to *Approved* status and the DME vendor will be able to claim using the product's HCPCS in the SS medical portal in P1.

c. If a one-fourth or one eighth length bed rail is recommended (also known as bed cane, mobility bar/rail, bed support handle, standing bar, and many other names), follow all instructions in 8.c. above.

Self-Directed Care

An adult with a functional disability living in their own home can direct and supervise a paid personal care aide (Individual Provider) to help with health care tasks that they cannot do without assistance because of their disability. Examples of Self-Directed Care (SDC) tasks include help with medications, injections, bowel programs, bladder catheterization, and wound care. Self-Directed Care under Chapter 74.39 RCW must be directed by an adult client for whom the health-related tasks are provided. The adult client is responsible to train the Individual Provider in the health-related tasks which the client self-directs.

For potential self-directed care (SDC) cases, you may refer to the Self-Directed Care Checklist (below) as a reminder of things to consider when doing an assessment. At the conclusion of the assessment process and plan development, obtain the client's signature of agreement to the plan.

Self-Directed Care Checklist

This checklist is not mandatory and does not need to be put in the client's file. The checklist is designed to help staff remember things they should consider in SDC cases and indicate what additional coordination is needed to assist the individual to self-direct their care.

Remember to ask the individual (client) and yourself these questions when assessing or reassessing a case:
1. Does the individual live in their own home (e.g., a residence that does not require licensure)? Self-directed care can only happen in a private home. Self-directed care (RCW 74.39.050) does not apply to clients living in licensed facilities.
2. Does the individual have an Individual Provider (IP) through the CDE under CFC, MPC, New Freedom or Chore programs? HCS/AAA/DDA clients who are presumed competent, receiving CFC, MPC or any waiver program, and live in a private, non-licensed home can legally self-direct an individual provider. • An IP can be a family member. • The IP cannot perform health care tasks for anyone else, only the person who has hired them to perform those tasks.
3. Does this individual have a functional disability that prevents them from performing a healthcare task for themselves? The individual must be over 18 years of age. The client could have a traumatic brain injury (TBI), mental health or developmental disability and self-direct if the disability does not prevent them from having the ability to explain the procedure and to

supervise the IP. There are varying degrees of function with every disability. The healthcare practitioner who prescribed the treatment or medication has the responsibility to ascertain if the individual understands the treatment or medication administration and can follow through on the SDC task.
4. Has the SSS/CM informed the individual of the SDC option at the time of Initial assessment and reassessment? The SDC publication should be given to clients who potentially could self-direct their care, no matter what setting they are in.
5. Does the individual have a legal guardian? (Only guardianships of the person limit personal decision-making. Guardianships of the estate only limit financial decision-making.) The individual self-directing is presumed competent. The health care practitioner who prescribed the treatment has the responsibility to ascertain if the person understands the treatment and can follow through on the SDC task just as they would when a person without a disability goes to the doctor and is given a prescribed treatment. No additional verification is needed.
6. Did the individual inform the prescribing health care practitioner of their intent to self-direct? Is the prescribing health care practitioner's name, address and telephone number documented in the CARE assessment?
7. Has the individual provided the SSS/CM with the source of the treatment order? The SSS/CM should document in the CARE assessment the source of the treatment information. Examples are directions from the client, prescription container/Rx script, written directions from the prescribing health care practitioner, protocols from a professional association or protocols from a rehabilitation facility or institution manual. An actual copy of the treatment order or written directions is not mandatory but may be helpful for more complicated health-related tasks.
8. On the *Treatment* or *Medication Management* section of the Medical screen in CARE, has the SSS/CM documented SDC tasks and selected "Self-Directed Care (IP only)" as a Provider Type for the treatment listed on the Treatments section?
9. Does the client want to self-direct any portions of her/his care? The law does not require the individual to self-direct their healthcare. **The law does not have a task list.**

The responsibility of the client (person with the disability) is to:

- Inform the prescribing healthcare practitioner who ordered the treatment or medication of the intent to self-direct;
- Inform the SSS/CM;
- Inform and provide training to the IP for those SDC tasks and ensure the IP has a copy of the current Service Summary and Assessment Details;
- Possess the necessary knowledge and ability to train the IP to those tasks;
- Supervise the performance of the IP; and

- Ask for assistance in training, if necessary.

The SSS/CM must:

- Inform the client of the SDC option. Share the SDC publication with the client at the time of assessment and reassessment; and
- Coordinate with the client to identify the SDC tasks and who will perform them and then, document on the *Treatments* and *Medication Management* sections of the Medical screens in CARE; and
- Provide copies of the current Service Summary and Assessment Details to the client and the IP.

Problem Solving: If the SSS/CM feels that the way the client instructs the tasks to be done is potentially harmful or if the assessment reveals that the client has cognitive issues, memory loss, disorientation, or impaired judgment and the client is requesting to self-direct, the SSS/CM will:

- Discuss the situation with the client.
- Consult with a nurse consultant and case management supervisor.
- Clearly document concerns in a SER.
- After obtaining a signed Consent Form (DSHS 14-012) from the client, confer with the prescribing health care practitioner.
  - If the prescribing health care practitioner agrees the tasks are being done in a harmful manner, the case manager will not authorize the SDC tasks to be done.
  - If the client refuses to give permission to consult with the prescribing health care practitioner and concerns remain, the SSS/CM must consult with their supervisor to determine whether to authorize SDC tasks. The supervisor will thoroughly review the case and determine whether SDC should be authorized.
- Outcomes of the discussion with the client, and any other actions taken by the SSS/CM and/or client, must be clearly documented in a SER.
- If SDC is not authorized, the SSS/CM must develop an alternative plan of care, offer it to the client and document this in a SER.
- If SDC is not authorized, the IP may still be paid to perform other ADLs and IADLs if they meet the other requirements to be an IP. The IP may refuse to do SDC tasks at any time. The law does not force the IP to do SDC tasks they are not comfortable doing.

Necessary Supplemental Accommodations (NSA)

Clients who have a mental, neurological, physical, or sensory impairment or other problems that prevent them from getting program benefits in the same way as those who are not impaired are considered in need of necessary supplemental accommodation. (See WAC 388-472-0020)

Developing Necessary Supplemental Accommodations (NSA)

Discuss with clients any issues that would hinder their ability to access DSHS programs and services and determine if they require any necessary supplemental accommodation services to ensure that they can submit the necessary information to the Public Benefits Specialist (PBS) for an initial (or on-going) determination of eligibility for Medicaid. If the client requires or requests NSA:

1. Select "Yes" on the *Care Plan* screen that the client has a need for an "NSA".
2. Identify any special needs the client may have which would impact their ability to complete the initial application for public assistance and any reviews for ongoing eligibility.
3. Identify the family member, significant other, or other individual who can be identified as the person the PBS can contact (may require Consent – DSHS Form #14-012).
4. In the comment box labeled "NSA Description" on the *Care Plan* screen indicate how client's need for an NSA will be met and by whom.
5. Assist clients who are unable to manage this issue independently if no NSA is identified.
6. Indicate and describe the NSA on the 14-443 sent to the PBS through Barcode.

EXAMPLE: The client has significant cognitive impairment and cannot be responsible for the application and eligibility review process. Her daughter, who is her DPOA, will be identified as the contact person for the financial application and eligibility process.

EXAMPLE: The client cannot read. All forms must be sent to the designated representative.

EXAMPLE: The client has a hearing impairment so staff should not contact the client by phone or would need to use the TTY system when appropriate.

Implementing the Necessary Supplemental Accommodation (NSA)

In addition to documenting NSA information on the *Care Plan* screen, you must:

1. Describe the needed special accommodations to the PBS on form 14-443. Include the address of the person identified as the client's representative.
2. Document in a SER that this information was added to the 14-443 to the PBS via Barcode.
3. Add the identified NSA to the *Collateral Contacts* screen and select the Contact Role of "Personal NSA".
4. If the client does not have anyone to assist them, indicate that the CM/SSS will need to arrange for or provide assistance with, completing forms, obtaining needed information, explaining the department's adverse actions, requesting fair hearings, and providing follow-up contact on missed appointments. CM/SSS may be notified by a PBS that the client needs further assistance with their Medicaid eligibility reviews to ensure that there is no interruption in Medicaid eligibility.

HCS/AAA case records must be identified if the client has specific needs (e.g., large size print for forms, hearing impairment, cognitive impairments, limited reading ability, etc.) that are in addition to the required accommodations that are already recognized in HCS policy. Although all ALTSA LTSS clients are treated as if they are NSA, only develop an NSA plan and mark the case "NSA" in CARE if the client has specific NSA needs.

MINIMUM STANDARDS

The intent of Minimum Standards is to describe the process and expectations of developing and completing a care plan, post assessment interview completion. Use the Minimum Standards when transferring a case from one office to another.

CLIENT STANDARDS	
Interpreter required	Follow guidelines outlined in Chapter 15A/B.
Residence History	When client changes residence, start a new line (+). Do not edit the old line as this prevents history from being built. Use the Multi-Client Residence tab for in-home clients when appropriate.
Residence Type	Select the appropriate Residence Type from the dropdown. If the client is living with others, use the *Collateral Contact* screen to document their name(s) and their relationship to the client.
Collateral Contacts	List all household members and anyone who has contact with the client. When adding a new contact or removing an old contact from the collateral *Contacts* table, use "+ Add new contact" and "Delete selected contact" buttons. Do not use "Edit" elements of *Contact Details* to replace the information in the table. Backspace or delete should only be used to make a correction to a current contact record, not to change the contact to a new individual or organization. **Emergency Contact:** List the name and phone number of the person who should be contacted in case of an emergency, (i.e., temporary backup care, wildfire, power outage, etc.). Collateral Contacts other than an in-home personal care provider and/or household member should be considered first. **Informal support:** List the name and phone number of the client's informal support and select the Contact Role of "Informal Caregiver." This may be a family member, a friend, neighbor, or community resource. If the informal support is a person, it is not required that they live with the client rather than that they visit regularly and are willing and able to respond to the needs that the client may have. This role must be assigned when status in ADL and IADL screens indicate met or partially met tasks. **Substitute decision maker:**

	When the client has a legal substitute decision maker, the assessor must not accept or seek the person's decisions without a copy of the paperwork that confirms the legal relationship. When the client has only an informal decision maker, this arrangement can only continue if the client can tell this person what they want. The assessor will need to confirm any decisions made by the informal decision maker with the client. A General Power of Attorney may only be used if the client is cognitively intact. **Individual Provider(s):** as known, list first and last name of each known and intended (client chosen) Individual Provider (IP), and their relation to the client, when services are provided by the Consumer Direct Care of Washington (CDWA). When determining familial relationships, these are individuals who are important to, and designated by the client and who need not be a relative (RCW 70.127.010(4)). **Healthcare providers:** List the name and phone number of the client's primary healthcare provider and any other healthcare provider(s) who have a role in the client's plan of care. If the client does not have a primary healthcare provider, make sure the client has an emergency contact.
Financial	Financial eligibility must be verified and active (i.e., not in pending status) for the functional program being authorized (including Fast Track). Financial eligibility verification must occur at least annually. Indicate the method of verification (ACES online, financial award letter, etc.) on the *Financial* screen.
ASSESSMENT	
Reason for Assessment	State the reason for this assessment, documenting the client's or referent's perception of the problem. For reassessments, delete the old reason for assessment and enter the current reason/circumstances for the reassessment.
Source of information	The client must be the primary source of information unless they cannot participate because of mental or physical reasons.
Planned living arrangement	Select "Lives with paid provider" on the Assessment Main screen if the client and their paid provider live together. Select "Multi-client household" on the Assessment Main screen if there are other clients in the household. If both apply, select "Multi-client household."
Adult Family Home (AFH) Evacuation Level	Select the Evacuation Level from the dropdown on the Assessment Main screen. All AFH plans of care and negotiated plans of care must identify the resident's level of evacuation capability (see WAC 388-76-10870).
Medications	Include information about each prescribed medication, if available, with at least the route of administration

Diagnosis	Confirm the diagnosis with the client's healthcare provider when inconsistencies are noted, or the source of the information is not reliable. Document the source of the information. Use *Functional Limitations*, indicators, and/or comment boxes to provide information regarding the client's physical functioning.
Treatments	• Check the treatment definitions to ensure an accurate description of the client's needs. • Identify all providers for each treatment. • Rehab/Restorative Training (walking, transfer, bed mobility, etc.) over the past 14 days. Before you can select these activities be sure that: a. Measurable objectives and interventions are included in the therapist's care plan; b. Caregivers are trained in techniques that promote client involvement; c. Programs are periodically re-evaluated by a skilled professional. Document this in the SER or comment box; d. Time spent on each program must be at least 15 minutes a day; e. You document in the comment box that the plan has been viewed, or a copy is in the file. All criteria mentioned above must be met before "Walking" can be selected. This item does not include a recommendation by a healthcare provider that the client walk on a regular basis.
Self-directed care	Document self-directed care (SDC) tasks on the screen in which the task is addressed. Typically, these will be documented on the *Treatments* section on the Medical screen using "Self-Directed Care/IP only" as the provider type or on the *Medication Management* section (Administration of Medications). Include the name of the healthcare provider prescribing the task as well as a description of the task being self-directed in the applicable comment box(es). Identify the SDC provider and schedule on the *Supports* screen.
Behavior	A current behavior must be addressed with a current intervention(s), provide individualized caregiver instructions (person-centered to the client's interests) in the comment box. When caregiver instructions are the same for multiple behaviors, one comment box of the caregiver instruction is sufficient. For other behaviors that the caregiver instruction applies to, indicate so in the comment box.
Depression	If the client has a score of 10 or higher, document a discussion about a referral to a healthcare provider or mental health resource. Follow the Guidelines for Referrals.

Memory	If the response to the Short-Term Memory question is not consistent with the client's ability to recall the 3 items in the MMSE as well as other information in the assessment, document the inconsistency in the applicable Comment box.
MMSE	Administer the MMSE to each client: • At the Initial assessment. • Whenever the period from the last MMSE equals 12 or more months. • When a significant change assessment is completed because of a reported change in cognition. The MMSE may be omitted when the client is under 18, has moderate to profound intellectual disability, has severe delirium/dementia, or is non-verbal. Use the *Other Factors* Comments box to document client characteristics that may affect the score.
Suicide	If the client answers "yes" to any of the questions, discuss a referral to an appropriate healthcare provider; follow the Guidelines for Referrals. If the client has a plan, the means to carry it out and a time planned, contact the local mental health professional or crisis clinic.
Supervision of providers	If the client is unable to always supervise the in-home provider, identify an informal support person (not a paid caregiver) who can provide supervision. Only clients who are coded as "Independent" or "Difficulty in New Situations" may supervise their paid provider. When no informal support can be identified to meet this need, document in the comment box how monitoring of the case will occur. To increase contact, place the client on targeted case management and consider using more than one IP or an agency caregiver.
Emergency plan (Evacuation/Back-up Plan)	**Evacuation plan** • The intent of an evacuation plan is to document how the client and/or providers would respond to emergency situations. • Discuss evacuation/emergency planning with the client and document the plan by selecting standard language on the Safety Screen under "In-home evacuation plan." • Use the Comment boxes to add client-specific information if necessary. **Back-up plan of care** • If lack of immediate care would pose a serious threat to the health and welfare of the client, include a backup plan. Examples of clients who fall into this category are those who use devices that require electricity or constant monitoring; or clients who require continuous monitoring for a medical condition. • Discuss the backup plan with the client and backup caregiver.

	– CARE Web: Document in the Client Safety screen using the selections under "Caregiver instruction(s) and safety concerns." Use the Comments box to add client-specific information if necessary. • Identify the back-up caregiver on the *Collateral Contact* screen.
Potential for abuse and neglect	Follow APS guidelines. If there are no indicators of abuse or neglect, select "None observed or reported" in the Legal Issues section on the Safety screen.
Alcohol/Substance abuse CAGE interviews	Follow the guidelines on the Substance Use screen and the Guidelines for Referrals.
Explanation of inconsistencies	Use Comment boxes to explain inconsistencies or conflicting information in relevant screens. For example, when one ADL is scored Independent, and another, scored Total Dependent, Comment boxes must document explanation.
ADL and IADL screens	Use the bucket selections to provide a clear description of the client's strengths, preferences, limitations, and caregiver instructions. Use the Comment box, if necessary, to provide specific instructions to the caregiver that are not available in the buckets. **Status (Looking forward):** If the client will receive non-ALTSA-paid informal support for any ADL or IADL, the assessor will select Met or Partially Met and identify the amount of support under Assistance Available (Looking Forward), using the chart provided in the *Assessing Status* section or CARE Web Assessor Manual/Help screen. Examples of non-ALTSA-paid informal support are family members, neighbors, Adult Day Care, or Adult Day Health. **NOTE:** if a Need is documented on the Medical screen that DME or an assistive device might be helpful, please see the Appendix > Bed Rail Policy.
Guidelines for Referrals	When a non-mandatory referral is indicated (e.g., Depression score of 10 or more or pain score of four or more, etc.), document a discussion with the client in the Comments box on the appropriate screen. Discussion may consist of providing information sheets developed at the local level for self-referral. If the client requests assistance with a referral, document this in CARE on the corresponding screen[4]. Include the date you referred the client and who is responsible to follow through.
CARE PLAN	

[4] APS, Suicide, and Skin Observation Protocol (SOP) are mandatory referrals.

Client is eligible for:	Program selected must match services authorized in ProviderOne. For example, if a client is converted from CFC to CFC+COPES, the correct program must be selected in the Care Plan screen and the correct program authorized in the payment system.
Necessary Supplemental Accommodation (NSA)	Include an NSA Description, if applicable. This is appropriate if the client has a special need (mental, neurological, physical, or sensory impairment – does not include Limited English Proficiency) that prevents them from getting program benefits in the same way that a person without an impairment would get them. Indicate and describe the NSA on the 14-443 sent to the PBS through Barcode.
Referrals to Nursing Services	If a Critical Indicator is listed on the *Triggered Referral* screen, enter the date a referral was made and the reason for the referral. If a referral was not made, identify why a referral was not necessary. Follow the nursing services policies outlined in the Chapter 24, Nursing Services.
Supports screen	• All tasks identified in the Supports Screen must be assigned unless a task is awaiting coordination • Document a schedule when the client has a preferred schedule. Do not identify more hours than what the client is eligible for and what is authorized in the payment system • Unmet tasks are assigned to at least one paid provider. Assign providers using the paid providers search function or "providers from current plan" tab, NOT the contacts or resources tabs • Partially Met tasks are assigned: – to at least one paid provider from the paid providers search or the "providers from current plan" tab, AND – and at least one informal support from the contacts or resources tab • Met tasks are assigned to an informal support only from the contacts or resources tabs
Community First Choice (CFC) Services	CFC Services must be included in the client's plan of care prior to authorization. In addition, the assessment must support the client's eligibility for CFC. **Personal Care:** • Relief Care: Personal care hours may be authorized to an alternate provider. Document a relief care provider in the Collateral Contacts screen and assign tasks in the Supports Screen if a relief care provider is in place. • Nurse Delegation: If nurse delegation is in place, identify Nurse Delegation and IP or Agency as providers in the *Treatments* section of the Medical screen and assign the nurse delegator and paid personal care provider(s) to the task on the *Supports* screen. For medication management, assign the nurse delegator and paid personal care provider(s) on the *Supports* screen.

	– For treatments, if nurse delegation is not yet in place, identify Nurse Delegation and IP or Agency in the *Treatment*s section as providers and add a comment that the task will be delegated when the provider completes the training. – For medication management, if nurse delegation is not yet in place, state in the Comments box that the task will be delegated when the provider completes the training. – In the meantime, if the treatment/medication management is being performed by an informal provider, identify the informal provider on the *Supports* screen and assign the task. Reassign the task to the delegating nurse and paid provider after the IP and/or agency provider has completed the Nurse Delegation training. **Skills Acquisition Training:** • A client may choose to use some of their personal care hours for Skills Acquisition Training (SAT) authorized to an agency provider, IP, or supported living provider. • Document on the ADL or IADL screen who will be providing the SAT and what task the client is wanting training on (e.g. learning to shave with electric razor with non-dominant hand due to stroke on dominant side – this would be listed in the Comments box on the Personal Hygiene screen) **Back-up Systems:** • **Personal Emergency Response System (PERS):** select "PERS unit" and/or "PERS installation" from the Walk/Locomotion equipment list. Assign a contracted PERS provider on the *Support* screen. Following LTC chapter 7b, "Community First Choice (CFC)," document the client's eligibility for PERs unit in the *Safety* screen. • **Relief Care:** document a relief care provider in the Collateral Contacts screen and assign tasks in the Supports Screen if a relief care provider is in place • **Caregiver Management Training:** document date materials were sent or the web link provided on the CFC screen in CARE. If more than one type of material was issued, choose only one, adding both is not required. • **Community Transition Goods or Items:** select "Community Transition Goods or items from the Programs list in the *Treatments* section. Describe the type of goods or items the funding will be for in the corresponding Comments box. Address in the Care Plan, including assigning a provider on the *Supports* screen when appropriate. • **Community Transition Services (CTS):** select "Community Transition Services" from the Programs list in the *Treatments* section. Describe the type of services the CFC CTS funding will be for in the corresponding

	Comments box. Address in the Care Plan, including assigning a provider on the *Support*s screen when appropriate. See Chapter 7b for eligibility criteria and more information. • **CFC state fiscal year (*SFY) annual limit:** CFC SFY annual limit comprises of purchases/payments for both Assistive Technology (AT) and Skills Acquisition Training (SAT). If items/services are to exceed this limit, an ETR request to the CFC Program Manager is necessary. See Chapter 7b for more information. *SFY is July 1 to June 30. – **Assistive Technology (AT):** Includes add-on services to the basic/standard PERS (e.g. fall detection, GPS, Medication Reminder/Dispenser) and other adaptive/assistive items/devices that will increase an individual's independence or substitute for human assistance with an ADL, IADL or health-related task. Document in the relevant screen in CARE and select "Assistive Technology" from the corresponding equipment table. Please consult the CFC Covered AT Items list to confirm that desired item is approved. See Chapter 7b for more information. – **Skills Acquisition Training (SAT):** may be purchased using CFC SFY annual Limit. See Chapter 7b for more information. – **Budget Calculator in CARE:** use to identify, track, and calculate the use of a client's CFC SFY Annual Limit. This is especially useful and helpful to quickly look at what the client has already used and if the case is transferred to another case manager.
COPES Waiver Services	Waiver services must be included in the client's plan of care (Assessment Details or Service Summary) prior to authorization. In addition, the assessment must support the client's eligibility for each service. • **Environmental Modification**: select environmental modification in the *Environment* section on the Safety screen and describe the project in the comment box. Assign a contracted Environmental Modification provider on the *Supports* screen. • **Skilled Nursing**: select "Skilled Nursing/Waiver" from the Treatments list in the *Treatments* section of the *Medical* screen. Describe the type of skilled care in the Comments box. Assign a provider on the *Supports* screen. • **Client Training**: select "Client Support Training/Waiver" from the Rehab/Restorative Training list in the *Treatment* section of the *Medical* screen. Describe the type of training in the Comments box. Assign a provider on the *Supports* screen. • **Adult Day Health (ADH)**: select "Adult Day Health" from the program list in the *Treatments* section of the *Medical* screen. Assign a provider on the *Supports* Screen. (Status adjustments must be coded in the relevant CARE

	screens for the assistance with ADLs and IADLs provided by ADH staff while at the ADH) • **Adult Day Care (ADC)**: select "Adult Day Care" from the Programs list in the *Treatments* section of the *Medical* screen. Assign a provider on the *Supports* screen. (Status adjustments must be coded in the relevant CARE screens for the assistance with ADLs and IADLs provided by ADC staff while at the Adult Day Care center) • **Specialized Medical Equipment**: select "Specialized Medical Equipment" from the appropriate equipment table and describe the item in a Comments box for that ADL. Assign a provider on the *Supports* screen. • **Client Transportation**: assign a provider to Transportation need on the *Supports* screen. • **Home-Delivered Meals**: assign a provider to Meal Preparation task on the *Supports* screen. Document the hour adjustment in the In-home Adjustments tab on the Care Plan screen and assign the paid provider on the *Supports* screen. • **Wellness Education:** select "Wellness Education Service" from the Program list in the *Treatments* section of the Medical screen and use the provider type "other". Assign "Smart Source, LLC" as the provider on the *Supports* screen. • **Community Choice Guide (CCG):** select "Community Integration" from the Program list in the *Treatments* section of the *Medical* screen. Document CCG tasks via Pre-*Transition & Sustainability* screen > *Sustainability Goals* screen. Assign the paid provider on the *Supports* screen. • **Community Support:** Goods and Services (available only for individuals moving from a licensed residential setting to in-home): Select "Other" from the Program list in the *Treatments* section of the Medical screen. Describe the Community Support needed in the corresponding Comments box. Assign a provider on the *Supports* screen.
Environmental Modifications/ Durable Medical Equipment	Enter the date the Durable Medical Equipment or Environmental Modification is expected to be completed/obtained in the "Act By" field. The Follow Up screen must include updated detail in the Comment Box of current status/steps taken, related to "Who Acts."

Case File Standards

This section outlines standards for what is required in the electronic case record, record retention, obtaining original documents/signatures, and utilizing the Document Management System in Barcode.

HCS Imaging Unit (HIU) and Electronic Case Records (ECR)

HCS IMAGING UNIT is a subset of the Barcode application which was written and is maintained by Economic Services Administration (ESA). HCS IMAGING UNIT manages and stores documents creating an electronic case record known as the ECR eliminating the need for a paper case file. Once a document arrives at the Hub Imaging Unit (HIU) it is scanned and indexed to the appropriate client and assignments based on each office's set of assignment rules or Assignment Matrix and then will display as a *Tickle* assignment on the appropriate workers *Barcode To-Do* list.

What should be sent to HIU for imaging into ECR?

The following documents that have not been superseded by a more recent version:

- 14-225 Acknowledgement of Services
- 14-012 DSHS Consent
- 16-172 Client Rights and Responsibilities
- (D)POA/Guardianship paperwork and documents, if not submitted previously
- 10-234 Individual with Challenging Support Issues
- 10-234A Individual with Complex Behaviors
- 14-534 Specialized Dementia Care Program Eligibility Checklist
- Residential clients' Negotiated Care Plan or Negotiated Service Agreement
- Least Restrictive Alternative (LRA) documents
- **ANY OTHER CRITICAL CLIENT INFORMATION THAT IS NEEDED FOR CONTINUITY OF CARE AS DETERMINED BY CM/SSS AND SUPERVISORS.** Be mindful of the volume of documents sent for imaging. Send only the critical documents or pages**.**

Medical records including Medical Administration Records (MAR) are NOT required to be scanned into the client's ECR. If there is something identified in a medical record that is determined to be critical for the ECR and for service continuity, be mindful of the volume of pages sent for imaging. Send only the critical portions of the medical record.

Original Signatures and Electronic Transmission

Certain forms require that the original signatures be available in the client's file. To meet this requirement, the Secretary of State's Office has certified imaged documents as originals only if documents sent to HIU are as the client originally submitted the item to a DSHS office. Example: If the client returned the original signed document, this original signed document must be sent to the HIU. HIU does have the ability to accept faxed documents directly from clients or providers and these items will be considered "original" documents, but they must be submitted by the client or provider.

If a site has received an electronic transmission, such as fax or PDFs as attachments to e-mails, these will be accepted as originals if the site first prints these items and sends to the HIU to be imaged to the client's ECR. Electronic records and signatures created are considered original source documents.

Organization of Electronic Case Record

Client documents are housed and managed digitally within the Electronic Case Record (ECR), which is part of the Barcode application's HCS Imaging Unit (HIU). The ECR can be accessed from the Barcode Welcome Screen (select AU search), or from within CARE > Launch Menu (rocket ship icon:), or, once the client is in view (barcode icon:). When viewing a client's ECR, you can search by document type and specify the timeframe (history).

Documents are sent to HIU to be scanned into and associated with the client's ECR. HIU staff scan each document and identify the type of document based on a list of general categories, assign the document a code from those categories and match the document to the client. The document then runs against a matrix from the site that sent the document to the HIU. This matrix identifies how each document type is to be assigned for each office. A complete list of document codes is available in Barcode and on the HIU SharePoint website.

Training and additional information about HIU and ECR is available at the ALTSA Training Page: (http://adsaweb.dshs.wa.gov/training/).

Documents contained in the client's electronic case record cannot be deleted by the HIU after they have been submitted for imaging unless there are exceptional circumstances (e.g., a client is protected by address confidentiality program).

Adult Protective Services (APS) documents: APS documents must never be sent to HIU and should not be included in the ECR. The APS investigator will provide a paper copy to the client's CM/SSS in order for any appropriate SER documentation to occur and then the CM/SSS must then destroy using a secure destruction method (shred box) according to Administrative Policy 5.04. APS maintains paper files and can be contacted to access APS documents on a need-to-know basis. Please refer to APS Policy & Procedure.

Frequently Asked Questions about the Electronic Case Record (ECR) and the HCS Imaging Unit (HIU)

Q How will staff receive training to use Barcode and ECRs?

A Articulate trainings are available to social work, technical and supervisory staff and available at the ALTSA training site: http://adsaweb.dshs.wa.gov/training.

Q How will Hub Imaging Unit (HIU) staff assign documents?

A HIU staff do not assign any work. HIU staff are tasked with imaging documents, identifying the document type/office, and then matching these imaged documents up to existing clients. Once these processes are completed, the HIU system will run all newly received documents against the identified office's matrix. The matrix is a set of rules for a site that tells HIU how to assign each type of document.

Q What happens to documents that cannot be matched up to a client?

A Each site has a Mystery Mail view (accessible from your To-Do list) that will display all documents that arrived for your office but could not be matched to a client. If you can identify

the matching client to a document found here, you or the HIU can link the document in the system.

Q How will staff be notified of any Barcode/HIU outages?

A To receive updates, social services and case management staff and Public Benefits Specialist and Regional financial program staff that use Barcode should subscribe to IT Solutions topics available in GovDelivery: Washington State Economic Services Administration (govdelivery.com)

Q How do I use the two different types of coversheets? (The Social Services Invoice / Receipt Packet Cover and Financial Document Packet Coversheet)

A The PACKET COVER SHEET - SOCIAL SERVICES (DSHS Form #02-615) is used by the SSS/CM to submit final invoice(s) and/or receipts to HIU for imaging. By using the Social Services packet coversheet, the document will be indexed as a Social Services Receipt, rather than an RX (an RX is a type of financial document). Note: All home care agencies have been informed to include the code SSR when sending letters regarding client's unpaid participation so these items can be indexed correctly. Staff must ensure receipts have an SSR cover sheet attached.

- If you are an SSS/CM inside the DSHS firewall, you may access the PACKET COVER SHEET - SOCIAL SERVICES (DSHS Form #02-615) via Forms Picker: DSHS Form #02-615
- For public access (or you are an CM outside the DSHS firewall), you may access via imaged icon below:

DSHS Form #02-615.docx

The PACKET COVER SHEET - FINANCIAL (DSHS #02-614) is used to keep documents that are of a different type together so they can be indexed as a single document, most often used for NGMA or Overpayment Packets. A document coversheet is not needed if a doctor's report is being sent to the HIU or just because a document has several pages. Do not mix the dates when using the batch cover sheet. The date on the cover sheet is the date that will be used even if other documents have different dates. The date stamped on the document should be the date received at the office.

- If you are a SSS/CM inside the DSHS firewall, you may access the PACKET COVER SHEET - FINANCIAL (DSHS #02-614) via Forms Picker: DSHS #02-614
- For public access (or you are an CM outside the DSHS firewall), you may access via imaged icon below:

DSHS Form #02-614.docx

Q What should staff do if a client document gets placed in the wrong electronic file?

A Request an HIU Document fix. From within a client's ECR, highlight the document that has been indexed incorrectly and select from the dropdown menu "Document Tools" and "Request HIU Doc Fix"; then select the best description of the problem from the dropdown list.

Q Can staff request documents be deleted that have already been sent to the HIU for imaging?

A No, documents cannot be deleted unless there are exceptional circumstances such as APS or a client protected by address confidentiality program.

Q Can I complete assignments for workers in other offices?

A Only if you also have an account in that office. Staff may only complete assignments for others if they are sure the other staff person does not need to see the assignment.

Q What is the Department policy on imaging CARE Service Summaries?

A All versions of the Service Summary should be imaged in the event of a fair hearing request covering the usual record retention period of 6 years. CARE retains past versions of Service Summary in most instances when a new Service Summary is created; however, if changes are made to a Current assessment in the plan of care e.g. change of providers, you will want to send an updated Service Summary to be imaged to the ECR. If the complete Service Summary is sent to imaging and then the client returns the signature page, staff do not need to send the entire Service Summary to HIU again, just the signature page.

Q Should staff include a copy of the drawing and simple sentence that is administered to the client through the MMSE during the CARE assessment?

A Retaining this document is optional but can be useful to note cognitive changes from one assessment to another. Because this document is also used by CSD, it is coded as a Doctor Request (DR) type document rather than a CARE Case Manager (CAR). The form is generated in CARE to be easily scanned to the correct ECR.

Q I have a client enrolled with the Address Confidentiality Program (ACP). How will staff record the client's physical address and coordinate care planning?

A If your client is enrolled in ACP, the actual residential address must not be maintained in Barcode or in CARE. CRM/CM/SSS staff who need to visit the client will maintain residential addresses in a locked location within the office and this information will only be given to providers on a need-to-know basis. When coordinating with service providers, CRM/CM/SSS staff will contact the client first to provide an opportunity for the client to coordinate themselves. If client instead prefers the CRM/CM/SSS to coordinate instead, the CRM/CM/SSS will ask for their Consent to share the physical address with the provider, explaining to the client that this is only to coordinate services and provide the necessary services and/or care to the client. A substitute mailing address (given by the ACP program) is the only address to be maintained in electronic records. The client may request communication occur only in a preferred way such as e-mail, a particular phone number or contact time. This information must not be maintained in the electronic record.

Q What is the policy concerning the storage of translated documents in the client's ECR?

A When sending documents to the HIU, staff must send the English and translated versions together except for the CARE documents listed below. These documents do not have to be sent in English and may be sent in the translated version only:

- Assessment details

- Care Results
- Planned Action Notices
- Personal Care Results (PCR) or Personal Care Results Comparison (PCRC) – In-home and Residential
- Service Summary generated by a new CARE assessment

NOTE: If changes are made to a Current assessment in the plan of care e.g. change of providers, there may not be a historical record, so this document must be sent in English along with the translation to HIU. While the translated version of documents may be signed by the client who is LEP, the English versions of all documents that require client signature are the official versions and must be signed by the LEP client.

For Braille Transcription:

1. See Chapter 15A/B for complete instructions for obtaining Braille Transcription
2. The ADA/LEP Program Manager will send an e-mail to the field staff who requested the translation. The SSS/CM will send this e-mail to HIU for imaging. The e-mail will include:
   - A statement that the text was transcribed into Braille and sent to the client;
   - Confirm the date the Braille notice was sent by postal mail with USPS tracking number to the client;
   - Whether or not the notice was returned as undeliverable by the post office and, if so, the date of the notice

Q Where can staff get additional HIU supplies (envelopes, completed stamps)?

A **For HCS staff:** Templates to place the envelope orders have been transferred to your sites. Staff should be able to order these through the normal process. HCS sites will reorder any "Completed" stamps needed for staff.

- **For AAA Staff:** We are not able to transfer templates to your areas for reorder. Sites needing more envelopes or "Completed" stamps* must send an e-mail to Melanie McGuire, melanie.mcguire@dshs.wa.gov. The subject line of your E-mail should read: ATTN: HIU Supplies/Barcode Site # (#= your Barcode site number). Melanie will be placing orders on the first of each month.
- Please continue ordering "Completed" stamps through your sites supply channels if they are available. Remember stamps must be in black ink.

Forms and Brochures

FORM/BROCHURE TITLE	REQUIREMENTS
Medicaid and Long-Term Care Services for Adults Brochure (DSHS #22-619)	Review with the client at the Initial assessment.
Voter Registration (ABVR) forms	At least annually, during in-person visits, continue to ask the client if they would like to register to vote and if they need assistance with filling out the form. Use Agency Based Voter Registration (ABVR) forms and complete the voter registration screen in CARE.
Estate Recovery Information	Review (Estate Recovery For Medical Services Paid For By The State, from the NW Justice website) with the client at the Initial assessment.
Self-Directed Care (DSHS Form #22-388)	Review with the client at the Initial assessment or when Self-Directed Care (SDC) is first authorized.
Client Rights and Responsibilities (DSHS 16-172) **Available in CARE*	Review with the client at the initial (or at the Significant Change/Annual if the form has not been signed). Have the client sign two copies; one copy for the client's file and leave one copy with the client. If an updated version of a signed form exists, have the client sign the updated form.
Acknowledgement of Services (DSHS 14-225) **Available in CARE*	Review with the client who is considering a waiver service or the Community First Choice (CFC) program. When Roads to Community Living (RCL), a waiver or the CFC program has been chosen, have the client sign two copies; one for the client's file and leave one copy signed also by the case manager, with the client. If an updated version of a signed form exists, have the client sign the updated form.
DSHS Notice of Privacy Practices (DSHS 03-387) **Available in CARE*	Review the form with the client at the initial assessment. Provide a copy of DSHS Privacy Practices to the client/ARep.
Consent Form (DSHS 14-012) **Available in CARE*	Prior to gathering information from collateral contacts or sharing information with others, you must have the client review and sign the consent form annually. The consent form is utilized by multiple agencies under DSHS. Each agency's use of the consent form is independent of another's. The most recent consent form presented by HCS/AAA CM/SSS and signed by the client replaces previously signed forms, as the expression of the client's intention of what to disclose.

	Information Included section: Clients must indicate what records are covered by the consent. If any records include information, such as a diagnosis, medication, treatment, or instructions relating to mental health (RCW 71.05.620), HIV/AIDS or STD testing or treatment (RCW 70.02.220), or drug and alcohol services (42 CFR 2.31(a)(5)), the client must mark these areas specifically to give permission to share these records. *The 14-012 includes the following phrase on page 1: "DSHS may still share information about you to the extent allowed by law."* Specifically, regarding mental health information: RCW 70.02.230 applies to mental health information as it provides more protection than HIPAA, which HIPAA allows. RCW 70.02.230 allows certain disclosures without patient authorization, including under RCW 70.02.050. In turn, RCW 70.02.050(1) states A health care provider or health care facility may disclose health care information, except for information and records related to sexually transmitted diseases which are addressed in RCW **70.02.220**, about a patient *without the patient's authorization* to the extent a recipient needs to know the information, if the disclosure is: *(a) To a person who the provider or facility reasonably believes is providing health care to the patient.* So, in a case involving necessary treatment, mental health records can be released without patient authorization.
FDA Bed Rails Brochure "A Guide to Bed Safety"	Provide to the client, family, and personal care providers, when a request for new bed rails is made. Include Translated Versions for LEP recipients as needed.
Notice and Consent of Communication via Text or Unencrypted Email (DSHS #27-156)	Have client sign when they indicate they (client) would like to receive communication by text messaging or email, via unencrypted email. Place signed copy in client's ECR.

Assessment Location Grid

TO	From hospital…[5]	From SNF…	From residential…	From in-home…
Hospital (Rehab/ Transitional Care units)	HCS will coordinate with the discharge planner and assess within 7 days of referral or when ready to discharge to the community, whichever is earlier.	N/A	N/A	N/A
In-home	• HCS performs initial assessments for Medicaid applicants requesting long-term care services (except for Asian Counseling and Referral Service (ACRS) and Chinese Information Service Center (CISC) clients). • AAA/DDA will update the care plan or perform a Significant Change assessment for existing in-home clients who are returning home within 30 days of their hospital admit. The AAA will transfer the case to HCS if the client's out-of-home hospital stay exceeds 30 days.	• HCS performs an initial assessment for Medicaid conversions; • HCS/AAA/DDA performs a Significant Change assessment if there has been a significant change in an existing client's condition. • The AAA may transfer the case to HCS if an existing in-home client's out of home stay exceeds 30 days. AAA and HCS may negotiate whether to transfer the client, if it appears the client will return home within a reasonable timeframe. Continuous Hospital and SNF days are totaled to determine days out of the home.	HCS performs an initial assessment (for new clients) or a Significant Change assessment and/or updates the *Care Plan* screen to reflect the change in setting.	HCS performs initial assessments for Medicaid applicants requesting in-home long-term care services (except for Asian Counseling and Referral Service (ACRS) and Chinese Information Service Center (CISC) clients).

[5] HCS must also complete assessments prior to patients being discharged from Eastern or Western State Hospital.

TO	From hospital…[5]	From SNF…	From residential…	From in-home…
Residential	• HCS performs initial assessments for Medicaid applicants requesting long-term care services. HCS informs the client of choices of settings. • For existing clients, HCS/DDA will perform an Interim or Significant Change assessment, if needed.	When clients are ready for discharge, HCS performs an initial assessment for Medicaid conversions and a Significant Change assessment for existing clients.	HCS/DDA updates the *Care Plan* screen to reflect changes if it is a different setting (e.g. AFH to AL).	AAA/DDA shall make any changes to the plan and/or perform an in-person assessment if the client's condition has changed since the last assessment.
SNF	HCS will review the record and use the NFLOC screen to determine that the resident meets institutional status per WAC 388-106-0355 for: • MPC and Chore clients • Medicaid recipients/applicants (clients who are receiving Medicaid, but not home and community programs) • Individuals who require a Level II PASRR but are not otherwise receiving DSHS services (regardless of payor source); and • Clients who are requesting or need Alien Emergency Medical. • Clients who are requesting State-funded Long Term Care for Non-Citizens (LTC-NC) program;	• For residents who, after being admitted, convert to Medicaid payment, HCS will review the record to determine that the resident meets institutional status per WAC 388-106-0355 and notify financial using the 14-443 and complete the NFLOC screen. The client must have first paid privately to be considered a conversion. • For a client on the N-Track (MAGI): If the client is covered by the AH MCO rehab or skilled nursing benefit, then no NFLOC is required. • If a MAGI client is not admitting to the nursing facility under a benefit covered by the MCO, enrolls in an AH MCO after date	For CFC+COPES clients, HCS updates the care plan to reflect the change in setting. For MPC clients HCS performs a Significant Change assessment or completes the NFLOC screen prior to admit. The client's medical chart, nursing assistant notes, and staff interviews and other records can be used to supplement interviews with the	• For CFC+COPES clients, the AAA updates the care plan to reflect the change in setting. • For MPC clients and Chore clients who don't already meet NFLOC, the AAA/DDA performs a Significant Change assessment or completes the NFLOC screen prior to move to SNF. • If the client is to remain out of the home less than 30 days, the AAA/DDA maintains the case. • If the AAA/DDA maintains the case, pursue MIIE. • For new Medicaid applicants, HCS explains all options available prior to

TO	From hospital…[5]	From SNF…	From residential…	From in-home…
	Note: The NFLOC screen may be completed after admission to the nursing facility.	of admit, or if the client's rehab or skilled nursing benefit is ending (or has ended) with the AH MCO, the facility will notify HCS for an intake. HCS must determine NFLOC and notify HCA by completing form 15-442 in Barcode. • No assessment is required when the client is moving from one facility to another.	client to assess activities of daily living, cognition, etc. to perform the NFLOC assessment.	admit. If NF is chosen, HCS completes a NFLOC. *While HCS approves moves to a SNF, all CFC and CFC+COPES clients are eligible for (and may choose) to reside in a SNF. See Chapter 10/Nursing Facility Case Management and Relocation, related to admitting to a SNF from a community setting.

LTSS ETR Types and Approval Authority

NOTE: All ETRs sent to HQ for approval must have been processed to HQ by a Field Approver first.

ETR Category	ETR Type	Waiver Type	Outcome Value Rate ($), Unit (Each), Quantity (?)	Approval Authority
Medicaid Personal Care (MPC)	Personal Care: In Home	N/A	Hours	HQ Approval by ETR Committee
	Personal Care: Residential	N/A	Rate	
CFC Personal Care	Personal Care: In Home	N/A	Hours	HQ Approval by ETR Committee
	Personal Care: Residential	N/A	Rate	
	Personal Care: Limitation Extension	N/A	Hours	
New Freedom Personal Care	Personal Care: In Home	N/A	Hours	HQ Approval by ETR Committee
	Personal Care: Limitation Extension	N/A	Hours	
Residential Support Waiver Personal Care	Personal Care: Residential	RSW	Rate	HQ Approval by ETR Committee
Waiver Services (Ancillary Services for COPES recipients)	Environmental Modifications	COPES	Rate, Units, Quantity	Field Approval (AAA or Regional)
	Special Medical Equip and Supplies	COPES	Rate, Units, Quantity	
	Transportation Services	COPES	Rate, Units, Quantity	

ETR Category	ETR Type	Waiver Type	Outcome Value Rate ($), Unit (Each), Quantity (?)	Approval Authority
	Skilled Nursing: Rate or Hours	COPES	Rate or Hours (treat Hours as RN visits)	HQ Approval by Skilled Nursing Program Manager
	Client Training: Rate or Hours	COPES	Rate or Hours	Field Approval (AAA or Regional)
CFC Services	Community Transition Services	N/A	Rate, Units, Quantity	HQ Approval by CFC Program Manager
	Exceed CFC Annual Service Limit	N/A	Rate, Units, Quantity	
State Only	Chore Hours (to exceed CARE)	N/A	Hours	HQ Approval by ETR Committee
	Chore Spouse Provider	N/A	N/A	HQ Approval by Chore Program Manager
	Office of Attorney General Filing Status	N/A	N/A	HQ Approval by Guardianship Program Manager
	Residential Discharge Allowance	N/A	Rate ($), Unit (Each), Quantity (1)	Field Approval (Regional)
PDN (Private Duty Nursing)	Private Duty Nursing >16 hrs/day	N/A	Hours	HQ Approval by PDN Program Manager
	Personal Care In-Home	N/A	Hours	HQ Approval by ETR Committee HQ/ PDN Program Manager
Bedhold (initiated by Bedhold Unit only)	Bedhold-not hospital or SNF (associated assessment is not required)	N/A	NA	HQ Approval by Bed Hold Program Manager

ETR Category	ETR Type	Waiver Type	Outcome Value Rate ($), Unit (Each), Quantity (?)	Approval Authority
Social Leave	AFH/BH Leave >18 days/yr	N/A	NA	Field Approval (Regional)
	NH Leave >18 days/yr	N/A	NA	
Other Use for Assistive Technology (contact Linda Garcia), or Financial	Other (Associated assessment is not required)	N/A	All fields enabled	Varies
RCL –Personal Care	Personal Care In-Home	N/A	Hours	HQ Approval by ETR Committee
	Personal Care: Residential	N/A	Rate	
	Personal Care: Limitation Extension	N/A	Hours	
RCL/WA Roads-Services	Client Training: Rate or Hours	N/A	Hours	Field Approval (AAA or Regional)
	Community Integration (e.g. CCG)	N/A	Rate, Units, Quantity	
	Community Transition Services	N/A	Rate, Units, Quantity	
	Environmental Modifications	N/A	Rate, Units, Quantity	
	Skilled Nursing: Hours (Treat as RN visits)	N/A	Hours	HQ Approval by Skilled Nursing Program Manager
	Skilled Nursing: Rate	N/A	Rate	
	Special Medical Equip and Supplies	N/A	Rate, Units, Quantity	Field Approval (AAA or Regional)

ETR Category	ETR Type	Waiver Type	Outcome Value Rate ($), Unit (Each), Quantity (?)	Approval Authority
	Transportation Services	N/A	Rate, Units, Quantity	

ATTACHMENTS

Guide to Electronic Signatures

Guide to Electronic Signatures.docx

Voice Signature Script

Voice Signature Chapter 3 Attachmei

Service Summary Signatures

Chart of Scenarios.pdf

ETR FAQ for Providers

FAQforProviders.pdf

ETR FAQ for Hospitals

FAQforHospital.pdf

CFC Care Planning Advocate Flow Chart

Person-Centered Care Planning Advoca

ALTSA How to Identify a Guardian

ALTSA - How to Identify a Guardian

ALTSA Power of Attorney vs. Uniform Guardianship

ALTSA - Power of Attorney vs. Uniform

Social Service Intake

Chapter 4 describes the function and processes of Social Service Intake. Intake is the point of entry for all applicants seeking a functional eligibility assessment for Apple Health Long Term Services and Supports through Home and Community Services.

Ask the Expert

If you have questions or need clarification on the processes outlined in this chapter, please first contact your local Intake Supervisor. You may also contact:

Dru Aubert Case Management Unit Manager ALTSA HQ
360.725.2524 dru.aubert@dshs.wa.gov

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WHAT IS THE PURPOSE OF INTAKE?

- Act as a point of entry for information, referral and requests for service.
- Dedicated to help people make decisions about the services and supports that are best suited for the individual's particular needs based on self-referrals and referrals from other professionals such as primary care providers, hospitals, Long-Term Services and Supports (LTSS) providers, families or friends.
- Gather brief information needed to refer to the most appropriate program and service(s) based upon the needs of the individual and the availability and requirements of all the services, including Medicaid Transformation Project (MTP) programs, Medicaid Alternative Care (MAC) or Tailored Supports for Older Adults (TSOA), that focus on supporting unpaid family caregivers.
- Provide information about Medicaid and service requirements.
- Provide education and inform applicants of eligibility requirements to access services
- Have a process that is consistent and understood by the public and agencies that refer individuals to our services.
- Take necessary action prior to Case Manager assignment and functional assessment.

> For more detailed information about the intake process for programs in the Medicaid Transformation Project programs, MAC and TSOA, see Chapter 30b of the LTC Manual.

WHAT DOES SOCIAL SERVICE INTAKE DO?

Social Service Intake workers provide professional level assistance to applicants by doing the following:

- Educate the applicant about LTSS, including functional and basic financial eligibility requirements.
- Inform the applicant or representative about all the LTSS offered by ALTSA and the settings for which they are offered.
- Inform the applicant of the possibility of a cost of care for services and that Estate Recovery laws may apply.
- Refer applicants to alternative community resources if ALTSA LTSS are not needed or are declined, including other state or federally funded programs offered through the aging and disability network including Older American's Act and Family Caregiver Support Program (FCSP).
- Document relevant safety issues that an assessor should be aware of prior to making a home visit.
- Determine whether the applicant may need assistance in completing an application.

- Assign the case for a functional eligibility ([1]CARE) assessment to be completed if the applicant is interested in receiving care in a Nursing Facility or services in another Home and Community Based setting.
- Assign the case for a Presumptive Eligibility (PE) screening if the applicant is choosing Medicaid Transformation Project (MTP) programs such as MAC, TSOA or LTSS PE.

> The intake and referral form (DSHS 10-570) and instructions can be found on the Electronic DSHS Forms website.

WHAT IS THE DIFFERENCE BETWEEN A REQUEST FOR SERVICES AND A REFERRAL?

A ***request for services*** is any request that comes to Home and Community Services (HCS) regardless of source or eligibility. A request for service may not generate a referral.

A ***referral*** is any request for service that is accompanied by a Medicaid application or for a client with current Medicaid eligibility. A referral generates an intake. HCS is expected to assist individuals who may need assistance in completing an application.

WHAT IS THE DIFFERENCE BETWEEN AN APPLICANT, REFERENT, AND A REPRESENTATIVE?

An ***applicant*** is the individual seeking long-term support and services.

A ***representative*** is a person who the applicant has chosen or has been appointed by a court whose primary duty is to act on the applicant's behalf to make decisions about long-term services and supports. An applicant may also choose a representative who is not a DPOA or guardian (i.e., a parent, family member, advocate, or other person authorized by the applicant) to serve as a representative in connection with the provision of services and supports, and decisions made by informal decision makers (not legally appointed with verifying documents confirming the legal relationship) must be confirmed with the applicant. A representative that is not legally appointed, must be redesignated and documented in a SER note at each Initial, Annual and Significant Change Assessment. See Chapter 3, Assessment and Care Planning, for more information.

A ***referent*** is the person who referred the applicant for long-term services and supports (i.e., homeless shelter staff, hospital discharge planner/social worker, facility staff, external agency partner, etc.). A referent can be contacted initially to facilitate setting up an appointment for an

[1] CARE: Comprehensive Assessment Reporting & Evaluation

assessment, but a completed Consent Form (DSHS #14-012) would be needed for continued communication.

WHEN IS AN APPLICATION NEEDED?

An application is needed if the individual is not active on Medicaid.

HOW DOES THE INDIVIDUAL APPLY?

For Home and Community Services, the individual needs to apply through:

- Washington Connection online application site;
- Washington Health Benefit Exchange (for Community First Choice and Medicaid Personal Care only); or
- By submitting a completed HCA 18-005 form (classic Medicaid programs) or HCA 18-008 form (Medicaid Transformation Project, TSOA program).

FOR APPLICANTS CURRENTLY IN AN ACUTE CARE HOSPITAL

Paper: Hospital staff or applicant will submit an HCA 18-005 with an Acute Care Hospital coversheet.

Washington Connection: Application completed online at Washington Connection. When completing the application, the client/hospital representative should indicate the name of the hospital on the address line, and state that the client currently resides in a hospital in the additional comments section of the application.

WHEN IS AN APPLICATION FOR SERVICES NOT NECESSARY TO COMPLETE AN INTAKE REFERRAL?

There are times when an individual may not need an application to generate a referral and assignment to an assessor. These exceptions include, but are not limited to:

- Individuals on Hospice
- Imminent risk of hospitalization or nursing facility admission
- Individuals currently residing in an Acute Care hospital or Nursing Facility
- When the individual requests assistance completing the application
- Other circumstances on a case-by-case basis as reviewed and approved by a supervisor.

HOW DO I PROCESS AN INTAKE REFERRAL?

Adult Protective Services (APS) referrals related to abuse, neglect, or financial exploitation referrals must be reported using the APS intake phone line or online reporting site. Refer to APS Policy & Procedure For more information on the APS intake process.

HCS workers will process referrals in date of order received, unless they are notified by any source about situations that warrant prioritization.

HCS workers will do the following in the identified computer programs and by phone:

1) ***Barcode/[2]ACES Online:*** Review the application and the applicant's Electronic Case Record (ECR) to obtain the following information:
    a. Determine whether there is a communication (DSHS 07-104) from the Public Benefits Specialist that provides an estimated cost of care or other important financial eligibility information. Functional and financial eligibility are conducted concurrently and therefore details such as cost of care may not have been determined and that should not cause a delay in processing a referral.
    b. Identify whether the applicant needs an interpreter
    c. Identify whether the applicant has an informal decision maker, authorized representative (AREP), attorney-in-fact, or court appointed agent
    - Obtain and review document to ensure long-term care authorities; then upload to DMS for record retention.
    - Informal decision makers and authorized representative (AREP) must be redesignated and documented in a SER note at each Initial, Annual and Significant Change Assessment.

    d. Identify the applicant's current location/setting

2) ***[3]CARE:*** *See* CARE *Web* Assessor's Manual *for detailed instructions for these steps.*
    a. Search CARE for an existing client record:
        - If the case is active, review the Service Episode Records (SERs) to see whether any action is needed, and create an Information and Referral (I&R) record as needed.
            b. If the case is active and already assigned to a worker, an I&R record is not needed. Instead, notify the worker of referral and determine if the case needs to be reassigned to another unit.
        - If the case is not active, then reactivate the case in CARE.
        - If no record exists, create a client record and the intake in CARE.

[2] ACES: Automated Client Eligibility System
[3] CARE: Comprehensive Assessment Reporting & Evaluation

b. Once determined active in CARE, enter a SER to document the date the referral was received by the intake unit.
    a. Use Purpose Code "Intake Referral Received" and enter the contact date that the intake unit first became aware of the referral by any method (e.g., phone, fax, [4]DMS, etc.).
        i. Use this SER purpose code **ONLY** to document the receipt of a referral. Other information may be included in this SER if it is relevant to the referral.
    b. Use Purpose Code "Intake/Eligibility (HCS)" for all other intake related SER documentation (or other relevant SER codes). It is important to use this SER purpose code, using the criteria outlined here because the contact date associated to this SER will be used as a data point for reporting on intake and assessment timeliness.

c. Search to see if client record exists in ProviderOne. If yes, link to the ProviderOne record. If no, a record must be created completing the following steps:
    1. Complete the Residence Screen. Ensure the correct address is entered for "Residence, Mailing, and Temporary" addresses when applicable:
        - CARE Web: Client Details > Contact Details
    2. Complete all client demographics. If there is a current ACES record use the current information from ACES:
        - CARE Web: Client Details > Demographics
    3. Complete the Client Contact information:
        - CARE Web: Client Details > Contact Details
    4. Complete all known Collateral Contacts relevant to the applicant's upcoming assessment:
        - CARE Web: Client Details > Contact Details

d. Go to the ProviderOne Screen in CARE Web and link the client between CARE and ProviderOne following the steps in the CARE Web Assessor's Manual > Demographics > **ProviderOne** section.

    IMPORTANT: It is very important ensure linking of the correct records. Double check name spelling, Date of Birth and Social Security Number, especially when

[4] DMS: Document Management System

no match is found **BEFORE** creating a new record. If a new record is created when one already existed, it will cause payment problems.

If the individual is already residing on a private pay basis in a licensed facility that accepts Medicaid and needs to convert to Medicaid for ongoing payment purposes, skip to #4

3) Phone: Call the applicant and/or representative and discuss the following:

- Reason the individual is requesting services
- Identify the type of service(s) being requested
- Diagnoses and/or current challenges
- [5]ADL / IADL needs
- Is there anybody who is currently helping them with:
  - ADLs/IADLS
  - Finances
  - Getting to appointments
- Where does the individual want to receive services (In-home or residential)?
  - If in home, do they have an identified choice of provider (agency provider or Individual Provider)?
  - If residential, have they started searching for a facility type (Adult Family Home or Assisted Living Facility or specific facility)?
- The possibility of client responsibility and Estate Recovery
- If the referral came from anyone other than the applicant, ensure the referent is aware that participation in HCS services is voluntary for the applicant.
- The CARE assessment process takes about 2 ½ -3 hrs., is in-person and if conducted in a location other than where services will be provided, a home visit will be required. (Not pertinent to MAC/TSOA programs)
- Safety issues or concerns:
  - Document relevant information that an assessor should be aware of prior to making a home visit such as, whether there are locked gates, unmarked roads, or other hazards (such as extreme weather conditions or broken steps on stairways) that staff may encounter at the address, or lack of adequate cellular service.
  - Ask the client if they or anyone in the home has any concerns with their assigned Primary Case Manager completing a home visit to conduct their assessment. For instance, are there perfume or animal allergens to consider that the client, household member, or staff member must refrain from, are there animals in the home that must

[5] ADL/IADL: Activities of Daily Living/Instrumental Activities of Daily Living

be restrained prior to the home visit, any recent illness exposures amongst household members, or any environmental concerns, such as mold, bed bug/cockroach infestations, or do any household members own have weapons, and are these secured? Is there any illegal drug use or paraphernalia within the home?

- If LTSS are requested, assign a Primary Case Manager (PCM) in CARE by adding in the Overview screen. Add the PCM's supervisor as well. (Note: skip this step for MAC and TSOA applicants.). Send the applicant the booklet entitled Washington Apple Health and Long Term Services and Supports (DSHS 22-916(X)).
- Based on the applicant's preferred setting for LTSS, complete the following:
  - If in-home: determine if the applicant would like to choose an Individual Provider (IP) or a home care agency provider. If they identify a person they know, who would like to become an IP employed by the Consumer Directed Employer (CDE), obtain the name and phone number of the individual.
  - If Residential: also send the applicant the booklet entitled, Choosing an AFH or Assisted Living Facility

4) ***CARE HCS Intake Dashboard:*** In CARE, input the applicant into the HCS Intake. The following minimum data elements are required:

Name	Referral Type
ACES ID	ZIP
Received Via	LEP – Yes/No; if Yes, list language

MAKING CONTACT WITH AN INDIVIDUAL

1) HCS Intake staff will make at least 2 attempts on consecutive days to reach the applicant or representative using all telephone numbers available to them.
2) If the applicant cannot be reached and the Intake staff does not receive a call back within 3-5 calendar days, the Intake staff will send a letter documenting the multiple attempts to reach the applicant and give 10 calendar days to contact the Intake staff or the case will be closed. *See 10 day Letter*
3) Send a copy of the letter to DMS.
4) If the applicant or representative does not respond to the [6]10-day letter:

[6] Following a no response action to the 10-day letter, for applicants who (are active or pending an appropriate financial program) make contact or leaves a voicemail on the intake phone line after 10 calendar days, intake should consider a 30-day grace period to re-activate a case and process the intake interview or make one more call

a. Inactivate client record in CARE
b. Update the intake database to 'Information and Referral'
c. Send a 14-443 to financial documenting outcome

5) Document all activities in the SER in CARE

WHAT IF THE REFERRAL IS FROM A NURSING FACILITY?

A nursing facility must submit a Nursing Facility Notice of Action (NOA) (15-031) for all Medicaid clients in the facility (for financial). The facility must also submit an Intake and Referral form so that a Social Service Specialist (SSS)/Nursing Facility Case Manager (NFCM) is assigned to the case.

1) Once a referral is received from a Nursing Facility, the Intake staff will review Barcode to determine financial status within 2 business days, check eligibility in ACES and determine if the individual is in CARE. If an application is submitted or the individual is Medicaid eligible, assign to appropriate NFCM for functional assessment and refer to Chapter 10 of the LTC Manual for clarification.
2) If the client record is active in CARE and assigned to an AAA case manager or HCS SSS, determine if:
   - there is a current assessment
   - how long the client has been out of their residence (more or less than 30 days)
   - the client is choosing to return to their prior living situation or to change their living situation upon discharge
3) Submit a 14-443 to Public Benefits Specialist to notify them of the client's hospitalization
4) The holding agency (AAA or HCS) will transfer the case to NFCM as appropriate
5) Document all activities in a SER in CARE
6) If the client record is active in CARE and assigned to a DDA Case Manager or DDA PASRR RU, assign to appropriate NFCM for NFLOC assessment in CARE and document all activities in a SER in CARE. Refer to Chapter 10 of the LTC Manual for clarification.

WHAT IF THE REFERRAL IS FROM A HOSPITAL?

1) By the next business day after receipt of any hospital referral, Intake staff will review Barcode to determine what documents have been received and financial status.

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attempt to the applicant. If there is no answer then, there is no need to restart the intake process by making a second phone call and sending another 10-day letter.

2) Check eligibility in ACES and determine if individual is in CARE.
3) Contact the referring discharge planner at the hospital to determine the following, if the information was not already provided:
    - Is the individual still at the hospital?
    - If so, what is the anticipated date of discharge?
        - If unable to confirm discharge date and application was submitted (if needed) assign to SSS within 24 hours.
    - If not Medicaid eligible has an application been submitted, is so, what was the date submitted?
    - If the client record does not already exist in CARE, create the record using instructions from the CARE section above and assign to appropriate HCS SSS
    - If the client record is active in CARE and assigned to an AAA case manager or HCS SSS, determine if:
        - there is a current assessment
        - the client has been out of their residence for less than 30 days
        - the client is choosing to return to their prior living situation
        - the client is choosing to change living situations (e.g., it is unsafe for them to return to an in-home setting, and they request residential services)
4) Submit a 14-443 to the Public Benefits Specialist to notify them of the client's hospitalization
5) The Holding agency will transfer the case as appropriate
6) Document all activities in the SER in CARE

For further information regarding Hospital cases refer to LTC Chapters 9 a/b

WHAT IF AN APPLICANT WITHDRAWS THEIR REQUEST FOR SERVICES DURING THE INTAKE PROCESS?

It is not uncommon for an individual to withdraw a request for services prior to completing an intake. When an individual withdraws an application for services, attempt to connect the individual with other local resources that may be able to meet their needs and do the following in CARE:

- Enter a SER noting the reason for withdrawing
- Save the record as an Information and Referral (I&R) via the HCS Intake Dashboard.
- Inactivate the client record
- Send a 14-443 to notify the Public Benefits Specialist of the individual withdrawing (only when an individual has applied or is active on Medicaid with HCS).
    - For Skilled Nursing Facility (SNF) residents: If a client is active on a Medicaid Medical program, Nursing Facility Case Managers (NFCMs) still have an obligation and responsibility to determine Nursing Facility Level of Care (NFLOC) and confirm ongoing functional eligibility for the Nursing Facility services by

statute. Though a client may withdraw a request for community LTSS, it is unlikely that they would close out their established medical benefit which is paying for their SNF care.

WHAT IF AN INDIVIDUAL REAPPLIES FOR SERVICES?

If a request for services is received from an applicant who was assessed and found to be functionally ineligible in the past 30 days, the following steps should occur before reactivating the applicant's CARE record and creating a new referral:

1) Call the applicant to review their current situation and request for services.
2) Review the functional eligibility process with the applicant.
3) Since the last assessment was completed, ask if there has been:
    - a change in the individual's condition, situation, or supports
    - any recent hospitalizations
    - any new diagnoses or medical conditions, or
    - any other relevant changes
4) If there has been a change in condition since last assessment, process a new intake.
5) If there has not been a change in condition, and after reviewing the eligibility process, the applicant requests to withdraw the service request, document this conversation in the SER. Do not reactivate the case in CARE
6) If the individual chooses not to withdraw the request, the Intake staff will route the request to the supervisor of the last assessor.

The supervisor will:

1) Review the information identified in #1 of this section
2) Contact the individual
3) Review the previous assessment and determine the most appropriate course of action

If the supervisor determines a new assessment will be completed, the Supervisor will:

1) Determine who the assigned Social Service Specialist will be.
2) Route the request back to Intake for creation of a new referral.
3) Document all activities in the SER.

If the supervisor determines a new assessment will not be completed, the supervisor will:

1) Review administrative hearing rights with the individual, relative to the last assessment.
2) Document all activities in the SER.

WHAT IF THE REFERRAL IS FOR AN INDIVIDUAL WHO RESIDES OUT OF STATE?

An individual cannot be approved for and/or made active on Washington State Medicaid until they are a resident of the State of Washington, but Medicaid financial eligibility determinations can be initiated while the person resides in another state. The individual or AREP can be provided with an Application for Benefits and list of necessary verifications while out of state. Applications should be submitted before arrival in Washington State, but not more than 45 days before the individual becomes a resident.

Social services cannot determine whether an individual is functionally eligible for Medicaid under Washington State guidelines unless the individual is a Washington state resident. Social Service Specialists or nurses do not go out-of-state to conduct CARE assessments ([7]unless there is a Memorandum of Understanding (MOU) with a border state hospital).

If someone is moving to Washington and knows where they will be residing, an assessment can be scheduled prior to or upon their arrival but will occur once the individual is residing in Washington. Coordination with the individual and scheduling of the assessment are critical to ensure services start as soon as possible after arrival in WA.

WHAT APPLICANTS AND THEIR REPRESENTATIVES NEED TO KNOW

- LTSS cannot be approved retro-actively for in-home services or in facilities other than a Nursing Facility.
- DSHS cannot pay for services while a functional eligibility determination is being processed. An exemption to this is the Presumptive Eligibility (PE) process allowing for services to be provided during the PE period (usually less than 60 days) while the final functional and financial determination is being completed. See Chapter 30b/Initiative 2: LTSS - Medicaid Alternative Care (MAC) & Tailored Supports for Older Adults (TSOA), and Chapter 30e/Long-Term Services and Supports Presumptive Eligibility (LTSS PE), for more information on PE.
- It is typically not possible to assess an individual the same day or week they arrive in Washington. This means an individual will need to consider other options, such as:
  - Residing with friends or family until financial and functional eligibility has been determined. If eligible, the client will need to choose in-home or residential services then select a qualified provider; or
  - Moving into their desired service setting *on a private pay basis* until functional and financial eligibility can be determined. Medicaid will not begin to pay for services until both functional and financial eligibility have been established (unless the client has been approved for fast track).
- The intake process can feel complicated. Individuals applying for services or their family members may feel anxious and overwhelmed about how to navigate the system. If a call is received or an individual is greeted at the front desk wanting to understand how to go through this process and Intake staff feels a lack of confidence explaining this, please refer the matter to someone who is knowledgeable (e.g. a Social Service Supervisor or Public Benefits Specialist Supervisor).

[7] Some offices may have an MOU with a border state hospital (Oregon or Idaho) which is acceptable if the individual is active on WA Apple Health. This arrangement is not allowed for Canada residents.

WHAT IF A REFERRAL IS FROM AN INDIVIDUAL WHO IS IN JAIL OR PRISON?

Individuals in a jail or prison in Washington are considered residents of the State of Washington. Referrals for individuals in jails will follow the regular intake process. Medicaid financial eligibility determinations can be initiated while an individual is in either a jail or prison facility. The individual, representative, or staff at the jail/prison can be provided with an application for benefits or directed to the online application. Applications should be submitted as soon as a potential release date is known.

HOW ARE DDA CASES DIFFERENT?

HCS serves clients aged 18 and older. DDA serves clients from birth to end of life. Both HCS and DDA administer 1915c waiver programs, Medicaid Personal Care (MPC), and Community First Choice (CFC) services. Below is a table illustrating the 1915c waivers under each administration:

HCS	DDA
COPES	Basic Plus
New Freedom	Core
Residential Support Waiver	Community Protection
	CIIBS (Children's Intensive In-Home Behavioral Supports)
	IFS (Individual and Family Services)

Collaboration between DDA and HCS is required to determine which agency will conduct the applicant's CARE assessment and authorize services in the event of possible dual-eligibility, or while initial eligibility or eligibility re-determination[8]** for DDA eligibility is being conducted.

If HCS receives a referral for services from an adult receiving service through DDA:

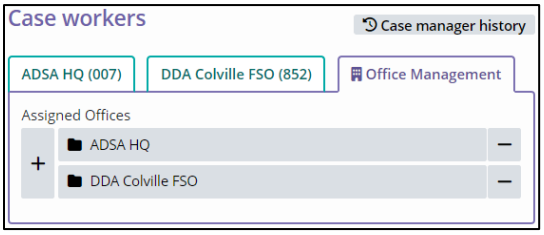
1) Consult with a Public Benefits Specialist in the LTC specialty unit to determine the appropriate program. Contact the specialty unit at 1-855-873-0642
2) If financially eligible for MPC or CFC:
    a. Inform the client/representative of the availability of DDA case management to assess, authorize and provide MPC or CFC services.
    b. Refer the client/representative to the DDA Non-Paid Services Intake line at 1-800-567-5582

See Chapter 7 *Intro. To Medicaid, State Plan, and 1915c Waivers* for detailed information.

[8] WAC that outlines DDA program eligibility changed in 2005. Any DDA client who was found to be eligible for their services prior to 2005 must go through eligibility re-determination when they apply for a paid service such as MPC or CFC**

How do I know a case has DDA involvement?

The Overview screen may look like the following:



The decision whether DDA or HCS will take a case is complex and includes a number of variables. The Intake Supervisor should always be consulted when there is any question about which agency should take action on a case that has existing DDA involvement of any sort.

WHAT IS CLIENT RESPONSIBILITY?

This section is informational. Intake is only responsible for providing basic information on estate recovery and cost of care.

Client responsibility is determined by a Public Benefits Specialist. It is composed of three parts:

- **Room and board** (R&B) is a portion of the total payment paid by the client to the residential provider for expenses related to food, shelter, heat, utilities, etc. All residential clients with income greater than the current Personal Needs Allowance (PNA) amount must pay towards the cost of Room & Board. Any R&B costs not covered by the client's income are paid for using state-only funds. Clients must pay R&B before the department pays the provider.
- **Participation** is a portion of the client responsibility paid by the client to the provider to cover part or all their cost of care. Unlike R&B, participation begins the first day the client receives services.
- **Third-party resource** (TPR) a portion of client responsibility that may include some types of Veterans Affairs benefits, L&I income, Trusts and Long-Term Care insurance. TPR may also be called Third Party Liability (TPL). Third-party resource amounts may be listed on the ACES award letter and included in the line, "Total amount you must pay."

Clients who do not have to pay client responsibility:

- A client who receives supplemental security income (SSI).
- Clients who just receive CFC and not a home and community-based waiver service.
- Clients enrolled in the MAC and TSOA programs.

- Clients who are otherwise eligible for Medicaid in the community – for example clients who receive SSI-related medical coverage but do not get an SSI payment. Most of these clients receive a type of Social Security disability or retirement benefit.
- Clients who receive MAGI-based coverage (N-track).

Which clients will have to pay client responsibility?

- Clients who are eligible for CFC but need to access a waiver service to be Medicaid eligible.
  - Clients under 65, not eligible for Medicare with income over 133% FPL who do not qualify for coverage through the Healthplanfinder. Before waiver services can be approved for a MAGI client, a disability determination must be made which may take 60-90 days.
  - Clients 65 or older or those under 65 who have Medicare who have income over the SSI benefit rate who do not qualify for regular Medicaid. These clients must access a waiver service to be eligible.
- All clients who live in a residential setting will be required to pay for their room and board. A MAGI client's room and board amount will be calculated by the assigned SSS. Instructions for this are in the Social Services Authorization Manual (SSAM).
- All clients who receive CFC ***and*** a waiver service will potentially be required to pay participation toward the cost of all the services provided, including personal care through CFC.

How much participation will clients pay?

It depends on many variables including where they live, whether they have a spouse or not, whether they have dependents, and whether they have any unpaid medical expenses or allowable deductions. Applicants should be referred to their Public Benefits Specialist to understand what their cost of care will be if they are on any form of "Classic Medicaid."

Explain that participation is like a co-pay; the client's portion is paid first to the provider and then DSHS pays the remainder of the client's cost of care to their in-home or residential provider. If a client has no income, they are not required to contribute to their cost of care.

There is no cost to the applicant to have a CARE assessment to determine functionally eligibility for services. Also, there is no cost to have a Public Benefits Specialist fully evaluate their case to determine if they will have participation and what the amount would be. Participation will only apply once services are authorized and received.

In-Home: Most clients who are single, keep up to 100% federal poverty level as a Personal Needs Allowance (PNA) and pay income over that, toward their cost of care. Married clients have a lower PNA, but also allowed an allocation to their spouse which reduces their income.

Many married clients do not end up paying participation because the allocation to the spouse can be quite high.

Residential: Generally, with most income sources the client retains a portion of their monthly income. This is called a Personal Needs Allowance (PNA). The remainder of their income is paid as room and board and participation. In turn, all their personal care, meals, utilities and toiletries will be provided by the facility.

WHAT IS ESTATE RECOVERY?

State law requires staff to fully disclose in advance, both verbally and in writing, the terms and conditions of estate recovery to all persons offered LTSS that are subject to recovery of payments. **All ALTSA services except services offered through MAC and TSOA and APS are subject to estate recovery.**

The estate recovery program recovers the cost of Medicaid LTSS and related hospital and prescription drug services from a deceased client's estate. 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.

More about Estate Recovery:

- 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.
- Some assets are exempt from estate recovery, and this includes most American Indian/Alaskan Native assets.
- DSHS will delay recovery under certain circumstances. Including when there is a surviving spouse who lives in the home or minor, blind or disabled children who still live in the home.

Required Publications

To meet disclosure requirements and to promote understanding by the applicant, DSHS must provide the documents linked below to all prospective and new clients and verbally explain both the estate recovery program and the community service options available.

These documents will be provided to the client/representative at the time of their assessment; however, if an applicant is hesitant to move forward with an assessment before learning more

about estate recovery, the Social Service Specialist (SSS) should mail the documents to the applicant and document this activity in the Service Episode Record (SER). The SSS should ask the individual if they would like to have Home and Community Services continue with their application while they review the information.

- Columbia Legal Services Article: Estate Recovery for Medical Services Paid for by the State;
- Northwest Justice Article: Native Americans and Alaska Native Property Owners: Exemptions from Estate Recovery
- HCS publication: Medicaid and Options for Long-Term Care Services for Adults (DSHS 22-619x)

RESOURCES

LTSS Definitions WAC
Apple Health Medicaid Manual
Chapter 7 a-h: Medicaid, State Plan, and 1915c Waivers and more
Chapter 30b Initiative 2: LTSS - Medicaid Alternative Care & Tailored Supports for Older Adults
Chapter 9a: Acute Care Hospital Assessments
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Chapter 10: Nursing Facility Case Management and Relocation
Chapter 11: Consumer Directed Employer

Acronyms

A complete list of Washington State Department of Social and Health Services acronyms can be found here.

AAA	Area Agency on Aging
ACES	Automated Client Eligibility System
AREP	Authorized Representative
APS	Adult Protective Services
CARE	Comprehensive Assessment Reporting & Evaluation
CDE	Consumer Directed Employer
CDWA	Consumer Direct Care Network Washington
CFC	Community First Choice
DDA	Developmental Disabilities Administration
DMS	Document Management System
DSHS	Department of Social and Health Services
ECR	Electronic Case Record
FCSP	Family Caregiver Support Program
HCS	Home and Community Services
I&R	Information and Referral
IP	Individual Provider
LTSS	Long-Term Services and Supports
MAC	Medicaid Alternative Care
MPC	Medicaid Personal Care
MTP	Medicaid Transformation Project
NFCM	Nursing Facility Case Manager
PE	Presumptive Eligibility
PNA	Personal Needs Allowance
SER	Service Episode Record
SNF	Skilled Nursing Facility
SSI	Supplemental Security Income
SSS	Social Service Specialist
TPL	Third Part Liability
TPR	Third Party Resource
TSOA	Tailored Supports for Older Adults

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
8/18/2020	Rachelle Ames	Overall changes to word choice and grammar to improve readability	
		Added more specific instructions or steps in multiple sections of the chapter to improve clarity of policy/procedure	
		Added policy related to documenting Intake activities in the SER	H18-049
		Added policy/procedure for referrals that come from jails or prisons	
		Upgrade to new format	
5/2023	Dru Aubert	Updated procedure to remove action steps related to CARE Desktop. If not already, CARE Desktop screens referenced in this chapter will be made read-only after 06/30/2023 CARE change/MB release.	
8/2023	Dru Aubert	Updated links. Removed former APS LTC Chapter reference; replaced with APS P&P policy location. Updated CARE Desktop reference(s) to CARE Web.	
4/2024	Dru Aubert	• Replaced naming conventions from Intake Database to CARE HCS Intake Dashboard. • Added clarification for an existing client under section, HOW DO I PROCESS AN INTAKE REFERRAL? • Added prioritization and clarified NFCM steps when case is active and assigned to DDA/DDA PASRR RU, under section, WHAT IF THE REFERRAL IS FROM A NURSING FACILITY? • Added section, WHAT IS THE DIFFERENCE BETWEEN AN APPLICANT, REFERENT, AND A REPRESENTATIVE?	
10/2024	Dru Aubert	• Added to section, HOW DO I PROCESS AN INTAKE REFERRAL?, for in-home settings, to instruct documentation of relevant information that an assessor should be aware of prior to making a home visit. • Added to section, MAKING CONTACT WITH AN INDIVIDUAL, to implement a 30-day grace period, following a no response action to the 10-day letter, for applicants who (are active or pending an appropriate financial program) make contact or leaves a voicemail on the intake phone line after 10 calendar days.	

4/2025	Anna Mitchell	• Added clarification about informal decision makers, authorized representatives, attorneys-in-fact and court appointed agents	

Case Management

Chapter 5 explains the philosophy of case management, HCS and AAA case management responsibilities, and the case management tasks required for in-home, residential, nursing facility, and hospital clients.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Natalie Lehl Care Management Program Manager
360.725.2330 natalie.lehl@dshs.wa.gov

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BACKGROUND

Goals

The primary goals of case management are to assist the client to develop a plan of care to enable them to reside in the setting of their choice and to monitor that plan. Case managers will support the client's independence by coordinating and offering assistance to access needed services. Case managers are custodians of the state's resources and must balance a client's choice with program limits.

Case managers:

- Educate clients, family members, support systems, and other service providers that a comprehensive plan of care is developed within the choices and resources available and that meeting *all* needs may not be possible.
- Must not view limited choice as a restraint on creative care planning. As a manager of state resources, staff should utilize naturally occurring resources or access non-traditional means to assist a client in meeting his/her needs and to develop supports based upon realistic expectations and coordinated problem solving.
- Provide client-centered services, evaluating informal and community supports, with an overarching goal of preventing unnecessary institutionalization.
- Support/maximize client independence and self-direction.

Functions

Core functions may not be waived by the client and include:

- **Assessment.** Perform a face-to-face assessment with the client in the client's residence to determine service needs and program eligibility at least annually.

- **Planning/Plan Monitoring.** Develop a plan of care with each client, authorize services according to that plan, and authorize the client's choice of qualified provider. Monitor, through periodic home visits (scheduled and unscheduled) and telephone contacts, to see if the plan is being appropriately implemented and if the services provided are meeting the client's needs.

> **Mandatory Reporting:** Report abuse, abandonment, neglect, or financial exploitation to Adult Protective Services (APS) per Chapter 74.34 RCW. Mandatory reporters are not required by law to report self-neglect by a vulnerable adult.
> Social Service Specialists and Case Managers are considered Mandated Reporters of abuse, abandonment, neglect, and financial exploitation of vulnerable adults. If information is reported to the SSS/CM about a client or other vulnerable adult ***and the person providing the information to the SSS/CM indicates they have already made a report to APS***, the SSS/CM may consider the following to determine if they too, should make a report to APS:

- An additional report by the SSS/CM is not required if verified that the report was made. This must be done by asking the reporter for a reporting confirmation or intake number or contacting APS to verify a report was made. These steps must be documented in the CARE SER.
- A mandatory reporter takes a personal risk and a risk to the agency they work for if they choose not to make a report to APS and there is a negative outcome for the vulnerable adult that was not reported to APS.
- See Adult Protective Services policy and procedure and Chapter 74.34 RCW for detailed information about mandated reporting, including consequences of failure to report.

- **Report Suicide Ideation:** If this client has a plan, the means to carry it out, and a time planned, do not leave the client alone. You may withdraw to a safe distance if you fear for your own safety (loaded gun, etc.) and call 911. Contact the local County Designated Crisis Responders, explain what the client has told you and that you are concerned for the client's safety.

- **Termination Planning.** It is good practice to let all clients know that their services are based on their current needs and can change if their needs change. This is especially true if they are ill with a temporary condition (e.g. post-surgical, broken bone). When the CARE assessment determines that a client is no longer eligible: make necessary referrals (if needed) to transition to other services, provide adequate notice, via a Planned Action Notice (PAN) and close services in the necessary timeframes.

> Note: If a client is receiving an ALTSA housing resource, you must contact the assigned HPM prior to inactivating the case. Please involve assign HPM in any case staffing's regarding the client. ALTSA has services to support housing needs. Please include HPMs if housing is a concern. For more information visit Chapter 5B.

Supportive functions may be waived by the client and include, but are not limited to:

- **Client Advocacy.** Support client self-advocacy. Intervene with agencies or persons to help clients receive appropriate benefits or services. Clients may also request assistance with advocacy from their case manager even when they are able to advocate for themselves.

- **Assistance.** Assist clients to obtain a needed service or accomplish a necessary task that, due to physical or cognitive limitations, they cannot obtain independently.
  Assistance can include but is not limited to:
  - Completing a form.
  - Researching a living situation.
  - Assistance with moving arrangements.
  - Arranging transportation.
  - Assisting with Medicaid eligibility review.
  - Other services related to the plan of care.
  - Assistance with locating, hiring, contracting, and terminating providers of their choice.

- Assistance applying for administrative hearings and access to an administrative hearing coordinator.

- **Referrals**. Making and following up on mandatory referrals as identified in the assessment.

- **Family Support**. Assist the family or others in the client's informal support system to:
  - Make necessary changes in the home environment and/or lifestyle that clients have agreed to;
  - Encourage changes in high-risk behaviors or choices that may improve the stability of the plan of care or improve health and psych/social outcomes;
  - Plan a move to or from residential care, etc.
  - Encourage caregiver self-care through support groups, education, and assistance accessing resources.

- **Crisis Intervention**. Assist with short-term crisis intervention in an emergency situation to resolve an immediate problem before a long-term plan is developed or current plan is revised. Crisis intervention may include, but is not limited to:
  - Use of an Exception to Rule (ETR) (see Chapter 3).
  - Arranging for a temporary move to an AFH or a NF.
  - Authorization of Client Training or other waiver or CFC services.
  - Calling 911.

- **Access Resources.** Examples of available resources include discharge resources, local community services, assistive technology and benefits under the Medicaid State Plan.

Handling Challenging Cases. Follow the "Challenging Cases Protocol" when the recommended plan of care, appropriate to the client's health, welfare, or safety, cannot be implemented.

Case Management Responsibilities

Per RCW 74.39A.095, case management responsibilities for long-term care clients are shared by Home and Community Services and the Area Agency on Aging.

Home and Community Services (HCS) Responsibilities

1. Newly admitted applicants or clients to a nursing facility (NF) who will likely stay in the NF for more than 30 days: Medicaid applicants, Medicaid clients, and dually eligible for Medicare/Medicaid.
2. Long-term Medicaid residents of nursing facilities and those residents who are converting or likely to convert within 180 days to Medicaid (from Medicare or private pay).
3. Newly admitted to or current Medicaid residents in Adult Family Homes (AFH), Assisted Living Facilities (ALF), Enhanced Adult Residential Care (EARC) facilities, and Adult Residential Care (ARC) facilities.

4. Any adult with prior Adult Protective Services (APS) involvement and in need of ongoing case management and not receiving Core services. See APS policy and procedure for more information on APS.
5. Initial entry into ALTSA-funded in-home or residential long-term care services.
6. Hospital discharge.
7. Private Duty Nursing clients.

Area Agency on Aging (AAA) Responsibilities

1. All clients, age 18 and older, receiving ALTSA-funded, community-based services in their home.
2. In-home Medicaid clients who are temporarily in institutional settings. See the Case Transfer Guidelines Section of this chapter for additional information.
3. Based on staff resources, adults age 60+ who reside in the community, and are not receiving LTC Core Services are assessed as able to remain in a non-residential setting, and:
   a) Require multiple services and/or related activities performed on their behalf;
   b) Are unable to obtain the required services and/or perform the required activities for themselves;
   c) Do not have family or friends who are able and willing to provide adequate assistance;
   d) Meet a-c above and require ongoing case management after an Adult Protective Services (APS) investigation has been completed.
4. If the AAA wants to limit the criteria outlined in 2, it must be approved by ALTSA and included in the contract.

TYPES OF CASE MANAGEMENT

In Home

HCS will:

1. Perform an initial assessment.
2. Develop the service plan.
3. Ensure clients are informed of choices among qualified providers.
4. Authorize services.
5. Make a telephone monitoring contact with the client if case is held longer than 30 days. See 'Transferring a Case' for more details.
6. Transfer the case to the AAA. Refer to the Case Transfer Guidelines within this chapter.

Once the AAA receives the case from HCS or another AAA:

1. Case managers will make a face-to-face visit in the client's home within 30 calendar days of assignment to the Primary Case Manager (PCM) in CARE in the following circumstances (case must be assigned to PCM within 5 business days per Case Transfer Guidelines):
   a) Client is identified as Targeted Case Management (TCM) by the receiving office or by the transferring office on the CARE Overview screen; or

b) Client has Behavior Point Score (BPS) >6 as documented in CARE (PCR, PCRC, and/or CARE results); or

c) Client has a documented current pressure ulcer; or

d) The current assessment was performed in a
   - SNF, or
   - Hospital, or
   - A different in-home setting than the one they are currently residing in, or
   - Residence screen indicates client has been homeless in the past twelve months; or

e) Explicit Terminal Prognosis is documented in CARE or End of Life/hospice is indicated on Case Transfer form or treatment screen; or

f) ***Supervisor or case manager has discretion to make a face-to-face visit even if any of the above criteria are not met to require a visit.***

2. If a client does not meet the criteria for a 30-day face-to-face visit, the case manager or a case aide must make a **telephone call to the client within 30 days** of initial assignment to the receiving worker and confirm that the client is receiving services as identified in their care plan. The telephone contact must be with the client. A client's representative may be contacted only if the client is unable to communicate. If someone other than the client is contacted, document the reason in the SER.
   - If the telephone call results in any concerns that require a face-to-face visit listed in #1 above, the case manager will schedule a face-to-face visit within 45 days from the date the case was initially assigned to a worker in the receiving agency.

The telephone or face-to-face (30-day) contact includes sharing and gathering the following information:

- CM/RN/CA introduction to client and reason for the contact.
- Confirming that the care plan is meeting the client's identified needs and preferences (e.g., personal care, equipment, resource/referrals, follow up appointments, client's comfort level with the care).
- Determining if there have been any changes in the client's condition, service plan, supports or preferences for case management follow up.
- Advising client/client representative to call the CM/RN if there are concerns at any time.
- Verifying the client has contact information for the CM/RN and knows how and when to contact the case manager.
- Document in a CARE SER note, using the appropriate Contact Code (Telephone Call or Home Visit) and the "30 Day Visit" Purpose Code, containing a summary of the discussion/results.

AAAs wishing to exceed the standard may use the 30-day call to schedule a face-to-face visit within 45 days from the date the case was initially assigned to a worker in the receiving agency, for the lower risk clients.

Note: If the file has been returned to HCS per the Case Transfer policy, a new 30-day period begins on the date of the latest electronic transfer to the AAA.

3. One **annual face-to-face assessment** in the client's home must be completed at least every annual cycle. Significant Change assessments (if they occur) reset the Plan Period annual clock (See Chapter 3 for discussion of assessment Plan Period and when a Significant Change assessment should be considered temporary). A **Plan Period Tickler** will warn 40 days before a Plan Period expires.

4. All clients will also receive regular monitoring contacts to **monitor the plan of care**, especially any issues that were not resolved at the time of the last face-to-face visit. Clients who meet any of the targeted case management (TCM) criteria will receive more frequent contacts (see TCM section).
    a) For Non-Targeted clients, **three monitoring contacts** are required annually in addition to the face-to-face assessment. These contacts can be by phone or in person. The 30-day telephone or face to face visit may count as one contact in the first year. Monitoring plan contacts made by HCS will also count in the first year.
    b) Contacts with the client to assist them with critical needs related to: health and safety; maintenance of community living status; or the plan of care will count toward the required annual monitoring contacts.
    c) Activity that originates around a supportive function can also be used as a monitoring contact if service plan delivery is discussed.
    d) You may contact a client representative or other collateral contact only if the client is unable to communicate. If you contact someone other than the client, document the reason in the SER.
    e) Document all contacts you consider as monitoring contacts in **SER** using **Purpose Code "Monitor Plan".** This will enable an automated Tickler to notify the CM if more than 4 months have passed since the last Monitor Plan SER entry.

Targeted Case Management (TCM)

Targeted Case Management criteria include, but are not limited to the following:

- Has a potential for abuse and neglect as identified in the assessment on the Safety screen or in the SER. This includes all clients who have: had an Adult Protective Service (APS) referral in the last year or had an open APS case.
- Lives in an environment that jeopardizes his/her personal safety, as identified in the assessment on the Environment screen or in the SER.
- Is not always able to supervise his/her paid provider as identified in the assessment on the Cognitive Performance screen and no one is identified on the Cognitive Performance screen as the person responsible for supervision.
- Has thought about suicide in the last 30 days, as indicated on the Suicide screen.

- Is sometimes or rarely understood, as identified in the assessment on the Cognitive Performance screen.

For TCM clients, the purpose of these contacts is to monitor issues related to the client's targeted criteria as well as client condition and service plan delivery. Document each discussion with the client in the SER. Examples of TCM include:

- Working with the client to find a payee to manage his/her finances when there is evidence of financial exploitation.
- Helping the client locate housing in a safe neighborhood.
- Encouraging the client to consult a mental health specialist about his/her suicidal ideation and depression.

Contact requirements include:

- At least one additional face-to-face visit in the client's home within one year from the beginning of TCM and each year following. If the 30-day visit occurs during the first year, it may count as the additional face-to-face visit. Visits may include AAA nursing assessments and /or collateral professional in-home contacts that have conferred with the case manager and agreed to represent the case manager's concerns and needs while on-site. These in-home contacts report back to the case manager after the on-site visit.
- In addition to the face-to-face requirements, at least four monitoring contacts with the client are required annually.
    - You may contact a client representative or other collateral contact only if the client is unable to communicate. If you contact someone other than the client, document the reason in the SER.
- Use the TCM Service Episode Record contact code to designate the date TCM began or was terminated. Document the reason(s) the client was:
    - Placed on targeted case management.
    - Terminated from targeted case management.
    - Not placed on targeted case management if they meet targeted criteria (Possible example: APS investigation in last year of an IP who no longer works for client).
- Use the "Targeted Case Management?" item on the Overview screen to indicate whether the client is currently receiving TCM services.

Guidelines to Support Move from In-Home to Residential Setting

If a client desires to move to a residential facility or nursing facility, follow case management guidelines outlined below. Prior to transferring the case to HCS, you will need to:

- Inform the client of alternative options to confirm their choice of living arrangement
- Discuss the personal needs allowance (PNA) limits in residential settings and that the client will have a responsibility to pay their provider every month
- Complete the necessary forms and perform another assessment as needed.

- Contact HCS and review the request for admission, residential setting options, and the most current assessment.
- Verify that the facility has a Medicaid bed available and is contracted to provide for any special needs (e.g. dementia).
- Have the client sign an Acknowledgement of Services form (DSHS 14-225), if appropriate.
- Request verbal approval prior to authorization of services in the new setting. Document plan approval in the SER and send documents for signature per Chapter 3 policy.
- Review the Assessment Details and Service Summary with the provider prior to the client's transition to the residential setting and document in the file.
- Notify financial using the DSHS 14-443 within Barcode and, if applicable, get updated participation amounts from financial. If the client does not enter on the planned date, the participation may need to be adjusted.
- Close all in-home authorizations and open residential authorizations.
- Notify HCS that the client has moved and transfer the case to HCS if the client is expected to stay more than 30 days in the residential or nursing facility.
- If appropriate, ensure current approved Behavioral Health Personal Care (BHPC) Request for Managed Care Organization (MCO) Funding form (DSHS 13-712) is in the client's electronic case record (ECR) file. See Chapter 22a of the LTC Manual for more information regarding MCO-funded BHPC Wraparound Support Services.

For Residential Settings (not Nursing Facility):

Perform either a significant change or interim assessment according to policy.

1. Update the 'Planned living arrangements' dropdown in the Assessment Main screen (When residential is chosen, the IADL screens will appropriately be cleared).
2. When the client chooses an AFH, the AFH evacuation level must be selected on the Safety screen.
3. Assign treatments to the appropriate Provider Type in the Treatments Screen.
4. Update the Supports Screen assigning appropriate tasks to the residential provider.
5. Change the 'Client chose/planned living situation' setting on the Care Plan screen.

Further information can be found in the Providing Residential Care Case Management and Nursing Facility Case Management sections of this chapter.

Residential

HCS provides initial and ongoing case management to all Medicaid clients in Adult Family Homes (AFH) and licensed boarding homes who have contracted with ALTSA to provide Assisted Living, Enhanced Adult Residential Care, and Adult Residential Care services.

Initial CM Responsibilities

1. Perform an Initial assessment.
2. Complete the:
   - Individual with Complex Behaviors (DSHS 10-234a) for clients with challenging behaviors (assaultive, destructive, self-injurious, inappropriate sexual behaviors, or history of misdemeanor behavior).
   - Behavioral Health Personal Care (BHPC) Request for MCO Funding (DSHS 13-712) for clients who meet the criteria for Wraparound Support services as listed in Chapter 22a of the LTC Manual.

Coordinating with the Client and Family

1. Work with the client and the family. If the client does not request the transition to a residential setting (often a member of the client's family will contact the social service specialist about moving a client), determine if the client is also requesting or agreeable to move to a new setting.
   a. Explain that the client will have a responsibility to pay participation to their provider every month and will have only a limited amount of money for personal use. Inform the client that failure to make the required payment to their provider may result in a transfer or discharge from the facility.
   b. Have the client sign an Acknowledgement of Services form (DSHS 14-225) if appropriate.
   c. Have the client sign the Service Summary or give verbal approval prior to authorization of services in the new setting. Document plan approval in the SER.

2. Use the AFH/BH Lookup Application to identify facilities with available Medicaid beds (Note: The lookup list does not reflect current Stop Placement actions). Send the list to the client and/or the family so they can visit as many as possible before making a choice. For client transitions to an AFH, if you identify clients with:
   - Dementia or special care needs, they must choose an AFH with that specialty designation.
   - An Axis I or Axis II DSM IV diagnosis, they must choose an AFH with the Mental Health Specialty designation.
   - Skilled nursing tasks needs, they must choose an AFH that has Nurse Delegation training. Skilled nursing may need to be provided by visiting nurses. Not all tasks are subject to nurse delegation and the client may need to choose an AFH owned and operated by a Registered Nurse.

Coordinating with the Residential Provider

1. Contact the facility to confirm a Medicaid vacancy. Provide and review assessment details and service summary with the facility to determine if the facility can meet the client's needs. Disclose the rate generated by CARE and discuss possible admission date. Document outcomes in the SER in CARE.

2. Within 30 days of the client's admit or conversion (as documented in CARE), assigned staff will visit the facility, meet with the client and facility staff to review, discuss, and sign the Negotiated Care Plan (NCP) or Negotiated Service Agreement (NSA) in any of the following circumstances:
    a) The client was admitted from a state hospital, Department of Corrections, or another specialized institution; (e.g. Hospital Psych Unit, Eval/Treatment center, etc.); or
    b) Client has Behavior Point Score (BPS) >6 as documented in CARE (PCR, PCRC, and/or CARE results); or
    c) Has a potential for abuse and neglect as identified in the assessment on the Legal Issues screen or in the SER. This includes all clients who have had an Adult Protective Service (APS) referral in the last twelve months or have an open APS case; or
    d) Is coded as making Poor Decisions or No/Few Decisions in the assessment on the Cognitive Performance screen and does not have an authorized representative (AREP) or informal decision maker identified in CARE; or
    e) Has thought about suicide in the last 30 days, as indicated on the Suicide screen; or
    f) Is sometimes or rarely understood, as identified in the assessment on the Cognitive Performance screen; or
    g) Client has a documented current pressure ulcer; or
    h) Explicit Terminal Prognosis is documented in CARE or End of life/hospice is indicated on Case Transfer form or Medical screen; or
    i) Supervisor or Case Manager/Social Service Specialist has discretion to make a face-to-face visit even if any of the above criteria are not met to require a visit.

> **Note:** For clients converting from private pay to Medicaid, if they have been in a residence more than 30 days prior to conversion, a 30-day visit is not required. The signed NCP or NSA may be obtained by mail or fax.

3. If a client does not meet the above criteria for a 30-day face-to-face visit in the facility, have the facility fax/send the NCP/NSA to the worker. The worker must phone the client and facility staff to review and discuss the Negotiated Care Plan (NCP) or Negotiated Service Agreement (NSA) within the same 30-day timeframe.

    - If the telephone call results in any concerns that require a face-to-face visit listed in #2 above, the worker will schedule a face-to-face facility visit within 45 days of the client's admission, conversion, or transfer to their current residence.

The 30-day telephone or face-to-face contact includes sharing and gathering the following information:

- Introduction to client and reason for the contact.

- Discussing whether the NCP or NSA is meeting the client's identified needs and preferences and determining their satisfaction with it.
- Determining if there have been any changes in the client's condition or preferences for case management follow up.
- Advising client/client representative to call the Case Manager/Social Service Specialist if there are concerns at any time.
- Verifying the client has contact information and knows how and when to contact the Case Manager/Social Service Specialist.
- Document in a CARE SER note, using the appropriate Contact Code (Telephone Call or Home Visit) and the "30 Day Visit" Purpose Code, containing a summary of the discussion/results.
- Include a copy of the NCP or NSA with signatures of the provider and client in the client's electronic file once received by mail or fax.

> **Note: If a copy of the NCP or NSA has not been returned within 30 days but has been requested by the CM/SSS, make a report to the Complaint Resolution Unit (CRU) by phone at 1-800-562-6078 or online.**

4. If items were not taken into account during the development of the NCP or NSA, meet with the provider and attempt to resolve these issues prior to signing the agreement. Formal meetings should occur as appropriate to resolve issues of concern.

Ongoing CM Responsibilities

Visiting and Assessing the Client Annually or Sooner

1. Determine the frequency of contact with each client based on the client's:
   - **Care needs.** Does health status change frequently and/or is the client unstable?
   - **Cognition.** Does the client have impaired cognition and/or communication skills?
   - **Emotional**, **psychiatric**, and/or **behavioral** problems.
   - **Support system**. Does the client have a family or social support network?

2. Perform Annual or Significant Change assessments. Obtain and document client consent to services in the SER using the plan approval purpose code. Provide the plan of care (assessment details/service summary) to the provider.

Coordinating with and Monitoring Providers

1. Review the NSA at every face-to-face assessment to ensure that the client's needs are being met. Reassess and ensure the NSA gets updated and is consistent with the DSHS plan of care.

2. Communicate with providers. The HCS Regional Administrator (RA) and the RCS Regional Administrator may arrange for regularly scheduled meetings between staff to facilitate

communication about the coordination of their efforts with providers that are having problems meeting a client's needs.

These meetings:

- Provide an opportunity to discuss new homes, new contractors, problem situations and concerns that need to be monitored;
- Should include appropriate HCS, RCS, AAA staff (such as social workers, community nurses, etc.), adult family home licensors, contract monitoring staff, nursing services personnel, and local ombudsman;
- Should explore options which include, but are not limited to, nurse consulting or nursing services intervention, referral to other community resources or services, and use of the discharge resources. See the Nursing Facility Case Management Chapter of the LTC Manual for more details on discharge resources.

3. Review the records kept by the provider to monitor for services provided against the frequency and level of care described in the DSHS plan of care/NSA/NCP.

4. Review with each client the frequency and quality of the service the client is receiving from the provider. If the client is not receiving the services they need or finds the services unsatisfactory, discuss this with the client, their representative, and the provider in order to attempt to resolve this issue. As needed, consult with the CNC, the AAA Nursing service, the Long-term Care Ombudsman, and Residential Care Services staff. Refer to the Move and Relocation procedures, if this intervention is not successful in resolving the issue(s).

5. If needed, document in the SER the services not provided and the reason. Document concerns regarding the quality of the service provided and how the issue was resolved by HCS staff, CNC or Nursing Services.

6. If the facility fails to develop a NSA, report this to Residential Care Services and document in the SER.

7. Consult with Nursing Services about her/his visitation schedule.

8. Refer the client for a nursing assessment to determine the appropriateness of Nurse Delegation services if it is determined that the client needs professional assistance with any nursing tasks.

Contacting the Complaint Resolution Unit (CRU)

Make an online report:

- Immediately if there is any indication of abuse, neglect, exploitation, or abandonment of a residential client;
- To enter a complaint if the residential provider does not implement the plan of care or does not achieve the appropriate outcomes;
- To report any issue of concern regarding the quality of life and care for all residents. Provide sufficient information about the issue for RCS staff to initiate an investigation.

Complaint Resolution Unit (CRU) staff or RCS investigators may contact you for additional information. Document in the SER activities or action taken. This information will be available to RCS staff to complete their investigation or to take corrective action.

Note: APS investigates allegations of mistreatment of a vulnerable adult living in an AFH, BH, or NH when the alleged perpetrator is not affiliated with the residential setting. The online reporting system may be used to report to APS or CRU. The system will direct the complaint to the appropriate department.

Moving a Resident

If a resident chooses to:

1. reside in a nursing facility, follow the guidelines outlined in the Nursing Facility Case Management section.
2. move to an in-home setting, consider discharge resources and follow the In-Home Case Management section.

Hospital

To learn more about hospital discharge planning, please see Chapter 9a/Acute Care Hospital Assessments or Chapter 9b/State Hospital Assessments chapters of the Long-Term Care Manual.

Nursing Facility Case Management

To learn more about Nursing Facility Case Management, see Chapter 10/Nursing Facility Case Management and Relocation, of the Long-Term Care Manual.

Joint Case Management

Joint case management may occur when there is a case staffing or when there is shared responsibility for a case.

Case Staffing

When do I hold a case staffing? Hold a case staffing when:

1. Case management needs arise as a result of a current or past Adult Protective Services investigation.
2. Significant complications or confusion exists that may place the client at risk of premature institutionalization, including concerns about the caregiver or environment.
3. There is a need to discuss and transfer case management oversight for complex cases that meet the criteria for targeted case management.

How do I conduct a case staffing?

1. If possible, hold it in the clients' residence or wherever they are receiving care.
2. Always include clients unless they choose not to or an extenuating circumstance prohibits them from participating.
3. As needed, include staff from HCS, AAA, other agencies, and formal and informal supports.
4. Ensure that clients have completed and signed a consent form authorizing all case staffing participants to discuss their information.
5. Involve your supervisor and/or administrator if there is disagreement among staff on how to resolve an issue.

Shared Cases

A case is "shared" when case managers from multiple offices are part of the client's team. Follow CARE guidelines when sharing a case, which means you and other team members will need to:

- Coordinate the assessment responsibilities.
- Use the same "look-back" periods.
- Ensure that there is one primary case manager per division (The AAA is considered part of HCS Division).

Shared Case Example:
When a Respite client applies for Core services, the case will be transferred to the HCS office. However, the Respite worker will need to remain on the team as long as AAA respite services are in place.

For information on sharing cases with DDA, see the online tutorial.

Non-Core Case Management

If a client is not eligible for Core services, they may qualify for non-core services funded through the Older Americans Act (OAA), Senior Citizens Services Act (SCSA) or through other funding for locally available services. Non-core services could include services such as respite care, nutrition programs, exercise programs, or other locally available services. Clients who may need and be eligible for non-core services should be referred to the local AAA/I&A office for assistance. The AAA provides case management to clients receiving these services.

DOCUMENTATION AND SERVICE EPISODE RECORDS (SERS) IN CARE

The intent of the SER in CARE is to document all contacts and activities related to the client's assessment, service plan, coordination and monitoring of care, and termination of services. Information about the functionality of the SER and a full list of contact and purpose codes can be found in the CARE Assessor's Manual/Help File.

Importance of Documentation

There are a number of reasons to maintain current and accurate documentation in the SER, including:

- Smoother transitions for the client and receiving CM/SSS/CRM
- Allows current and future CM/SSS responsible for the client's case to view historic and current interactions with the client and collateral contacts
- Provides a more holistic view of the individual
- Reduces the risk of gaps in service delivery
- Promotes more person-centered case management services to the individual
- Provides a record reflecting appropriate person-centered case management practices, rules and policies were followed

Documentation Best Practice

- **Be objective and factual:** Avoid subjectivity, opinions and judgements. Document facts including what was seen, heard, and/or information that was provided.

- **Be clear and concise:** Avoid abbreviations and acronyms only recognizable to the CM or other local staff.

- **Use readable and professional writing style:** Avoid grammar and spelling errors
-
- **Record Action: Individually document decisions made or action taken.**

- **<u>Include individual names: Use first and last names instead of the role for client contacts, vendors, and other client supports.</u>**

- **Enter SERs in a timely manner:** This will promote accuracy and more accurate recollection of conversations and events.

- **Make sure SER entries are for the correct client in CARE:** Once a SER is submitted, it cannot be deleted. If an error is made, append the SER in error and briefly explain the error without using any other client's name. Document SER in the correct client record.

Restrictions

- Do not document the names of other clients in a SER.
- Do not copy and paste emails in SER notes. Instead, summarize the content of the e-mail.
- Adult Protective Services (APS)
    - It is important to restrict the information about an APS report in the CARE SER due to confidentiality laws around APS information and risk of disclosure of the confidential APS record.

- In general, do not document information about APS intakes or outcomes in the CARE SER. This information exists in TIVA2.
- Create a SER that includes any observations that you have based on your own interaction with the client or collateral contacts regarding a situation of concern and any APS report that you made as a mandatory reporter.
- If there was a conversation with an APS worker, you should only document general information, for example, the conversation happened or there was a general update given on the case. Do not include details about the case in the SER.

TRANSFERRING & RETURNING A CASE

Guidelines

Use these protocols when transferring an electronic case record and paper file from one office to another. At any point during a case transfer, the Social Service Specialist/Case Manager may request a case transfer consultation or case staffing. The case staffing may be done via telephone or in-person.

When a client has an upcoming Annual Assessment due within 2-months of the Plan Period End date, the transferring office will be responsible for completing the Annual Assessment prior to transferring to the receiving office. For example, an assessment with a plan period end date of 10/31 would need to be transferred to the receiving office no later than 08/31. If the case is not transferred by 08/31, the transferring office will be responsible for completing the assessment.

Transfer Protocol

1. The transferring Social Service Specialist/Case Manager is responsible for the electronic case record completeness and accuracy. The Assessment and Care Plan section must meet minimum standards outlined in Chapter 3 (The receiving agency will assign the case to an individual Social Service Specialist/Case Manager within 5 business days). Prior to transferring a case where Fast Track Services are authorized, the transferring Social Service Specialist/Case Manager will verify and document in a SER that at least pages 1 and 2 of the Medicaid application has been received by financial services.

2. Environmental modifications must be arranged and contracted prior to transfer. Completion of the modification and payment of the services may be completed after the transfer of the case. Durable Medical Equipment (DME) must be arranged and ordered prior to transfer. Cases may not be transferred until a DME Exception to Rule (ETR) has been submitted and approved. Attach the Barcode Social Service Record (SSR) cover sheet before sending to HIU for quotes and receipts related to housing modifications or DME.

3. The transferring Social Service Specialist/Case Manager must complete the Electronic Case Transfer form in Barcode/DMS prior to transferring the case in the Barcode system as required by policy. The Case Transfer form is used to ensure all documents required for a particular program have been completed and included in the client's record. This form also serves as a means to communicate any special concerns with a case to the receiving office. The financial

worker will be able to see the case transfer form in the client's ECR and will know that the case was transferred.

4. In Barcode, the transferring office must send all required documents listed on the electronic case transfer form to the Hub Imaging Unit (HIU) as "Hot Mail" including:
   - 14-012 DSHS Consent
   - 14-225 Acknowledgement of Services
   - 16-172 Client Rights and Responsibilities
   - Service Summary signed by the client (Including Electronic Signatures)
   - Service Summary signed by the provider(s)
   - RCL Consent Form

If a client chooses or is required to update their consent form (DSHS 14-012) at any time, the most current signed version replaces all previous forms upon signature. For additional information regarding consent form requirements, please refer to Chapter 3 of the LTC Manual.

Unless otherwise mutually agreed upon between the transferring office and receiving office, all required documents listed on the electronic case transfer form must be visible in the client's Electronic Case Record (ECR) upon transfer.

Prior to transferring the case, the transferring Social Service Specialist/Case Manager must have called the client and/or the authorized service providers to verify that all services have been authorized. Use the phone call to notify the client of the imminent transfer and give the client contact information should they have questions/concerns prior to the receiving worker contacting them.

5. The transferring Social Service Specialist/Case Manager will verify record completeness using the Electronic Case Record Form before submitting to the supervisor for transfer. Once the "Submit To" supervisor field is enabled, the date sent to the supervisor is populated. The supervisor will receive notification that they have a transfer on their To-Do List. The supervisor will approve for transfer. If the supervisor determines additional items are needed prior to transferring the case, the supervisor will communicate this to the transferring staff from the electronic case transfer form with a note. The worker will resolve and resubmit to the supervisor for transfer. See LTC Manual Quality Assurance, Chapter 23 for supervisory file review requirements.

NOTE: The following forms must be re-signed and submitted to DMS when there is a break in service that results in the client going 30 days or longer without receiving services:

- 14-012 DSHS Consent
- 14-225 Acknowledgement of Services
- 16-172 Client Rights and Responsibilities

Barcode

DMS is a system that bases all assignments on the current case manager of record. Once a case has been transferred in CARE, and until the receiving office has identified a new primary case manager on the Client Overview screen, DMS creates duplicate document assignments to the default worker at the receiving office and the former case manager to ensure someone takes an action on a document. To alleviate this, the receiving office should assign a case manager as quickly as possible when cases are transferred between offices. However, case transfer policy states that the receiving agency will assign the case to an individual Social Service Specialist/Case Manager within 5 business days.

Once the Case Transfer Form is submitted, the receiving office will verify all required program documents are in the electronic case file and will have 5 days to assign the client to a case manager in CARE. During this time, assignments in Barcode are made to the default worker in both the sending and receiving office according to the matrix until the case is assigned in CARE.

Returning a Case

If the transferred case does not meet the minimum standards identified in Chapter 3, Assessment and Care Planning, or has payment/authorization errors:

1. The receiving agency will notify the transferring agency within 5 business days of receipt of the file.
2. The transferring agency is expected to make necessary corrections to the file documents. During this time, new assignments in Barcode will be made to the office of the case manager assigned in CARE. Necessary changes will be made by the transferring agency within 10 business days from the date notification was received. Unless the transferring agency is notified within the timeframe, the transfer will be deemed complete.
3. Track returned cases, using the form in the following section.
4. The transferring and receiving supervisors or designees are responsible for resolving issues related to case transfers. If any disagreement occurs, it will be addressed through the chain of command established by both the transferring and receiving agencies. Unresolved differences between the HCS regions and AAAs should be referred to the State Unit on Aging Office Chief and Home and Community Services Deputy Director of Field Operations, or their designees, for resolution.

> **Note:** Additional information regarding the case transfer of in-home, Nurse Delegation clients can be found in Chapter 13 of this manual.

Tracking Returned Cases

Use the format listed below to identify trends and patterns in files that are identified as needing correction. It is the responsibility of the receiving agency to document the reasons transferred files do not meet the transfer protocols. Use the forms in discussions between AAA and HCS at local

coordination meetings. The identified trends and patterns will be used to determine training needs and to address personnel related issues.

DATE	CLIENT NAME/	AGENCY CASE TRANSFERRED FROM	WORKER CASE TRANSFERRED FROM	REASON RETURNED CODE	COMMENTS

Reason Return Codes

A. Assessment/care plan does not meet minimum standards
B. Provider not qualified
C. Authorization not accurate

Guidelines for Institutional (Hospital, Nursing Facility, or ICF-ID) Settings

The intent of this case transfer policy is to encourage coordinated discharge/treatment planning in the best interest of the client. The AAA Case Manager, DDA Case Resource Manager, or HCS Residential Social Service Specialist should collaborate with the HCS NFCM to determine if, and when, a case transfer is appropriate for a client who intends to return to a community setting.

In that regard AAA, DDA, and/or HCS staff may:

- Assess a client in the SNF or hospital;
- Determine NFLOC in the NFCM screen of CARE (DDA does not have access to this screen. Refer to Chapter 10 for more information on how to complete a NFLOC for DDA clients);
- Attend care conferences at the hospital, SNF, or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-ID);
- Access discharge resources for clients, including MIIE for HCS clients;
- Review charts and/or files for discharge planning purposes.

Timelines

- The client file may remain with AAA/DDA for 30 days from initial admit to SNF, regardless of subsequent changes in institutional setting (hospital, SNF, ICF-ID). The client may be kept longer if a return to the in-home setting is imminent.
- If a hospital stay goes beyond 30 days, the AAA Case Manager will coordinate with the HCS Social Service Specialist regarding possibility of transfer to HCS.
- AAA/DDA Case Manager may transfer the client to HCS immediately if the client does not intend to return to the in-home setting.

CHALLENGING CASES PROTOCOL

Introduction

Federal home and community services rules (42CFR440.180) and 1915 c waiver rules (42CFR441.302(a)) require that the state must assure that, "…necessary safeguards have been taken to protect the health and welfare of the recipients of the services" (page 323). If the plan of care cannot assure the health and welfare of the client due to client environment or resource issues, invoke this protocol.

The purpose of the "Challenging Cases Protocol" is to promote statewide consistency in dealing with difficult to serve clients before denying or terminating services. The protocol promotes that service termination does not abdicate standard case management practice. The protocol recognizes the client's preferences of care, services, and life choices. Any one factor or several factors of such a magnitude to jeopardize the health, welfare, and safety of the client and others may invoke the protocol. However, every effort must be made toward resolution of issues that may lead to denial or termination of services.

HCS and AAA staff will implement the "Challenging Cases Protocol" when the recommended plan of care, appropriate to the client's health, welfare, or safety, cannot be implemented due to, but not limited to:

1. Client issues such as:
    - capacity (per RCW 11.88);
    - behaviors;
    - refusals of services vital to health, welfare & safety;
    - illegal/criminal activity;
    - safety of caregivers, staff, and other residents.

2. Physical and social condition of the client's environs
    - hazards, such as:
        - methamphetamine laboratories;
        - animals;
        - sanitation;

  - poor housing structure.
- caregiver issues, such as:
  - poor quality of caregiver of client's choice.
- other person(s) in home, such as:
  - illegal/criminal activity;
  - demonstrated dangerous behaviors (physical/sexual) to caregivers, staff, or other residents;
  - verbal/physical threats;
  - interfering with interview/service delivery;
  - hinders worker access to client.

3. Resource issues, such as:
   - lack or inadequate informal supports;
   - cost of care exceeds allowable costs;
   - care needs that exceed allowable costs in current setting, which threatens the client's health, welfare, and safety.

Client safety is a shared responsibility involving the client, family, friends, neighbors, the social services worker, the medical community, law enforcement, and other service agencies. The protocol involves the use of an interdisciplinary/interagency team (Regional Resource Team, A-Team, ad hoc team) as the vehicle for community entities to review and make recommendations for a challenging case. The interdisciplinary/interagency team differs from the 'multidisciplinary case staffing' in that all case management options/activities have been exhausted and the case is in jeopardy of closure.

You must complete all standard case management activities prior to invoking the protocol, including targeted/intensive case management and an APS referral if you have reason to believe that the client is abused, neglected, abandoned, or financially exploited. Continue services pending the outcome of the APS investigation and case management responsibilities.

Services Denial

Discuss with your supervisor identified hazards and/or compliance issues preventing services implementation. Refer to the *Challenging Cases Protocol Introduction* for a list of possible hazards and compliance issues (NOTE: Functional or financial ineligibility are not criteria to deny services under the 'challenging case' definition).

1. Contact the client to discuss obstacles to implementing services:
   - Identify a plan to remedy obstacles;
   - Inform the client of possible options or denial of services if obstacles are not corrected;
   - If appropriate, make a law enforcement referral if imminent danger exists;
   - If appropriate, make an APS referral if you have reason to believe that abuse, neglect, abandonment, or financial exploitation exists;
   - If the client agrees with the remedy and problems are resolved, proceed with the assessment/plan of care development/implementation.

2. If non-compliance or the problems continue, your supervisor *may*:
    - instruct you to convene an interdisciplinary/interagency team (refer to procedure for the team under *Interdisciplinary/Interagency Team*):
        - Identify options for the client;
        - If no options exist or client/representative refuses options offered, then, with your supervisor, refer to RA/AAA Director (or their designee) for a decision to deny services;
    - refer the case directly to the Regional Administrator/AAA Director (or their designee) for a decision to deny services;
    - follow client notification policy in Chapter 27

3. The Regional Administrator (or designee) must notify the HCS Deputy Director of Field Operations of the decision to deny services and the AAA Director must notify the State Unit on Aging Chief of the decision.

If an individual with a history of services termination/denial due to 'challenging cases' issues, reapplies for services:

1. Assess whether the issues that caused the termination/denial of services still exist.
2. Discuss the case with your supervisor including the previous reasons for termination/denial.
3. Review the following with the client:
    - Reason for the previous termination;
    - Responsibility of the client to notify the provider and/or provider agency (if used) and the social services worker about problems related to the plan of care implementation.
4. With supervisor approval, authorize services if the client agrees to follow the plan of care.
5. If the client does not agree to resolve issues that caused past services termination, follow the Services Denial procedure.

Service Termination

1. Consult with your supervisor. The supervisor may:
    - Perform a file review;
    - Make further suggestions for approaches or services not yet tried, such as nursing services, intensive case management, etc;
    - Recommend further monitoring and visits; and/or
    - Recommend contacting other collaterals and/or other entities with shared responsibilities.

2. If you and your supervisor feel all options have been exhausted, the supervisor may:
    - Confer with the AAG/agency attorney;
    - *In rare instances*, refer the case directly to the RA/AAA director (or their designee) for a decision to terminate the case (bypassing referral to the interdisciplinary/interagency team). The supervisor must document the reasons why the case was not referred to the interdisciplinary/interagency team; and/or

- Instruct you to proceed with the protocol and refer the case to the inter-disciplinary/agency team:
  - Current, active teams, such as the A-Team and APS Regional Resource Teams, may be utilized;
  - The supervisor chooses the relevant team members.

3. The supervisor reviews the team's recommendations with you and may recommend:
   - Visit the client to discuss the issues and possible consequences:
     - The 'team' or relevant members of the team may choose to visit the client to resolve health, welfare, and safety issues;
   - Determine if the client is able to understand the issues and consequences. Consider making a referral to obtain a capacity evaluation if you believe the client's capacity is significantly impaired;
   - Determine if other services are appropriate, such as a referral to counseling;
   - Determine if other supports are available, such as any informal supports.
4. Notify the client in writing (with supervisor approval) that his/her services will be terminated if she/he does not comply with service delivery provisions:
   - The client or other person must be given the opportunity to comply after the written notification is mailed.
5. If non-compliance continues, your supervisor will refer the case to the Regional Administrator/AAA Director for a decision to terminate services.
6. The RA (or designee) must notify the HCS Assistant Director of the decision to deny services and the AAA Director must notify the State Unit on Aging Chief of the decision.
7. Follow client notification of adverse action as LTC Manual Chapter 7 regarding use of the Planned Action Notice (DSHS 14-405).

Assessment Setting

When the initial assessment is not conducted in the setting in which services are authorized:

There may be instances when the social services worker authorizes services but does not observe the client's environment, for example, when a client is discharged from a hospital. Environmental or social hazards may exist that may jeopardize the client's health, welfare, and safety, that the social services worker may discover after authorizing services.

1. If information is identified during the first face-to-face visit in the setting the client is receiving services that jeopardizes the client's or the provider's health, welfare, and safety, AND this face-to-face visit occurs 30 days or less after the case was transferred to the receiving agency, THEN follow the protocol for SERVICES DENIAL procedure.
2. If the first face-to-face visit occurs after 30 days after the case was transferred to the receiving agency, follow SERVICES TERMINATION procedure.

   NOTE: The situation must meet the 'challenging case' criteria.

Documentation

1. Document all actions, consultation, and statements by the client and/or others in the SER.
2. Determine and document whether the client is aware of and able to understand the consequences of their or others' actions:
    - Request a capacity evaluation with the client's consent (DSHS 14-012);
    - Determine if the involvement of a County Designated Mental Health Professional is appropriate;
    - Determine if an APS referral is in order;
    - If the client is not aware of others' behaviors in their home, inform them of the behaviors.

Hazardous Conditions

The client's living environment may pose hazards that may threaten the safety of the provider or social services worker. These **hazards** may include, but are not limited to:

- Threatening, uncontrolled animals, such as dogs;
- Illegal drugs used by the participant or others in the home when the social services worker is in the home;
- Evidence of a methamphetamine lab;
- Presence of hazardous materials, such as exposed sewage in the home.

Services may be terminated when the client refuses to resolve the hazardous conditions that may **pose a danger to others.**

1. Determine whether the client is capable of understanding the hazards and consequences and whether a referral for a capacity evaluation is appropriate.
2. Give the client ample opportunity to remove the drugs and/or users in the presence of providers and the social services worker. If the hazard is a methamphetamine lab, neither providers nor the social services worker should go into the residence. Immediately call 911.
3. Discuss with the client the potential of the termination of services due to the presence of the hazards.
4. If the client refuses to remove the specific hazard, discuss the case with your supervisor for referral to the interdisciplinary/interagency team.
5. Follow Challenging Cases Protocol.

If the home contains sewage, vermin, lice, or other contaminants to such a degree that **may be harmful** to anyone, determine whether the client understands the danger of such hazards.

1. Make a referral to the local County Designated Crisis Responders if you believe the client has a mental disorder and is gravely disabled, or a danger to self or others.
2. Follow target/intensive case management policy—see LTC Manual, Chapter 5.
3. Consider making a referral to APS if you have reason to believe that the client is experiencing self-neglect and APS services may help them.
4. If the client's situation jeopardizes his/her health, welfare, or safety, follow the Challenging Cases Protocol.

Imminent Danger

"Likelihood of serious harm" and "imminence" are defined as per RCW 71.05 and the CDMHP Protocols:

- "Likelihood of serious harm" means (RCW 71.05.020(19):
  - A substantial risk that: (i) Physical harm will be inflicted by an individual upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself; (ii) physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm; or (iii) physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or
  - The individual has threatened the physical safety of another and has a history of one or more violent acts;
- "Imminence" means "the state or condition of being likely to occur at any moment; near, at hand, rather than distant or remote" (CDMHP Protocols, p. 16).

Services may be terminated if the "likelihood of serious harm" or "imminent" danger is present to the client or provider. For example, the situation where an extremely frail elderly client threatening to harm someone or kill them, when there are no weapons in the home, and it would be physically impossible for the client to carry out these threats, is not imminent danger and is not a cause for service termination or denial. However, the situation where a client or individual in the client's home brandishes a weapon, or has a history of physical violence and makes threats that the individual is clearly capable of carrying out, MAY be imminent danger. Having or using illegal drugs in the home may not be imminent danger. Evidence of a methamphetamine laboratory places anyone in close proximity in imminent danger.

If you receive information that the client or the provider is in imminent danger or the likelihood of serious harm is present:

1. Determine whether you need to call the police immediately and/or medical assistance; and/or
2. Determine if you have reason to believe that abuse, neglect, abandonment, or financial exploitation of a vulnerable adult is present and an APS referral is warranted.
3. Make a referral to the Local County Designated Crisis Responders if you believe the client has a mental disorder and is gravely disabled or a danger to self or others.
4. If the individual is applying for services or is a services recipient, and:
   - you have determined that the client is capable of understanding the issues impacting his/her or provider's health, welfare, and safety; and
   - you have listed the possible consequences of those issues; and
   - you have consulted with your supervisor regarding services termination and your supervisor agrees that you pursue termination of services; then
   - follow the Services Denial procedure.

Refusal to Comply

When clients refuse to comply with mandatory program requirements and service delivery provisions:

Services can be terminated if the client demonstrates a *substantial pattern* of behavior that prevents the determination of eligibility, carrying out the plan of care, or monitoring the services to assure the health, welfare, and safety of the client. First exhaust all standard case management activities.

Examples of refusal to comply with the service delivery provisions include, but are not limited to:

- The client is frequently away from his/her home when the provider arrives (without prior arrangements), so that services cannot be performed;
- The client has prevented or refused multiple providers' attempts to perform vital, authorized services;
- The client, or others in the home, has demonstrated verbal abuse, discrimination, or sexual harassment toward providers on numerous occasions.

If such a pattern of behavior resulted in resignation of multiple providers:

1. Visit the client to discuss the behaviors and inability to deliver services due to the behaviors.
2. Refer the client (or others in the home) to other services, such as counseling.
3. Monitor the client to determine if the client (or others in the home) has stopped the offensive behaviors. A monitoring schedule may be recommended by the interdisciplinary/interagency team; confirm the monitoring schedule with your supervisor; and/or
4. Determine whether another provider of another gender is appropriate (e.g., a male client insists on female providers and has demonstrated a substantial pattern of sexual harassment).

If the behavior is directly related to the client's disability, seek appropriate service referrals. Services cannot be terminated or denied under such reasons.

Interdisciplinary/Interagency Team

Introduction

Client safety is a *shared responsibility* involving the client, family, friends, neighbors, the social services worker, the medical community, law enforcement, and other service agencies. The protocol involves the use of an interdisciplinary/interagency team (Regional Resource Team, A-Team, ad hoc team) as the vehicle for community entities to review and make recommendations for a challenging case. The interdisciplinary/interagency team differs from the 'multidisciplinary case staffing' in that all case management options/activities have been exhausted and the *case is in jeopardy of termination/denial* because of, but not limited to (see introduction to Challenging Cases Protocol):

- client issues;
- physical and social condition of the client's environs; and/or
- resource issues.

The interdisciplinary/interagency team is responsible for:

- considering all available assessment information in its deliberations;

- identifying the services needed to meet the client's needs;
- identifying strategies for resolving obstacles that are preventing the implementation of the plan of care;
- estimating the costs for the types and amounts of services identified as necessary to meet the client's needs;
- determining whether the individual can be served safely in the community;
- developing the plan of care recommendations, including case closure.

Procedure

1. When the supervisor, RA/AAA Director (or their designee) instructs the social services worker to convene a team:
    - Current regional teams may be used for the purpose of reviewing a challenging case, such as Regional Resource Teams or A-Teams. The supervisor must review existing team membership to determine if all disciplines/agencies relevant to the case are represented. If appropriate disciplines/agencies are not represented, the supervisor will identify such members;
    - If the need to convene a team is immediate and other existing teams meeting dates are not convenient or such a team does not exist in the local community, the supervisor may arrange for an *ad hoc* team;
    - The RA/AAA Director (or their designee) may also arrange for an interdisciplinary/ interagency team to be convened.

2. The social services worker will attempt to obtain a signed release of information from the client. If the client refuses, the social services worker will:
    - Send notice of the challenging case review at the interdisciplinary/interagency team only to those entities with case management responsibility, giving the client's name and other identifying information. If there are team members present not affiliated with the case, the social services worker will discuss the case using the client's initials and not use the client's name.

3. The social services worker will complete a referral form. The social services worker may use existing referral forms specific to the team, or use the Interdisciplinary/Interagency Team Documentation form as a referral form for an ad hoc team.

4. A supervisor/program manager and the social services worker will present the case at the team meeting.

5. All team members must sign an oath of confidentiality.

6. The social services worker presents and facilitates the case presentation, using initials only if team member not affiliated with the case are present.

7. The team may:
    - decide for the social services worker and/or relevant team members to visit the client to:
        - clarify safety/welfare issues;
        - review rights and responsibilities with the client;
        - discuss with the client consequences of not accepting services vital to health, welfare and safety;
        - involve family and informal supports;
    - decide if multiple, frequent visits are necessary;
        - develop a monitoring schedule involving the social services worker and/or relevant team members;
    - coordinate with other community resources;
    - decide to recommend that services be terminated, identifying what other services must remain open or be put into place.

8. The team will develop the plan of care recommendations;
    - the social services worker will document the team's recommendations on the team's documentation form;
    - the social services worker will distribute copies of the team's documentation form to all team members;

9. The supervisor will discuss with the social services worker whether all, some, or none of the team's recommendations are to be implemented.

10. Continue with the Challenging Cases Protocol.

Team Members

Relevant team members include those entities with shared responsibility. Such members may include but are not limited to:

- HCS/AAA/DDA supervisor (*required*)
- law enforcement (e.g., tribal police, local sheriff, etc.)
- home health agencies
- hospice
- Mental Health/CDMHP
- Other DSHS divisions
- hospital/NF social services worker
- emergency response team
- Division of Alcohol and Substance Abuse
- governing entities (i.e., tribal council)
- ALTSA Housing Program Manager (ALTSA Housing Regional Map)
- HCS/AAA/DDA worker (*required*)
- home care agencies
- adult day health
- Department of Corrections
- Adult Protective Services worker
- health care provider
- Residential Care Services
- fire department
- local health department
- other informal supports
- Office of Housing & Employment Program Managers (ALTSA Housing Regional Map)

Team Outcome Documentation

The social services worker presenting the case is responsible for documenting team recommendations and actions chosen based on these recommendations.

1. Choose the following forms to document a referral to a team or document the team's outcomes:
   - Team specific form such as:
     - Regional Resource Team Referral Form;
     - A-Team Referral Form;
   - Interdisciplinary/Interagency Team Documentation Form.

2. At the very minimum, documentation of the team's recommendations must include:
   - team member names, organizations, and phone numbers;
   - person presenting the case;
   - case name;
   - reason for the referral (what is jeopardizing the client's health, welfare, and safety);
   - the services in place;
   - the interventions tried and failed;
   - the needs not being met; and
   - recommendations and reasons why the needs cannot be met.

3. If consensus on recommendations cannot be reached, document the reasons given and by whom.

4. Send each team member a copy of the completed form.

5. File the form in the case record.

RESOURCES

Related WACs and RCWs

RCW 74.34	Abuse of Vulnerable Adults
RCW 74.38.010	Legislative recognition—Public policy
RCW 74.38.040	Scope and extent of community based services program
RCW 74.39.005(7)	Long-term Care Service Options – Purpose (Case Management)
RCW 74.39A.040 (3)(c)	Department assessment of and assistance to hospital patients in need of long-term care.
RCW 74.39A.090	Discharge planning—Contracts for case management services and reassessment and reauthorization—Assessment of case management roles and quality of in-home care services—Plan of care model language

RCW 74.39A.095	Case management services—Duties of the area agencies on aging—Consumers' plans of care—Notification to consumer directed employer
RCW 70.41.310	Long-term care—Program information to be provided to hospitals—Information on options to be provided to patients
RCW 74.42.057	Notification regarding resident likely to become Medicaid eligible
RCW 74.42.058	Department case management services

Acronyms

AAA	Area Agency on Aging
AAG	Assistant Attorney General
AFH	Adult Family Home
APS	Adult Protective Services
ALTSA	Aging and Long Term Supports Administration
ARC	Adult Residential Care
AREP	Authorized Representative
BH	Behavioral Health
BHPC	Behavioral Health Personal Care
BPS	Behavior Points Score
CA	Case Aide
CDE	Consumer Directed Employer
CDWA	Consumer Direct Care Network Washington
CM	Case Manager
CNC	Community Nurse Consultant
CPS	Child Protective Services
CRU	Complaint Resolution Unit
DMHP	Designated Mental Health Professional
DMS	Document Management System
DOC	Department of Corrections
DSHS	Department of Social and Health Services
EARC	Enhanced Residential Care
ESH	Eastern State Hospital
HCS	Home and Community Services
ICF-ID	Intermediate Care Facilities for Individuals with Intellectual Disabilities
LTC	Long Term Care
MCO	Managed Care Organization
NCP	Negotiated Care Plan
NF	Nursing Facility
NSA	Negotiated Service Agreement
PAN	Planned Action Notice
PASRR	Pre-Admission Screening and Residential Review
PBS	Public Benefit Specialist
PCM	Primary Case Manager

PCR	Personal Care Results
PCRC	Personal Care Results Comparison
PNA	Personal Needs Allowance
RA	Regional Administrator
RCS	Residential Care Services
RN	Registered Nurse
SER	Service Episode Record
SNF	Skilled Nursing Facility
SSS	Social Service Specialist
TCM	Targeted Case Management
WSH	Western State Hospital

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
10/2020	Beth Adams	Moved to new template and edits to improve grammar and aesthetics,	
2/2021	Rachelle Ames	Repaired broken links, added form links and replaced the term “placement” with more person-centered language	
2/2021	Rachelle Ames	Updated “Social Worker” terminology to “Social Service Specialist”	
2/2021	Victoria Nuesca	Updated language related to MCO and Behavioral Health Personal Care	
2/2021	Rachelle Ames	Replaced “placement” language with person-centered language	
2/2021	Rachelle Ames	Added guidance about SER documentation	
5/2022	Kellie Nelson	Updated required documents/process for conversion to CDE	
2/2023	Sun-Young Pak	• Replaced the “APS Chapter” with "Adult Protective Services policy and procedure” • Updated language related to “Mandatory Reporting” • Replaced “local Designated Mental Health Professional (DMHP)” with “local County Designated Crisis Responders” • Updated the outdated CARE screens names	
8/2023	Natalie Lehl	• Fixed broken links	
6/2024	Natalie Lehl	• Updated the “Transfer Protocol” section.	

		• Updated case management "Guidelines to Support Move from In-Home to Residential Setting". • Clarified Termination Planning section: for a client receiving an ALTSA housing resource, the assigned HPM must be contacted prior to inactivating a case.	
10/2024	Natalie Lehl	• Example added to Transferring & Returning a Case Guidelines • Clarification on consent forms • Fixed broken link to Chapter 13	
03/2025	Natalie Lehl	• Added SER Policy Language	

APPENDIX

For Word version or other languages, visit Electronic DSHS Forms.

DSHS 05-246 **Notice of Action Exception to the Rule** (Excluding AFH)

DSHS 10-234 **Individuals with Challenging Support Issues**
- For any clients entering a residential facility who have challenging behaviors (assaultive, destructive, self-injurious, inappropriate sexual behaviors, or history of misdemeanor behavior).

DSHS 13-712 **Behavioral Health Personal Care (BHPC) Request for MCO Funding**

DSHS 14-012 **Consent for Services**

DSHS 14-225 **Acknowledgment of Services**

DSHS 14-300 **PASRR Level One**

DSHS 14-405 Planned Action Notice (in CARE)

DSHS 14-443 **Financial/Social Service Communication**
- For communication with the financial worker regarding the status of the client (e.g. placed in a NF).

Community Transition or Sustainability Services/Washington Roads

The purpose of this chapter is to educate staff about the state-only funded service packages of Community Transition or Sustainability Services (CTSS) and Washington Roads (WA Roads), the benefits these transition and sustainability services may offer to participants, and to provide instruction on how to utilize these services in coordination with Medicaid State Plan or Waiver Programs.

Ask an Expert

If you have questions or need clarification about the content in this chapter, please contact:

Julie Cope RCL/NFCM Policy Unit Manager
360.725.2529 julie.cope@dshs.wa.gov

Amanda Speck RCL Enrollment Specialist
360.870.6309 amanda.speck@dshs.wa.gov

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BACKGROUND

In 2007, DSHS was awarded the "Money Follows the Person" (MFP) grant from the federal Centers for Medicare and Medicaid Services (CMS) for the "Roads to Community Living" (RCL) demonstration project. The purpose of the RCL project is to examine how best to successfully help people with complex long-term care needs transition from institutional to community settings.

The lessons learned and cost savings seen through the first year of the RCL project helped convince the 2009 Washington State legislature to approve additional funds for individuals who may not be eligible for RCL. The funding was for a package of services named Washington Roads.

WA Roads services were previously available only to individuals transitioning from an institution to a community setting. These services are also available as a resource for challenging or complex cases involving individuals who are currently living in the community, but who are at risk of losing their community living setting.

WA Roads services have proven to be an integral part of successful community living and, as a result, many services are now available through other funding sources and waivers. For those individuals whose eligibility allows them to access transitional or sustainability services through the State Plan or Waiver programs, those programs are priority. For those individuals who do not meet transition or stabilization eligibility criteria for the State Plan or Waiver programs, they may access State Funded CTSS or WA Roads transitional and sustainability supports.

WHO IS ELIGIBLE FOR CTSS/WA ROADS SERVICES?

These state funded services are intended to fill specific gaps to provide transitional or stabilizing supports for ALTSA clients to sustain community living. Not all participants will meet the eligibility requirements for these state funded transition or sustainability services. Case managers should utilize existing resources for these individuals.

ALTSA clients are eligible for state funded Community Transition or Sustainability Services through CTSS or WA Roads when one or more of three eligibility criteria are met. Eligibility includes individuals who are in the N05 Medicaid coverage group in ACES, and those who meet the Non-Citizens eligibility criteria as outlined by Chapter 7g with HQ approval. **Individuals are eligible when:**

1. **Transitioning from an institution to a community setting, and are:**
   - aged 18 and older in a hospital or nursing facility;
   - Medicaid recipients in the hospital or nursing facility for at least one day, or Fast Track eligible;
   - functionally and financially eligible (or Fast Tracked) for State Plan or Waiver home and community-based services (HCBS) which currently include MPC, ABP-MPC, CFC, COPES, RSW, and New Freedom.
   - Clients enrolled in programs for State Funded long term care for non-citizens. These eligibility groups will require HQ approval from Emily Watts or delegate. See Chapter 7g for additional information on these programs.

   NOTE: After hospital or nursing facility discharge, these individuals are not required to receive ongoing home and community based services (HCBS). Please note that for Medicaid clients that do **not** meet functional or financial eligibility for HCBS**, *Community Transition or Sustainability Services (CTSS)*** continues to be a resource.

2. **Residing in the community, are functionally and financially eligible for State Plan or Waiver HCBS, AND are experiencing of one or more of the following:**
   - Unstable residential or in-home settings (e.g. homeless, frequent transfers, etc.)
   - Frequent institutional contacts (ER visits, SNF stays, hospital admits, etc.)
   - Frequent turnover of caregivers
   - Multiple systems involvement (Dept. of Corrections (DOC), psychiatric institutions, etc.)

3. **Residing in subsidized housing (e.g. NED and 811 vouchers, ALTSA Subsidies, etc.) that was coordinated through ALTSA.** This eligibility criteria is regardless of whether the client is currently eligible for, or receiving, State Plan or Waiver HCBS. Please Reference Chapter 6a-d for additional Housing Resource policy information.

Individuals that are not eligible for CTSS or WA Roads include:

- Clients residing in Intermediate Care Facilities for the Intellectually Disabled (ICF/IDs) or Residential Habilitation Centers (RHCs)
- Clients enrolled in managed long-term care programs such as PACE

May a DDA client receive CTSS/WA Roads services?

A DDA client that is transitioning out of a nursing facility or acute care hospital, meets all other eligibility criteria, and will exit either a NF or hospital on an HCS waiver is eligible for CTSS or WA Roads. DDA clients that are already residing in the community are not eligible for CTSS or WA Roads.

May a client on the Residential Support Waiver (RSW) receive CTSS or WA Roads services?
A client in an RSW setting may utilize state funded Community Transition or Sustainability services available through CTSS or WA Roads when they meet eligibility criteria, as listed above. A contracted Community Choice Guide (CCG) may be employed to assist with transitional tasks, such as coordinating a move, on a very limited basis. An example of this is when a CCG is obtaining community transition goods or services to support the community stabilization. Utilizing state funding for these transitional tasks is a last-resort option and may be used only when all other resources have been exhausted.

- For Expanded Community Services (ECS): It is the responsibility of the caseworker along with the ECS Coordinator or designee to determine the appropriate ECS setting; setting determination may not be assigned to a CCG, though after the setting is chosen the CCG can support the client's move to that new community setting. In addition to staffing the case with a supervisor prior to authorizing state funded CCG services, the ECS Coordinator must review and approve of the request. The approval must be documented in a SER.

- For Specialized Behavior Supports (SBS) and Enhanced Residential Services at an Enhanced Services Facility (ESF): In addition to staffing the case with a supervisor prior to authorizing state funded CCG services, the HCS Field Services Administrator (FSA) must review and document approval of the request. The approval must be documented in a SER.

- For more information on the Residential Support Waiver please review the RSW Chapter in the LTC Manual.

State Funded CTSS/WA Roads services should only be used when:

1. Community Transition Services (CTS), available through Community First Choice (CFC), does not cover all the services or items necessary for an individual to relocate to the community from an approved institutional setting: a skilled nursing facility (SNF), an institution for mental disease (IMD) or an intermediate care facility for individuals with intellectual disabilities (ICF/IID); and the client is not eligible for RCL. Recall that a HQ-approved ETR through CFC CTS may be requested. When necessary, CFC CTS may be used in combination with state funded CTSS or WA Roads.
2. All other options have been tried and the client is at risk of losing their community setting. All CTSS and WA Roads services are provided through state-only funding and should be authorized only when no other services are available to stabilize the community setting. **CTSS or WA Roads services should not be used to supplant services that could be available through COPES or other waivers.**

3. For those individuals eligible for LTSS and are approved for a Non-citizen's eligibility group as outlined in Chapter 7g, State Funded Services available through WA Roads could be approved to assist a client with returning to a community setting. This requires HQ Program Management approval and may take the place of the Supervisory approval SER required for WA Roads authorization.

To ensure client well-being and cost effectiveness, you must document in CARE:

- How the services or supports are of direct benefit to the participant's successful transition and community living.
- How the authorizations are necessary for the client's health, welfare, safety, and well-being. Ensure services authorized are consistent with needs identified in the CARE assessment.
- If authorizing multiple contracted service providers, documentation is required to ensure that these consultants are not duplicating services.
- When purchasing Goods or Items: the process you followed demonstrates that the Goods/Items are in addition to those supplied by Medicare/Medicaid, and does not replace covered equipment, goods or items.
- If necessary, authorizations for a service/item exceed the maximum amount allowable, you must complete a local ETR prior to authorization.
- For those accessing state funded CTSS or WA Roads services and who are on the Address Confidentiality Program, see Chapter 3: Assessment and Care Planning for additional information.

Individuals may receive CTSS/WA Roads services in the following settings:

- Any hospital setting or nursing home (to facilitate return to the community)
- The individual's owned or leased home or apartment
- The individual's temporary community living setting, such as a shelter or hotel
- A community-based residential setting (adult family home, assisted living, an RSW setting etc.)

SERVICES AVAILABLE UNDER WA ROADS INCLUDE:

Behavior Support Services H2019

Behavior Support services are for participants transitioning from institutional to community settings or requiring stabilization while residing in the community in those instances where the authorized Medicaid benefit amount, duration or scope of service does not meet the individual's needs. (Client Training: Behavior Support is available through COPES and RCL. Client Training: Behavior Support should be accessed through those programs for all COPES or RCL eligible individuals; only individuals ineligible for COPES or RCL should receive this service through WA Roads.)

CARE Assessment Documentation for Client Training-Behavior Support:

- On the Treatments screen in CARE: Select Client Training/Waiver under the Rehab Restorative Training header.
- On the Pre-Transition and Sustainability screen found below the Client Details section in CARE, select the Sustainability Goals tab. From the drop down, select the goal description, and describe the goal of behavior support in the comments. This section helps the provider understand the specific reasons for the development of a behavior support plan.
- On the Care Plan Supports screen, assign Client Training to the behavior support provider.
- Send the chosen behavior support provider a copy of the Assessment Details, Service Plan, and Sustainability Goals.

The behavior support provider will **develop a behavior support plan** within 30 days of the client's assessment and provide this to the case manager. The behavior support plan will address things such as:

- Factors that are associated with an individual's documented or identified behaviors
- Written strategy of behaviorally specific interventions designed to address those behaviors and promote optimal functioning with recommendations for improving the client's overall quality of life, teaching methods and environmental changes designed to decrease the behaviors that may be impacting the client remaining or transitioning to a community setting
- Direct interventions with the client to decrease the behavior that compromises their ability to remain in the community. This could include demonstrating and practicing new interventions and skills with formal and informal supports and significant others to support the individual in their community setting.
- Case Consultation regarding escalating situations.
- Make recommendations for treatment and assisting with making referrals for community behavioral health services

Emergency Rental Assistance (ERA) SA298

ERA is a one-time payment made directly to landlords on behalf of a client who is facing an immediate eviction due to non-payment of rent. As part of the assistance request, clients must demonstrate they are able to pay their rent going forward and maintain their independent housing as a part of their community setting stabilization. This resource should only be requested when there are no other community options to fully or partially meet the need. Please Reference Chapter 6b: Interim Housing Resources (Motel Interim Stay for Transitions & Emergency Rental Assistance) for additional information.

ERA does not include pre-tenancy deposits or move-in costs, including first month's rent, required at move in. There are other resources that may cover these one-time expenses; please see service codes SA297 or SA291.

How is a request for ERA made?
The ERA form must be completed and submitted following all instructions on the form. Local supervisor approval for the request is required prior to submission to the ALTSA Housing Team for review. The client's plan to pay ongoing rent should be specified in detail in the space provided on the form. Please reference Chapter 6b: Interim Housing Resources (Motel Interim Stay for Transitions & Emergency Rental Assistance) for the Emergency Rental Assistance request form with instructions.

How is payment made to the landlord?
A Community Choice Guide or a DSHS contracted Supportive Housing Provider is authorized to make the ERA payment directly to the landlord and reimbursed using ERA service code SA298. The approval email and SER from the Regional Housing Program Manager will contain specific steps to follow. Please note that this service is also available to those who are enrolled onto Roads to Community Living. Please reference Chapter 29 for any additional information related to Roads to Community Living.

Environmental Modifications in a Residential Setting: S5165 UB

Environmental Adaptations for Residential (S5165-UB) assists the client in meeting their needs to stay safely in a residential setting and is specified in their care plan. This service allows the client to live in the least restrictive setting.

Note: All items and services must be identified in the client's plan of care. Document the client's approval for WA Roads in a CARE SER.

SERVICES AVAILABLE UNDER CTSS AND WA ROADS INCLUDE:

Community Choice Guide (CCG) SA263

Payment for specialty services which provide assistance and support to ensure the eligible client's successful transition to the community and/or maintenance of independent housing as authorized by HCS and/or AAA staff. CCG services may include, but are not limited to the following:

- Locating and arranging appropriate, accessible housing; including working with local housing authorities and other community resource providers when applicable.
- Maintaining or assisting with obtaining affordable housing.
- When relevant, liaising among and with the client, nursing or institutional facility staff, case managers, housing providers (including AFH providers), medical personnel, legal representatives, formal caregivers, family members, informal supports and any other involved party.
- Necessary assistance to support the client's community living, including assistance in settling disputes with landlord.
- Educating client on tenant rights, expectations and responsibilities.

- Assisting client with filling out forms and obtaining needed documentation to aid in maintaining successful community living (forms may include initial and renewal voucher forms, lease agreements, etc.).
- Providing emergent assistance to avoid utility shut-off and/or eviction.
- Assisting client with locating and arranging transportation resources to effectively connect with community resources.
- Assisting client to locate and engage community integration activities.
- Training or education to client about accessing community settings or health services.
- Assisting to find a qualified caregiver.

Detailed instructions on how to make a CCG referral using Service Codes SA263 and SA266 can be found in the Chapter 7d: COPES of the LTC Manual. The updated CCG Activity Tracking Form can be found in the resources section of this chapter and in Chapter 29: Roads to Community Living.

NOTE: Services such as pest eradication, janitorial services and packing/moving services must be performed by a contracted provider who holds the Community transition and Sustainability Services (CTSS) contract and paid directly via ProviderOne.

Shopping/Paying: Client not Present SA266

Based on a client's eligibility:

- Shopping for necessary household goods/items or paying for rental deposit, utility hookup fees, or rent/emergency rental assistance service when client is not present. This shopping/paying code will rarely be authorized without the accompanying SA263 CCG Services code.
- This service assists clients transitioning out of institutions or when needed to stabilize community settings.
- This service code is to compensate the provider for the time spent shopping/paying when the client is not present.
- The provider is also reimbursed for the authorized purchases after it is verified the client received the goods or service. Authorization for the item/service is under a separate service code and case managers will process the reimbursement(s) for these one-time goods and services supports to the CCG as timely as possible. This reimbursement should not exceed 30 days after the CCG has provided an invoice/receipt as proof of the purchase.
- If the client is present during shopping, SA263 Community Choice Guide should be authorized.

Detailed instructions on how to make a CCG referral using Service Codes SA263 and SA266 can be found in the Chapter 7d: COPES of the LTC Manual. The updated CCG Activity Tracking Form can be found in the resources section of this chapter and in Chapter 29: Roads to Community Living.

Community Transition or Sustainability Goods SA290

One-time purchase of necessary essential goods to provide basic living for a client who is discharging to the community from a hospital or nursing facility and/or needs CTSS or WA Roads stabilization services to maintain community living. Purchasing of items should only be authorized under this code when the authorized Medicaid benefit amount, duration or scope of coverage does not meet the individual's needs. Goods obtained with these funds shall be in addition to any medical equipment and supplies furnished under the State Plan, Medicare, or other insurance. Items may include, but are not limited to:

- Goods necessary to establish a residence such as essential household furnishings.
- Items needed to help stabilize community living for a client.
- To capture this in CARE, select "Community Transition Goods or Items" on the treatments screen and select the appropriate provider type and frequency from the Provider List. (It is recommended that the service goods also be listed in the comments.) Assign to the contracted provider in the Supports table.
- Goods may include:
  Furniture, essential furnishings, and basic items essential for basic living outside the institution. For AFH Settings reference WAC 388-76-10685, and for Assisted Living Settings reference WAC 388-78A-3011 which outline resident unit furnishings in these settings. In the event a residential setting indicates they are unable to provide the required furnishings as outlined in WAC, proceed with authorizing the essential furnishings necessary to facilitate the transition, notify the provider of their requirements as outlined in WAC, and also submit a referral to RCS to document the provider's inability to meet residential unit furnishings per WAC.

Community Transition or Sustainability Services: SA291

Payment of necessary one-time services to provide basic living for a CTSS or WA Roads eligible client who is discharging to the community from a hospital or nursing facility or needs state funded stabilization services to maintain community living and payment is made directly to the provider through the DSHS payment system. Services include but are not limited to:

- Packing assistance
- Moving assistance
- Utility set up fees or deposits
- Non-recurring health and safety assurances such as pest eradication, allergen control and/or extreme cleaning
- Rental deposits: all pre-tenancy payment requirement, including first month's rent, can be bundled as one deposit and reimbursed to a Community Choice Guide or a DSHS contracted Supportive Housing provider.
- Trial visits to a prospective licensed residential setting.
- To capture this in CARE, select "Community Transition Services" in the Treatments screen and select the appropriate provider type and frequency from the Provider List. (It is

recommended that the service type, such as Moving Assistance, be listed in the comments). Assign to the contracted provider in the Supports table.

NOTE: Community Transition Services – Items (SA290) does not permit payment of tips. With online orders/pickups, some companies have added an automatic tip to the overall total of the transaction. This cannot be reimbursed using Community Transition Services-Items. If the automatic tip cannot be removed from the transaction total, shopping at these companies should be avoided altogether.

Paying a money order/cashier's check fee as part of a move-in cost (payment of first month's rent/deposit) is allowable.

NOTE: A contract is not required if another payment mechanism is utilized.
Options include:

1. Using a client services HCS P-Card (state issued credit card available to HCS HQ staff); or
2. Authorizing a contracted provider to pay for rental deposits and community living set-up fees directly and be reimbursed (such as a CCG or a DSHS contracted Supportive Housing Provider).

Unit compensation to the contracted provider for issuing payment (such as SA266) does not count towards the funding limits associated with service codes SA290 & SA291.

More information regarding the HCS P-Card can be found in the Resources section of this chapter.

Other services available under CTSS and WA Roads:

These codes should only be used when the client is not eligible for the service or item through the medical benefit or another Long-Term Services and Supports (LTSS) program:

- Durable Medical Equipment (See Blanket code lists)
- Spec. Medical Equipment Service/Repair: K0739
- Non-Medical Equipment and Supplies: SA421
- Assistive Technology (Non-CFC): SA075 U2
- Non-Medical Transportation: T2003

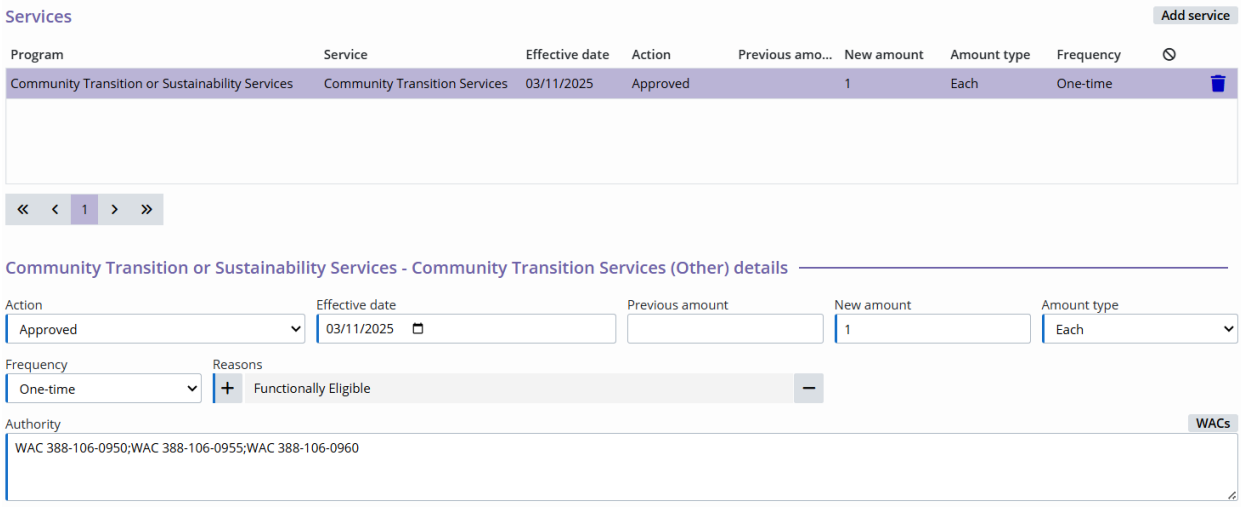
How long may state funded CTSS/WA Roads services be authorized?

Some services, such as Client Training: Behavior Support and Community Choice Guiding, may be authorized for up to three months depending on the client situation. Upon completion of the first three

months, an additional three months may be authorized with documented supervisory approval when the client would continue to benefit from the service, and the service is proving effective with progress being demonstrated. Some services are identified as a non-recurring or one time service. Review the service code data sheets for specific information. Once a client's situation has stabilized, it is anticipated that services will discontinue.

HOW DO I AUTHORIZE COMMUNITY TRANSITION OR SUSTAINABILITY SERVICES (CTSS)?

1. Use the CTSS eligibility criteria listed above to verify eligibility for these state funded services.
2. Prior to any CTSS utilization, you will ensure the need for this state only services are captured in the CARE assessment.
    a. For state funded goods or services, such as essential household goods or furnishings or pest eradication, select "Community Transition Services" and/or "Community Transition Goods or Items" on the treatments screen and select the appropriate provider type and frequency from the Provider List. (It is recommended that the service type/goods also be listed in the comments.)
3. Add the CTSS RAC (3105) to the client's RAC Eligibility list in CARE.
4. Complete a SER outlining the service you are authorizing and/or the items you are purchasing and how they are necessary for the client's service plan.
5. A client can have both the state funded CTSS RAC and a federally matched program RAC such as CFC, COPES or RSW assigned.
6. Receipts for all purchases must be included in the participant's electronic case record (ECR). Attach all receipts/bids to the Packet Cover Sheet: Social Services Invoice/Receipt Packet Cover (DSHS Form 02-615)
7. Create a PAN outlining one-time CTSS are approved.



HOW DO I AUTHORIZE WA ROADS SERVICES?

Prior to any WA Roads service utilization, you will want to SER Supervisory approval to use these state only funds.

For a resident transitioning from an institution:

1. Use the WA Roads eligibility criteria listed above to verify eligibility.
2. Note in the Service Episode Record (SER) that the client is eligible for WA Roads transition services and that you have Supervisory approval to authorize state only funds.
3. Have the client or their representative review and sign the DSHS (14-012) Consent form.
4. Add the WA Roads RAC (3120) to the client's RAC Eligibility list in CARE.
5. Complete a SER outlining the service you are authorizing and/or the items you are purchasing and how they are necessary for the client's service plan.
    a. Authorization for emergency rental assistance (SA298) must be approved by both the supervisor and an ALTSA HQ Housing Specialist prior to utilization.
    b. The WA Roads Emergency Rental Form must be submitted (see Chapter 6b: Interim Housing Resources (Motel Interim Stay for Transitions & Emergency Rental Assistance) to access form)
    c. Document both approvals in the SER in CARE.
6. For WA Roads services such as Community Choice Guide, choose "Community Integration" on the Treatments screen in CARE and select the appropriate provider type and frequency from the Provider List. (It is recommended that the Sustainability Goals are completed in CARE and incorporated as part of the WA Roads service referral to the provider.)
7. Receipts for all purchases must be included in the participant's electronic case record (ECR). Attach all receipts/bids to the Packet Cover Sheet: Social Services Invoice/Receipt Packet Cover (DSHS Form 02-615)
8. Upon discharge, and with the client's consent, follow the procedures outlined in Chapter 7 of the Long-term Care Manual to enroll the client in the core LTC program for which they are functionally and financially eligible.
    a. If a client declines waiver/state plan HCBS, follow all procedures in the Long-Term Care Manual to document their decision.
9. Enter the discharge date on the Nursing Facility Case Management screen or the State Hospital screen in CARE. For Acute Care Hospitals, you may enter the Medical Hospital end date under the Short Term Stay screen in CARE.
10. Make a note in the "Additional Information" section on the Case Transfer Form that WA Roads services were used as part of discharge planning.
11. Following all instructions in the Social Services Authorization Manual (SSAM), select the appropriate RAC and authorize on-going services such as personal care for the client.
12. An individual transitioning from an institution using WA Roads is eligible to receive up to six months of WA Roads services post discharge to provide stabilization as necessary, without reevaluating eligibility for WA Roads services.

a) A client can have both the WA Roads RAC (which is not an assessment-based RAC) and an assessment-based RAC such as CFC or MPC assigned.
b) After six months, an individual who has transitioned to the community from an institution may have access to WA Roads services when they meet other WA Roads eligibility criteria for clients living in the community or living in ALTSA coordinated subsidized housing.

For ALTSA clients residing in community settings who are eligible for WA Roads services:

Ensure that CARE clearly documents that all care planning and service resources available through HCBS waiver/state plan have been examined and utilized.

1. Conduct staffing between case manager and supervisor to review and ensure that all aspects of CARE clearly indicate the need and approval for WA Roads.
   a) Recommended: have a third party review the documentation in CARE prior to authorization of WA Roads services. (This process is to be determined locally. An example might include requesting a Nursing Care Consultant or JRP to review the assessment and/or care plan.)
2. Complete a SER outlining:
   a) The Supervisor's approval to authorize WA Roads services.
   b) The service you are authorizing and/or the items you are purchasing and how they are necessary for the client's service plan.
   c) The desired outcome of services authorized.
      i. Authorization for emergency rental assistance (SA298) must be approved by both the supervisor and an ALTSA HQ Housing Specialist prior to utilization.
      ii. The WA Roads Emergency Rental Form must be submitted (see Chapter 6b: Interim Housing Resources (Motel Interim Stay for Transitions & Emergency Rental Assistance) to access form).
      iii. Document both approvals in the SER in CARE.
   d) For members of this eligibility group who return for a brief institutional stay, WA Roads services can be authorized while in the institution, as needed, to facilitate a return to the community.
3. Add the WA Roads RAC (3120) to the client's RAC Eligibility list in CARE (if there is an authorization, there must be a note in the SER, per instruction above).
   a) A client can have both the WA Roads RAC (which is not an assessment-based RAC) and an assessment-based RAC such as CFC, COPES, or RSW assigned.
4. If there has been no change in the client's cognition, ADLs, mood/behaviors, or medical condition complete an Interim assessment to document the need for the WA Roads program.
   a) For WA Roads services such as Community Choice Guide, choose "Community Integration" on the Treatment Screen in CARE and select the appropriate provider type and frequency from the Provider List. (It is recommended that the Sustainability Goals are completed in CARE and incorporated as part of the WA Roads service referral to the provider.)

b) For Washington Roads sustainability items or services, such as essential household goods, select "Community Transition Goods or Items" or for furnishings or pest eradication, select "Community Transition Services" in treatments and select the appropriate provider type and frequency from the Provider List. (It is recommended that the service type also be listed in the comments.)

5. All other case management requirements for clients receiving ALTSA supports, including quarterly contacts, should be followed.
6. Regarding clients who have received ALTSA coordinated subsidized housing: The ALTSA HQ Housing Specialist will send an informational email alerting both the HCS and AAA office when a client in their region/PSA will be moving or has just moved to the community using a housing voucher.
7. Individuals in areas participating in the Steps to Employment (S2E) pilot projects who are interested in receiving employment services will be referred to the HCS Employment Program Manager for service assessment and authorization.

For an individual with a housing voucher/subsidy that has been coordinated through ALTSA, but who is not currently receiving ALTSA supports. Please Reference Chapter 6a-d for additional Housing Resource policy information.

ETR Considerations

Each region will utilize a local ETR process for State Funded CTSS and WA Roads services. HQ ETRs are only used for:

- **Personal Care through other programs:** CTSS or WA Roads services should be explored before requesting additional personal care or increased residential rates for individuals meeting CTSS or WA Roads eligibility criteria.
- **Bathroom Equipment through other programs:** Follow all procedures to request bathroom equipment through the ETR process as outlined in the Social Services Authorization Manual when there are no other resources available (e.g. medical benefit, COPES, etc.). Bathroom Equipment is now generally covered by the medical benefit.
- **Emergency Rental Assistance:** Follow all procedures to request Emergency Rental Assistance as outlined in Chapter 6b: Interim Housing Resources (Motel Interim Stay for Transitions & Emergency

WA ROADS GRIEVANCE PROCESS:

Washington Roads (WA Roads) services are discretionary; case managers may identify individuals who are eligible and authorize WA Roads services based on their professional judgment. The grievance process outlined below is offered instead of the Office of Administrative Hearings process, which is available for other types of programs. **A Planned Action Notice should not be sent for WA Roads services**.

The grievance process is as follows:

1. If an individual or his or her representative does not agree with a decision that denied or terminated a WA Roads service,
    a. the assigned case manager will send a copy of the grievance process notifying the client in writing that he or she may request a review of the decision by following the steps outlined below (use the form below, printed on local letterhead); and
    b. document in a SER that the client was notified of the denial or termination and was given a copy of the grievance process

2. The individual or their representative may request a review by contacting their social service worker's supervisor. The supervisor will review the decision and respond in writing within ten (10) business days of receipt of the request for review.

3. If the individual or their representative does not agree with the decision of the supervisor, they may request a review by the WA Roads Grievance Workgroup by writing to:

    Aging and Long-Term Support Administration (ALTSA)
    Washington Roads Grievance Workgroup
    PO Box 45600
    Olympia, WA 98504

    A review by ALTSA's WA Roads Grievance Workgroup will take place within seven business days of receiving the written request for review.

4. The results of this review will be shared with the individual or his or her representative within three (3) business days of the date of the review.

WHAT ABOUT CONTRACTING?

Most client services contracts are executed through the AAA unless other local agreements are in place that state otherwise. All contractors providing CTSS or WA Roads services must have a current contract before providing services.

Services are performed within the scope of practice of the contractor's license and in compliance with professional rules, as defined by law or regulation, and are provided in a manner consistent with protecting and promoting the client's health and welfare, and appropriate to the client's physical and psychological needs.

Note: In addition to specific contracted duties, each provider is responsible for reporting any instances of abuse, neglect, or exploitation of a vulnerable adult or child.

RESOURCES

WA Roads Forms


WA Roads Grievance Process Notice.pdf


DSHS Form #02-615.docx

Goods and Services Program and Service Package Table:


CTSS and WA Roads Goods and S

Client Services Purchasing Card Process (HCS Only)/ Amazon Purchasing (NFCM Only)


HCS Purchasing Card.docx


Desk Aid for Amazon Business .p

Community Choice Guide (CCG) Activity Tracking Form


CCG Activity Tracking Form - Inst


CCG Activity Tracking Form MON


CCG Activity Tracking Form WEE

Rules and Policy

WAC 388-106-0950	Community Transition or Sustainability Services
WAC 388-106-0955	Community Transition or Sustainability Eligibility
WAC 388-106-0960	Community Transition or Sustainability Services limits

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
3.2025	Samantha Dunham Desiree Vallejo	• Updated multiple references to updated Housing Chapter. • Included Amazon Business purchasing for Community Transition Goods (NFCM Only) • Updated the CCG Activity Tracking Forms • Updated PAN example	

10.2024	Julie Cope	• Included hyperlink to Housing Resources Chapter for Emergency Rental Assistance • Included hyperlink to Assessment & Care Planning Chapter for Address Confidentiality Program information.	
7.2024	Julie Cope	• Included hyperlink to COPES chapter for CCG authorization steps • Replaced CTSS PAN screen shot to reflect CARE Web. • Added CCG Activity Tracking form to Resources Section. The form includes the option for providers to submit the form directly to the Imaging Unit via fax.	
12.2023	Julie Cope	• Added P-Card Process and Procedure • Updated DMS Packet Cover form 02-615 • Clarification on SA266 use and CCG reimbursement timeliness • Added description of trial visit • Included non-medical transportation services	H23-090
2.2023	Julie Cope	Removed Emergency Rental Form and referenced Chapter 5b for this document. Strengthened language regarding using WA Roads for Non-Citizens programs.	H23-017
11.2022	Julie Cope	Updated Eligibility to include State Funded Non-Citizens Programs Relocated Housing Resource policy and procedure information to Chapter 5b	H22-064
05.2021	Stephanie VanPelt	Updated HQ purchasing protocols and DMS cover packet form (02-615)	H21-050
2.2020	Jonnie Matson	Emergency Rental Assistance Request Form Updated	
12.2019	Julie Cope	Added one time state funded sustainability supports available under CTSS RAC 3105	H19-066

ALTSA Subsidies & GOSH Services

Chapter 6A outlines the policies and procedures related to the ALTSA Subsidy, providing guidance on its administration and management. This chapter also details the Government Opportunity for Supportive Housing (GOSH) program, which offers housing assistance to eligible clients. Additionally, it addresses protocols for managing cases where a client no longer receives Long-Term Services and Supports (LTSS) but continues to have an ALTSA Subsidy. The chapter ensures consistency in case handling and provides steps for transitioning clients appropriately while maintaining compliance with policies.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Jonnie Matson — Rental Assistance Unit Manager
360.628.0183 jonnie.matson2@dshs.wa.gov
Or
Whitney Joy Howard — Housing Integration Unit Manager
360.791.2358 whitney.howard@dshs.wa.gov
Or
Stephen Miller — Supportive Housing Unit Manager
564.200.3510 stephen.miller@dshs.wa.gov

For additional information please visit our website: Office of Housing and Employment

TABLE OF CONTENTS

BACKGROUND

The ALTSA Office of Housing and Employment (OHAE) is dedicated to offering housing and supported employment resources that honor client choice. We work to eliminate barriers and expand opportunities that align with an individual's vision for their life regardless of mental health, substance use disorder, race, language, age, ability, or other status.

OHAE brings together federal, state, and local resources to create opportunities and strategies to help clients access independent housing, and in collaboration with our community partners, help build an individualized array of services to support them. This chapter provides specific guidance around ALTSA Subsidies & GOSH Services and can help you refer ALTSA clients who are eligible for them.

Whenever possible, we can offer guidance about difficult housing situations you might encounter with your client, including tips about working with clients experiencing homelessness. Affordable housing and tenancy support are complex topics that often do not have easy or quick solutions. Please let us know about other topics or obstacles you would like to see addressed in this chapter.

ALTSA SUBSIDY VOUCHERS

The **ALTSA Bridge** subsidy program was launched in 2012 as a part of the Roads to Community Living Demonstration program. Bridge rental subsidies are intended to support individuals moving from institutional to community settings.
The **ALTSA Acute Care Hospital (ACH)** subsidy was launched in 2024 to help transition individuals from an Acute Care Hospital (ACH) setting, when housing is barrier.

The **ALTSA GOSH** subsidy is available as part of the larger Governor's Opportunity for Supportive Housing (GOSH) program for individuals discharging or diverting from Western State Hospital or Eastern State Hospital. The GOSH subsidy is paired with Supportive Housing services that assist the person with their transition back to the community and remains with the person if they are eligible.

ALTSA contracts with the Spokane Housing Authority (SHA) to issue, track, and monitor these subsidy payments throughout all of Washington State to housing providers to help streamline the program.

Video: ALTSA Subsidy Training Overview

What is the goal of ALTSA subsidies? ALTSA subsidies provide rental assistance for eligible ALTSA clients in the form of a monthly rent subsidy that is paid directly to housing providers, like tenant-based housing choice vouchers. The client is responsible for a portion of the rent, paid directly to the landlord, calculated at approximately 30 percent of the household's total income.
ALTSA subsidies are intended to assist clients in transitioning into affordable housing while they remain on waitlists for permanent, affordable housing.

What is Global Leasing?

Global Leasing is an ALTSA program centered on Housing First that aims to quickly lease up referred clients who face high housing barriers. It braids ALTSA Long-Term Services & Supports (LTSS) and housing resources with risk mitigation funds as an added layer of security for both landlords and lease holders while offering housing options for clients.

Where in Washington State are ALTSA subsidies available?

ALTSA subsidies are available statewide. The Spokane Housing Authority is contracted to administer the subsidy on behalf of ALTSA, but clients may live in any area of the state.

What are the basic eligibility standards for ALTSA subsidies?

There are three eligibility tracks for an ALTSA subsidy:

1. **ALTSA Bridge**: Clients exiting from a Skilled Nursing Facility who will transition to the community on In Home services.

2. **ALTSA Acute Care Hospital**: Clients transitioning from an Acute Care Hospital (ACH) setting, when housing is a barrier.

3. **ALTSA GOSH**: Clients exiting or diverting from Eastern or Western State Hospitals. The ALTSA GOSH subsidies are a part of the larger GOSH service that includes Supportive Housing services. Please see the GOSH section for more in-depth information on the GOSH service and how to make a referral.

To receive the ALTSA Bridge or GOSH subsidy, an individual must sign the ALTSA Subsidy Participant Agreement. Click here for more information about ALTSA Subsidy Policies and Procedures and client document Tips for Maintaining LTSS.

What are Spokane Housing Authority's and ALTSA's responsibilities in determining eligibility for the ALTSA subsidy?

Both ALTSA HPMs and the Spokane Housing Authority play a role in determining eligibility for the ALTSA subsidy.

ALTSA Housing Program Managers:
Are responsible for screening and referring eligible ALTSA subsidy applicants to the Spokane Housing Authority. Individuals that contact the Spokane Housing Authority outside of this process will be directed to ALTSA Housing Program Managers.

Spokane Housing Authority (SHA):
After receiving initial application packets from ALTSA, SHA will process subsidy applications and manage the subsidy process statewide for ALTSA. SHA communicates with landlords for inspections, provides documents needed during the lease-up process, and calculates the monthly ALTSA subsidy amount to be paid to the landlord, and communicates with client.

How do I make a referral for a client who I believe is eligible for an ALTSA subsidy?

- For **ALTSA Bridge subsidy referrals**, contact your Regional Housing Program Manager with the client's name and ACES ID or complete a Bridge Subsidy Referral Form and send it to your regional HPM. Please also see the Bridge Referral and Application Process form. An individual needs to have been determined both functionally and financially eligible through an assessment to receive the ALTSA subsidy. HPMs will screen your client by looking in CARE to determine setting and eligibility. If clients are financially eligible for ALTSA services, then they are financially eligible to receive the subsidy. If your client is eligible to apply, the HPM will send you the application.

- For **ALTSA Acute Care Hospital subsidy referrals,** completely fill out ALTSA Subsidy- Acute Care Hospital Referral Form and submit to email hospitalsubsidy@dshs.wa.gov. Once the referral is received, a Regional Program Manager will follow up with the HCS/AAA case manager within 2 business days. If the individual is found eligible for the ALTSA Acute Care Hospital (ACH) subsidy, the Program Manager will provide the case manager with the subsidy application. **Please Note: At the time of the referral submission, the individual needs to have been assessed and determined both functionally and financially eligible and be in an Acute Care Hospital setting.** The HCS/AAA case manager will need to authorize a Community Choice Guide for housing search and transition services for the individual, or if the individual desires ongoing housing supports, a Supportive Housing Provider will need to be authorized.
- For information regarding the **ALTSA GOSH subsidy**, contact your GOSH Supportive Housing Program Manager.

What is the documentation required for my client to apply?

The ALTSA subsidy is a low-barrier application. Below is a list of documentation to include with the application:

- Current state-issued photo ID
- Copies of Social Security card
- If available: copies of current year's Social Security award letter or other first party income verification. If not, HPM can provide an income verification letter for the application.

Please reach out to the HPM if your client does not have the above documentation. Clients should be actively working on obtaining the above documents as they will be needed to apply for units where the subsidy will be used.

How will I know when there are ALTSA subsidies available?

Based on the funding availability for the ALTSA Bridge subsidy, openings will be announced via NFCM Workspace emails monthly. Regional Housing Program Managers can also be contacted for availability.

ALTSA Acute Care Hospital (ACH) Subsidies are limited. Please reach out to hospitalsubsidy@dshs.wa.gov for availability.

ALTSA GOSH Subsidies are regularly available to clients who are accepted in the GOSH program.

Is there a waitlist for ALTSA subsidies?

Currently there is a waitlist maintained for ALTSA Bridge subsidies as they are limited by funding availability. Referrals and applications are only accepted when funding is available. Please check in with your regional HPM for availability.

The ALTSA Acute Care Hospital (ACH) Subsidy is limited. There is no waitlist.

The ALTSA GOSH Subsidy is regularly available to clients who are accepted to the GOSH program. There is no waitlist for the ALTSA GOSH Subsidy.

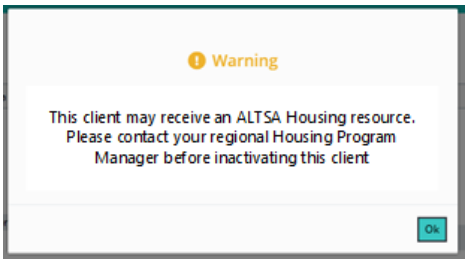
How do I document the ALTSA subsidy in CARE?

The HCS CM must enter the following into the CARE assessment:

- Add "Housing subsidy (HCS/AAA)" as a Treatment for ALTSA Bridge and ALTSA GOSH subsidy recipients.
  - On the Medical Screen in CARE, choose the Program "Housing Subsidy (HCS/AAA)"
  - Check "No" for Received in the Last 14 days?
  - Check "Yes" for Need
  - Choose "Agency" for the Provider
  - Choose "PRN" for Frequency
  - For Comments, type: "*Client will be receiving the ALTSA Housing Subsidy administered by Spokane Housing Authority.*"
- Add Spokane Housing Authority as a Paid Provider in the Care Planning section under the Supports Screen and assign the provider the task of "Housing subsidy (HCS/AAA)".

The Housing Subsidy treatment identifies a client who is receiving the ALTSA rental subsidy. This subsidy is paid for and managed by ALTSA and should be added when an individual receives the subsidy. This treatment should not be removed at annual or change of circumstances assessments unless approved by a Housing Program Manager.

When "Housing Subsidy (HCS/AAA)" is in the Treatment screen and you go to inactivate a client, you will receive the following pop-up message:



This warning is informational only and it will not prevent the user from inactivating the client. That said, policy is to reach out to your Housing Program Manager prior to closing the client.

Additionally, the CM must:

- Add ALTSA Housing Program Manager as a collateral contact.
- SERs regarding housing should be entered using *Housing* purpose code.

After transition, the client's file is typically transferred from HCS to the local AAA office. For clients utilizing the ALTSA Bridge subsidy, the AAA CM will be notified by the HPM that their client is receiving an ALTSA Bridge subsidy and will be informed on how the subsidy will be maintained.
An initial email from the HPM to the AAA CM is sent, introducing themselves as the ALTSA Bridge subsidy contact. This email will also share information and expectations about working with a client who has an ALTSA Bridge subsidy. The email will include information on:

- The expectation of supporting the client's tenancy through utilizing Community Transition Services or Foundational Community Supports - Supportive Housing program.
- Assisting the HPM with the annual subsidy recertification process.

What is needed to transfer an ALTSA subsidy client from HCS to the AAA?

- Please see Chapter 6D- section "*Pairing Services with Housing Resources section*".
- Clients should transition from institutional settings to independent housing with an open Community Choice Guide authorization for the client's continued utilization as needed once the case is transferred to the AAA. An exception to this would be if a client has been referred to FCS Supportive Housing or GOSH services. However, clients can still access other goods and services through Community Transition Services as needed.

How do CM's assist in maintaining the ALTSA Subsidy?

- For Bridge recipients, HPMs typically utilize CARE to verify the client is still residing in their unit. However, the HPM may reach out to the CM and may ask for assistance in contacting the client when needed.
- CMs can utilize GOSH Supportive Housing Providers (SHPs) to assist with the recertification for GOSH clients. CMs can also authorize a Community Choice Guide (CCG) or Foundational Community Supports - Supportive Housing Provider to assist Bridge clients with this task.
- ALTSA Subsidy clients are required to complete an annual recertification to maintain their subsidy. It is a simple packet, mostly requiring client signatures. The process is as follows:

    1. The HPM will send CM recertification documents, along with a cover letter that indicates to the client a return due date.
    2. The CM will send documents to client and collect them back with signatures.
    3. CM will scan and send the completed documents back to the HPM.
    4. If the CM is unable to connect with the client, HPM must be informed prior to the due date on the cover letter. HPM may ask that a CCG be authorized to assist with the task.

Note: When an ALTSA client is already enrolled in a housing service (GOSH, MIST, housing voucher) and any type of assessment (Initial, Annual, Interim, or Significant Change) is conducted with the client, and there is a possibility client is no longer functionally eligible for LTC services, HCS/AAA CM will review the assessment with the client prior to scheduling a staffing with SHPM, and before moving the assessment to current/history. A SER note is required for the assessment review with the client.

How are the ALTSA subsidy payments made?

The ALTSA subsidy rent payments are made utilizing a process between ALTSA HQ and Spokane Housing Authority (SHA). ProviderOne is no longer utilized to make rent payments to SHA. Please note: an ALTSA Subsidy is a LTSS service.

"May a client be absent from the unit for an extended period?"
Yes, a client with a subsidy may be out of the unit and retain the subsidy in the following situations: When a client is absent from their unit for health-related reasons or incarcerated, ALTSA will pay the subsidy for up to 6 months (180 days).

GOVERNORS OPPORTUNITY FOR SUPPORTIVE HOUSING (GOSH SERVICES)

Supportive Housing (SH) is a philosophy and a program that is rooted in the belief that no one should have to prove "housing readiness" to be housed. The service is an evidence-based practice with decades of research, as well as personal and professional stories, that highlight the success of community living paired with intensive, personalized supports. A person is supported in the process of securing community-based, affordable housing of their choice along with individualized support to assist the person with stabilization and self-identified goals. SH adheres to the principles of Housing First, Harm Reduction, Trauma Informed Care, Motivational Interviewing, Person Centered Planning, and Strengths-Based Approach. Program participation, medication adherence, and abstinence are not required to keep one's housing.

SH services are available in two ways for ALTSA recipients:

- Individuals who are currently residing in the community may be eligible for Supportive Housing services under Healthier Washington Medicaid Transformation: Foundational Community Supports (FCS) - Supportive Housing services. For more information about FCS-SH services, see Chapter 30d.
- Individuals who are currently residing at Eastern or Western State Hospital or can be diverted from these institutions may access Supportive Housing Services through the Governor's Opportunity for Supportive Housing (GOSH).

For more information about how Supportive Housing services can complement other Long-Term Services and Supports or for information on working with Supportive Housing clients who are not

currently receiving personal care services, please see LTC Manual Chapter 30d: Foundational Community Supports: Supportive Housing, specifically the ***Supportive Housing and Case Coordination*** section. For more information or materials on ALTSA Housing resources , please see our website Office of Housing and Employment .

History

In 2016, as part of the Governor's Behavioral Health Innovation Fund, created in ESSB 6656, ALTSA was awarded a small amount of state funds to pursue Supportive Housing services for individuals eligible for discharge from Eastern or Western State Hospitals. The original budget allowed for approximately 15 individuals to transition out of the state hospitals with Supportive Housing services with the option of a state-funded housing subsidy. ALTSA began contracting directly with community Supportive Housing Providers and the Governor's Opportunity for Supportive Housing (GOSH) was born.
In the 2017-2019 enacted budget, funding for GOSH was expanded and ALTSA was authorized to hire 3 FTEs dedicated to GOSH Program Management across the state. The ALTSA State Hospital Discharge and Diversion (SHDD) unit was also created. While GOSH pre-dates SHDD, it is one part of this larger initiative that has been approved by the state legislature under Mental Health Transformation.

Eligibility

The GOSH service is available for individuals who are choosing In-Home setting and:

- are willing to work with a Supportive Housing Provider, and
- qualify for ALTSA services (financially & functionally eligible), and
- are discharging or being diverted from Eastern or Western State Hospitals,
- Diversion is defined as: An individual with a 90- or 180-day commitment order for further involuntary treatment who is discharging from a local community psychiatric facility into Home and Community Services Long-Term Services and Supports (HCS LTSS); or an individual who is detained through the Involuntary Treatment Act who is stabilized and discharged into HCS LTSS prior to the need to petition for a 90- or 180-day commitment order.
- If you have a diversion client that was discharge from the hospital immediately after an assessment was completed. If you still have contact with the client, a referral can be made 30 days post discharge.

Please note, acceptance into the GOSH program is contingent on provider capacity and discretion.

Note: For more information on HCS assessment and transitions for those currently residing in the state psychiatric hospitals, please see LTC Manual Chapter 9b: State Hospital Assessments.

GOSH Eligibility Expansion

To ensure ALTSA's mission to transform lives by promoting choice, independence, and safety through innovative services, GOSH eligibility has been expanded to include:

- ALTSA clients who are currently living in a residential setting who transitioned or were diverted from Western/Eastern State Hospital within the past 18 months, as documented in CARE and counted by SHDD team, and wish to live independently.

Note: An ALTSA client who is discharging or diverting from Eastern or Western State Hospital who already has an apartment or other independent housing in the community can still be referred to GOSH for transition support and intensive, ongoing tenancy support services to help maintain their housing.

Presumptive Eligibility

Through the Medicaid Transformation Project 2.0. Long-Term Services & Supports (LTSS) Presumptive Eligibility (PE) is an opportunity for individuals to quickly access an abbreviated benefit package of services while full functional and financial eligibility are being determined. One service included in the Presumptive Eligibility NFLOC package is Supportive Housing.

- Where does Presumptive Eligibility and GOSH Overlap?
  - Phase 1 of Presumptive Eligibility is for ALTSA clients who are discharging or diverting from an acute care hospital and/or a psychiatric hospital, and have an ITA hold in this setting, are eligible for GOSH.

"Does a person experiencing homelessness qualify for Presumptive Eligibility?"
GOSH clients are eligible to utilize the Motel for Interim Stay Transitions (MIST) program. MIST can be authorized for up to 6 months. If the ALTSA client qualifies for Presumptive Eligibility, and desires GOSH, and has no safe place to stay or resources to pay for a place, the HCS/AAA case manager can utilize MIST. When a GOSH recipients are paired with MIST, they are not considered homeless and can then access the PE benefits.

GOSH Referral Process

1) Obtain confirmation that the client would like to be referred for Supportive Housing (SH) services and additional information needed for GOSH Referral Form. Please note, there is no participation for Supportive Housing.
2) Completely fill out DSHS Form 11-153, "Governor's Opportunity for Supportive Housing (GOSH) Referral" and email to your Regional GOSH Referral inbox:

DSHS Region 1: R1GOSHReferral@dshs.wa.gov
DSHS Region 2: R2GOSHReferral@dshs.wa.gov
DSHS Region 3: R3GOSHReferral@dshs.wa.gov

The email must include all additional required documents as attachments, as outlined on the GOSH Referral. Please note:

a) For referrals meeting diversion criteria to be verified, CMs must include a copy of the court commitment paperwork, signed by a judge or commissioner, which documents that:
   i) the client is on a 90- or 180-day commitment order for further involuntary treatment, or
   ii) the client is on a civil commitment detainment under the Involuntary Treatment Act (this includes 120-hour, 14-day, 90-day or Revoked 90/180 LRA orders).
b) Commitment orders must be verified and uploaded to DMS by Primary CM. State Hospital screen needs to be updated.

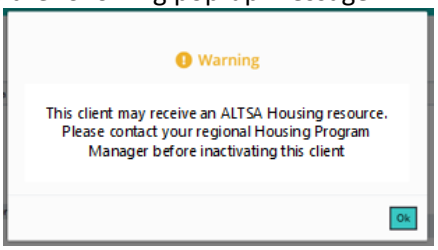
- If a client meets diversion criteria and is being case managed by an Area Agency on Aging (AAA), the AAA CM may refer the client for GOSH.

3) As of the March 31, 2023 CARE Release, GOSH is on the State Hospital/Hospital/E&T screen in CARE. When you are entering a client's most recent psychiatric hospital stay, you now will be prompted to enter if a GOSH referral was made, the referral date and whether they were approved for GOSH. If you select "no" for "Was GOSH referral made?" there will be no further questions.
4) If a client is eligible for GOSH, the SHPM will make a direct referral to the ALTSA contracted Supportive Housing Provider (SHP) and complete a Service Episode Record (SER) with their actions. The SHP has two business days to respond to the SHPM.
5) If a client is not eligible for GOSH, the SHPM will inform the referring CM by email and enter a SER with this information.

GOSH Client Accepted

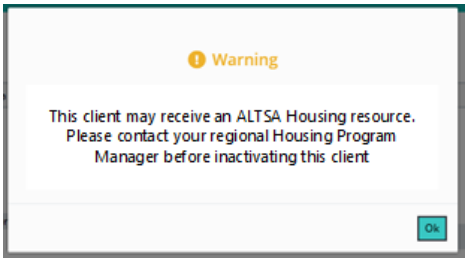
1) Once the referral has been accepted by the SHP:
   a) The SHPM will communicate this through a secure email to CM, additional care team (discharge social worker, MCO liaison, Peer Bridger, Outpatient Behavioral Health Provider, etc.) and the SHP. The SHPM will update their section of DSHS Form 11-153 and include the complete referral form as an attachment in their email.
   b) The referring CM will submit the GOSH Referral to DMS.
   c) The SHPM will open RAC 3131 – LTSS Housing Stabilization and then the pre-tenancy Supportive Housing service code, SA299-U1, to open the SH authorization in CARE. The SHPM will document these actions in a SER.
      i) RAC 3131 is the RAC the SH service code is tied to.
      ii) It is the SHPM's responsibility to open, extend and close authorizations for service code SA299, U1.
      iii) It is the CM's responsibility to complete the remaining steps for authorization of services, as outlined in LTC Chapter 3, including complete electronic form DSHS 14-443 in Barcode.
   d) The SHPM will create and send the client a Planned Action Notice (PAN) informing them that SH services are approved.

2) Once client is authorized for Supportive Housing, the CM must:
   a) Add Supportive Housing Provider to Collateral Contacts screen
   b) Add "Supportive Housing" as a Treatment
      i) On the Medical Screen in CARE, choose the Program "Supportive Housing (HCS/AAA)"
      ii) Check "No" for Received in the Last 14 days?
      iii) Check "Yes" for Need
      iv) Choose "Agency" for the Provider
      v) Choose "PRN" for Frequency
      vi) For Comments, type: "*Client has been referred to the Governor's Opportunity for Supportive Housing (GOSH) service. [Enter name of Supportive Housing Provider] to assist with pre-tenancy search for affordable housing or transition back to their apartment, assist with community integration, and to provide ongoing intensive tenancy support services."*
      vii) The Supportive Housing treatment identifies a client who is receiving Supportive Housing services through the Governor's Opportunity for Supportive Housing (GOSH) or Foundational Community Supports - Supportive Housing. This treatment should not be removed at annual or change of circumstances assessments unless approved by a Housing Program Manager.
      viii) When "Supportive Housing (HCS/AAA)" is in the Treatment screen and you go to inactivate a client, you will receive the following pop-up message:



This warning is informational only and it will not prevent the user from inactivating the client. That said, policy is to reach out to your Housing Program Manager prior to closing the client.

   c) If client is receiving the GOSH Subsidy, add "Housing Subsidy (HCS/AAA)" as a Treatment
      i) On the Medical Screen in CARE, choose the Program "Housing Subsidy (HCS/AAA)"
      ii) Check "No" for Received in the Last 14 days?
      iii) Check "Yes" for Need
      iv) Choose "Agency" for the Provider
      v) Choose "PRN" for Frequency
      vi) For Comments, type: "*Client will be receiving the ALTSA Housing Subsidy administered by Spokane Housing Authority."* The Housing Subsidy treatment identifies a client who is receiving the ALTSA rental subsidy. This subsidy is paid for and managed by ALTSA and should be added when an individual receives the subsidy. This treatment should not be removed at annual or change of circumstances assessments unless approved by a Housing Program Manager.
      vii) When "Housing Subsidy (HCS/AAA)" is in the Treatment screen and you go to inactivate a client, you will receive the following pop-up message:



viii) This warning is informational only and it will not prevent the user from inactivating the client. That said, policy is to reach out to your Housing Program Manager prior to closing the client.

d) Add "Other" for Community Supports under Treatments
   i) On the Medical Screen in CARE, choose the Program "Other"
   ii) Check "No" for Received in Last 14 days?
   iii) Check "Yes" for Need
   iv) Choose "Agency" for Provider
   v) Choose "PRN" for Frequency
   vi) For Comments, type: *"Community transition items and services as identified to assist with the client's return to independent living."*

e) Add the Supportive Housing Provider as a Paid Provider in the Care Planning section under the Supports Screen and assign the provider the task of "Supportive Housing (HCS/AAA)" and "Other" (for Community Transition Services)

f) If the client is receiving the GOSH Subsidy, add Spokane Housing Authority as a Paid Provider in the Care Planning section under the Supports Screen and assign the task of "Housing Subsidy (HCS/AAA)"

g) Please note, per Case Management policy, a task must be assigned to a Paid Provider to move an assessment to Current. You do not need to assign all paid tasks specifically to a paid care provider in order to move an assessment to Current. For GOSH clients who only have Supportive Housing services at the time of the assessment, adding the Supportive Housing Provider as a Paid Provider and assigning the provider the paid task of "Supportive Housing (HCS/AAA)" will suffice to move the assessment to Current. Do not assign the Supportive Housing Provider caregiving tasks.

h) Use the Purpose Code "Housing" for any SERs related to GOSH services or subsidy.

i) If there are any issues or concerns regarding a GOSH client, including eligibility concerns, protocol is for the case manager to staff with SHPM. Do not close a GOSH client prior to staffing with a SHPM.

Note: DSHS contracts directly with GOSH SHPs and the scope of work is spelled out in the contract. Therefore, SHPMs and CMs do not fill out the Sustainability Goals screen in CARE for SHPs.

GOSH Discharge Planning

1) Once Supportive Housing Provider (SHP) accepts the client, they start working with the client on:

a) Paperwork – running a background check, Housing Assessment form, GOSH subsidy, rental applications, etc.
b) Documentation – in partnership with the discharge workers, ensuring the client has a current ID or someone is working with the client on obtaining a current ID, Social Security card, income verification letters, etc.
c) Independent housing search – the SHP does not conduct residential searches.
d) Determining what items the client has or can access through community resources and items the SHP might request CM to authorize through the appropriate Community Transition services (e.g., furniture, household items, phone).
e) Discussion around all services the client needs in the community – these conversations should be ongoing with the client and the care team.

2) Best practice is for the SHP to provide weekly email updates to the care team (CM, SHPM, discharge social worker, MCO liaison, Peer Bridger, Outpatient Behavioral Health Provider, AAA as applicable, etc.).
   a) If you are not hearing from the SHP, reach out to the provider directly to request client updates.
   b) If you have ongoing communication challenges with the SHP that you are not able to work out directly, elevate to the SHPM for support.
3) Multidisciplinary meetings will determine which agency/provider will address service referrals pending community transition.
   - If need for additional staffing or more support needed from multidisciplinary team, CM can consider reaching out to Regional Transition Coordinator to add client to the appropriate Cross Systems committee staffing.
4) SHPM available for any support needs. If there are issues or concerns regarding a GOSH client, including eligibility concerns, protocol is for the case manager to staff with SHPM. Do not close a GOSH client without staffing with SHPM.

Note: When an ALTSA client is already enrolled in a housing service (GOSH, MIST, housing voucher) and any type of assessment (Initial, Annual, Interim, or Significant Change) is conducted with the client, and there is a possibility client is no longer functionally eligible for LTC services, HCS/AAA CM will review the assessment with the client prior to scheduling a staffing with SHPM, and before moving the assessment to current/history. A SER note is required for the assessment review with the client.

Once discharge date has been set:

Best practice for is the CM or SHP schedule a discharge planning conference meeting approximately 7-10 days in advance of a discharge. The timeline might be shorter for clients discharging from an Evaluation and Treatment Facility or inpatient from an acute care hospital.

1) Meeting should include:
   a) HCS CM, Public Benefits Specialist, Discharge SW, SHP, receiving AAA or HCS CM (if transitioning to Interim Setting), MCO Liaison, Outpatient Behavioral Health Team, Peer Bridger, Caregiving Agency supervisor (if known), client and any support individuals.
2) Discharge Planning Call should cover:
   a) Discharge logistics (e.g., transportation, personal items of client, medications – how much will they discharge with, what prescriptions, etc., what pharmacy, any cash that client received while

working or "gate" money, confirmation they have a copy of their ID and Social Security card, etc.).

b) Overview of the state of the apartment (furniture, food, household items, etc.).
c) Overview of appointments for the first week and discussion on who will be assisting in transportation.
d) Discussion on what "after care" services the client will have once discharged and what additional supports or services need to be authorized and by whom.
e) Financial logistics (will food stamps be turned on, what cash benefits will client receive, who will coordinate taking client to DSHS or Social Security Administration office, etc.).
f)

"Does GOSH services end if client cannot return to their previous residential setting & is admitted to the hospital?" No, if the GOSH client cannot return to their previous residential setting, the residential case manager will transfer the case immediately to an HCS hospital case manager. See Chapter 9 for additional information.

GOSH Interim Setting Process

ALTSA'S GOSH program supports in-home transitions for those discharging/diverting from Eastern or Western State Hospital by connecting them with a Supportive Housing Provider (SHP). The SHP works to transition clients to an independent apartment in the client's community of choice with supports. Apartments are not always secured before discharge occurs. Rather than delaying discharge, and when a client is in agreement, an interim setting may be sought while a client is waiting for housing to be secured.

To ensure there are no interruptions to Supportive Housing services or the independent housing search, any transitions in case management or the service team should include the ALTSA Supportive Housing Program Manager (SHPM) and Supportive Housing Provider (SHP) in communication and coordination. The Housing Team encourages discharge planning calls in advance of any transitions to an interim setting.

Please note: the role of the SHP is to search for independent housing. If a residential setting is being pursued as an interim setting and the CM is unable to conduct this search directly, they can look into the authorization of a Community Choice Guide (CCG) to search for and secure a residential setting for the client. The CCG should not also conduct a search for independent housing, as this would be a duplication of services with the SHP. The SHP's independent housing search does not cease during this period unless the participant no longer wishes to live independently or participate in GOSH.

An Interim Housing Option is considered anything outside of a client's own apartment/house. Examples include: HCS residential setting, Adult Residential Treatment Facility, Transitional Housing, motels, family/friends, etc.

When to use the Interim Setting process

1. An individual has been deemed ready to discharge prior to independent housing being secured and all parties agree that a continued stay is not in the individual's best interest.
2. The individual requests an interim setting and all parties agree it is a safe, viable discharge plan while waiting for independent housing.
3. An individual is diversion eligible and ready for/must discharge from their current setting.

When not to use the Interim Setting process

1. To explore a participant's "housing readiness."
2. An individual has been approved for independent housing, but the move-in date has delayed discharge. For example, repairs need to be made on the unit, so the move-in date is four weeks out. In this instance, every effort should be made to have the person wait in the State Hospital or diversion facility to avoid the extra move.

Procedures

1. HCS Case Managers search for interim housing options that are willing to accept clients in an interim status as they wait for independent housing through GOSH. It is important to locate an interim housing option in the county where the participant intends to reside permanently as this will aid the housing process. If an interim housing option is not available in the county the participant intends to reside in permanently, speak with your SHPM.

2. Once an interim housing option has been identified, the HCS/AAA Case Manager will speak with the client and/or their authorized representative and explain the temporary nature of the interim housing option while the client is still working with their SHP on securing independent housing. The HCS/AAA Case Manager will get verbal confirmation from the client that they understand and agree with this plan.

3. If an HCS residential setting is being utilized as an interim housing option, the HCS/AAA Case Manager will speak with the owner/operator/manager of the residential setting and explain that the client will reside there while they pursue independent housing. The HCS/AAA Case Manager will get verbal confirmation from the owner/operator/manager that they understand the client will be working with their SHP to find independent housing and that once independent housing is found, the client will be moving out of this setting.

4. For interim housing options that are not HCS residential settings, prior to transition, the HCS/AAA Case Manager will speak with the appropriate representative to inform them that the client is working with a SHP on securing independent housing.

5. Regardless of interim housing option, prior to transition, the HCS/AAA Case Manager will notify the SHP of the contact information for the appropriate representative of the interim housing.

6. After completing items 1-5, HCS/AAA Case Manager must enter the following SER:

"The writer has spoken with this client and/or their authorized representative and explained the temporary nature of the interim option and they understand and agree with this plan.
The writer has spoken with the owner/operator/manager of [*enter facility name*] and explained that the client will reside at this facility as an interim setting as they pursue independent housing and understand that this is temporary.

Appropriate representative of the interim housing understands client will be working with Supportive Housing team to find independent housing. Provider also understands that once independent housing is found, client will be moving out of this setting.

I have notified the SHP the contact information for the appropriate representative of the interim housing."

7. Depending on the type of facility selected as the interim setting, the following will take place:

   a) **Adult Family Home (AFH):** If both client and home approve of the placement, HCS Case Manager will transfer the case to the local HCS office and communicate that the client is on GOSH and working with a SHP.

   b) **Adult Residential Treatment Facility (ARTF):** HCS Case Manager should approach the local AAA Office to determine if they are willing to accept the case while the client is at an ARTF. If the AAA office declines, the case will be kept open and transferred to the local HCS office. Transferring HCS Case Manager should communicate that the client is on GOSH and working with a SHP.

   c) **All Interim Settings that are not licensed should be considered "In-Home":** HCS Case Manager should authorize needed Long-Term Services and Supports while the client is staying in the interim setting. HCS Case Manager should approach the local AAA office to determine if they are willing to accept the case. If AAA office declines, the local HCS office should hold the case. Transferring HCS Case Manager should communicate that the client is on GOSH and working with a SHP.

   d) **Regardless of Interim Setting:**

      - HCS or AAA CM keeps the case open. SHP will work with HCS/AAA Case Manager for authorization around Community Transition and Sustainability Services.
      - SHP should schedule time with interim setting staff working with the client (if applicable) and new HCS/AAA Case Manager to clarify roles and responsibilities and provide housing search updates.
      - SHP should include new HCS/AAA Case Manager in regular updates regarding housing search. Interim setting staff should be included as appropriate (if applicable).

- If a client is re-hospitalized or jailed, they are not automatically exited from their GOSH services or subsidy. GOSH is a state-funded service and, as noted in Chapter 3, page 3.26, state-only exceptions exist for paying for services when a client is institutionalized. Supportive Housing Providers continue to provide support services to clients through short-term hospitalizations or jail stays. Service authorizations are to remain open and clients active, as Supportive Housing Providers continue to work with the clients and the GOSH subsidy continues to be provided.
  - If you are made aware that a participant is in jail – staff case with the GOSH Program Manager. If a participant faces multiple court hearings, hold the case until final decision of the court is carried out. During this time, HCS/AAA CM, GOSH Provider and GOSH PM will have regular staffing meetings. GOSH program and HCS/AAA will still hold case on their case load. GOSH authorization remains active and the GOSH Provider is billing during this time.
  - If you are made aware that a participant is institutionalized – keep case open, regular staffing will occur between HCS/AAA CM and GOSH Provider. GOSH Provider will follow up with hospital/institution regarding the status of the client and provide updates to HCS/AAA CM. GOSH authorization remains active and the GOSH Provider is billing during this time.
  - If you have any questions or concerns, reach out to your Regional SHPM. Do not close a GOSH client prior to staffing with a SHPM.

Transition to Independent Living

Once the client has moved into their own apartment:

a) The SHPM will ensure RAC 3131 – LTSS Housing Stabilization's end date matches the CARE Plan end date.
b) The SHPM will close pre-tenancy service code SA299, U1, and open tenancy service code H0044.
   i) Please note, the date when the tenancy service code, H0044, is opened will vary based on the terms of the SHP's contract:
      (1) The tenancy service code may start the first full day in independent housing, OR
      (2) The tenancy service code may start after a 90-day transition period in independent housing.
   ii) It is the responsibility of the SHPM to close the authorization for SA299, U1 and open an authorization for H0044.
c) The SHPM will document these actions in a SER.
d) The SHPM will update the tenancy service code, H0044, on an annual basis. If there are any concerns around client eligibility, staff with the SHPM.
e) If the case has not yet been transferred to the local Area Agency on Aging (AAA), it is best practice to have a meeting between the HCS CM, assigned AAA CM and GOSH Provider. If it is

not feasible to have this meeting, the HCS CM should let the GOSH Provider know they are transferring the case and the assigned AAA CM should reach out to the GOSH Provider to let them know they are now case managing the case.

f) The SHP continues to provide intensive tenancy support services and work with the care team for cross-system collaboration.

g) At the time of Annual Assessment, the assigned HCS/AAA CM should reach out to the GOSH Provider as a collateral contact. The GOSH Provider provides an array of support to a client and the CM should speak with them about the services they are providing the client as part of the assessment process.

h) SHPM remains available for any support needs.

i) If a client is re-hospitalized or jailed, they are not automatically exited from their GOSH services or subsidy. GOSH is a state-funded service and, as noted in Chapter 3, page 3.26, state-only exceptions exist for paying for services when a client is institutionalized. Supportive Housing Providers continue to provide support services to clients through short-term hospitalizations or jail stays. Service authorizations are to remain open and clients active, as Supportive Housing Providers continue to work with the clients and the GOSH subsidy continues to be provided.

   i) If you are made aware that a participant is in jail, staff case with the GOSH Program Manager. If a participant faces multiple court hearings, hold the case until final decision of the court is carried out. During this time HCS/AAA CM, GOSH Provider and GOSH PM will have regular staffing meetings. GOSH program and HCS/AAA will still hold case on their case load. GOSH authorization remains active and the GOSH Provider is billing during this time.

   ii) If you are made aware that a participant is institutionalized, keep case open, regular staffing will occur between HCS/AAA CM and GOSH Provider. GOSH Provider will follow up with hospital/institution regarding the status of the client and provide updates to HCS/AAA CM. GOSH authorization remains active and the GOSH Provider is billing during this time.

   iii) If you have any questions or concerns, reach out to your Regional SHPM. Do not close a GOSH client prior to staffing with a SHPM.

Note: The SHPMs are responsible for opening, modifying and closing Supportive Housing service codes (SA299, U1 for pre-tenancy and H0044 for tenancy). Authorization of these service codes cannot be made by case managers as they need HQ approval. If a case manager attempts to open, modify, or close these service codes, the authorization will go into error.

When performing a CARE assessment for a GOSH client, consider the following:

1. Ask the client who they would like to attend the assessment appointment with them. Offer suggestions for who may be helpful in providing useful information (family, friends, Supportive Housing Provider, etc.).
2. Gather information from the client's legal representative or substitute decision-maker, as appropriate.
3. Gather other information from collateral contacts if it is needed to complete the client's assessment. See Chapter 3.

GOSH State Subsidy

The ALTSA GOSH Subsidy is a state funded housing subsidy that is available for individuals discharging or diverting from Western State Hospital or Eastern State Hospital. The subsidy is paired with Supportive Housing services that assist with transition and follow the person in the community to support housing stabilization over the long term. For more information on the ALTSA GOSH Subsidy, please see 6.4

Reimbursements

DSHS contracts directly with GOSH SHPs. While GOSH SHPs are reimbursed for Supportive Housing services, there are no set aside monies tied to GOSH for goods. GOSH is a Long-Term Service and Support that funds Supportive Housing services and a housing subsidy. In order to support the GOSH participant's transition and sustainability in independent housing, CMs should utilize Community Transition Services or Housing & Employment Stabilization Services dependent upon participant eligibility. With prior approval from the AAA/HCS CM or SHPM, the SHP is reimbursed by the CM for the authorized purchases after it is verified that the individual received the goods. If a CM has questions or concerns about a SHP's invoice, the CM should communicate these concerns directly with the SHP. If there are repeated concerns, after attempts have been made by the CM to clarify, reach out to your Regional SHPM.

1. Based on an individual's eligibility, the following services could be reimbursed to the SHP: tenant background screening to aid housing search, paying for rental deposit and first month's rent, utility hookup fees, purchase of furniture, purchase of essential items including needed clothing, and emergency rental assistance, etc through Housing and Employment Stabilization Services. Assistive technology can be accessed through Washington Roads and not via Housing & Employment Stabilization Services.
2. For more information regarding Community Transition Services including eligible goods/services, appropriate RACs and service codes to reimburse purchases, please review the CTS section in the LTC Manual Chapter 7.
   a. For ALTSA clients who have received a housing resource or had their housing coordinated through ALTSA **and** are only eligible for state funding, the HCS/AAA case manager will authorize the goods & services under RAC 3131- LTSS Housing Stabilization.
   b. Use Service Code SA294,U4 to authorize the necessary goods and services Please note, an ETR will be required if the total amount of goods & services exceeds $5000.
   c. Select the appropriate reason code. Options are "In-Home Community Stabilization or Employment Stabilization"
   d. When submitting an ETR, select "other" for both ETR/ETP category & type.
   e. Submit the ETR for approval/denial to "Committee, Housing ETR" and email housingcommitteeetr@dshs.wa.gov to inform us about the ETR requested.
   f. Note in the Service Episode Record (SER) that the client is eligible for LTSS Housing Stabilization services and that you have Supervisory approval to authorize state only funds.
   g. Complete a SER outlining the service you are authorizing and/or the items you are purchasing and how they are necessary for the client's service plan.
   h. Receipts for all purchases must be included in the participant's electronic case record (ECR). Attach all receipts/bids to the Packet Cover Sheet: Social Services Packet Cover Sheet (DSHS Form 02-615)

Note: When an ALTSA client is enrolled in Supported Employment, RAC 3131- LTSS Housing Stabilization Service Code SA294,U4, can be utilized to assist the client in obtaining or/and maintaining employment. This is a one-time expense to get identification card, food handlers' card, interview clothes, and first set of uniforms to begin work. This is not limited to once a lifetime but once per occurrence. See Chapter 30c

How is this funded?

Governor's Opportunity for Supportive Housing is one part in the larger State Hospital Discharge and Diversion (SHDD) initiative that has been approved by the state legislature under Behavioral Health Transformation. These services and subsidies are funded 100% through state dollars. Utilizing state dollars only allows for greater flexibility than programs also receiving federal funding. If you have policy questions on working with GOSH participants, please contact your GOSH Program Manager.

Note: There is no participation required for GOSH services.

Can a DDA services recipient receive GOSH services?

An individual receiving DDA services who is transitioning out of or diverting from Eastern or Western State Hospital, meets all other eligibility criteria, and can exit the hospital on an ALTSA program is eligible for GOSH. An individual receiving DDA services who is already residing in the community is not eligible for GOSH Supportive Housing.

What about contracting?

Governor's Opportunity for Supportive Housing contracts are executed and held at ALTSA headquarters. All contractors providing Governor's Opportunity for Supportive Housing services must have a current contract for waiver or RCL/LTSS Housing Stabilization individual services before providing services. Services are performed within the scope of practice of the contractor's license and in compliance with professional rules, as defined by law or regulation, and are provided in a manner consistent with protecting and promoting the individual's health and welfare, and appropriate to the individual's physical and psychological needs.
If you know of an agency that is interested in contracting for GOSH, please refer them to Becoming a GOSH Provider for more information.

Note: In addition to specific contracted duties, each provider is responsible for reporting any instances of abuse, neglect, or exploitation of a vulnerable adult or child.

WORKING WITH INDIVIDUALS ON ALTSA HOUSING RESOURCES WHO ARE NOT CURRENTLY RECEIVING ALTSA LTSS

How can ALTSA assist individuals who are no longer receiving LTSS?

Individuals who are residing in subsidized housing that was coordinated through ALTSA, whether through the state-funded ALTSA Subsidy or a federal voucher through HUD (NED/MSV/RVP and 811 vouchers), are eligible for Housing and Employment Stabilization Services regardless of whether the client is currently eligible for, or receiving, State Plan or Waiver HCBS. This section is specific to individuals who are stably housed with an ALTSA Subsidy or a federal voucher that was coordinated through ALTSA. This section does not apply to a client in housing search or only on housing-related services, such as GOSH services, without also being stably housed.

The following steps must be completed in addition to procedures found in Long Term Care Manual Chapter 3: Assessment and Care Planning. Please note that you may need to do an Interim Assessment to complete the following steps:

1. For an individual who is housed through ALTSA and is eligible for LTSS services but who is currently choosing not to receive them:

1. Enter the following treatments as a need: "Community Integration"; "Housing Subsidy (HCS/AAA)"; "Supportive Housing (HCS/AAA)", as relevant, and "Other". Move the assessment to *Current* and assign the appropriate RAC for the Program the individual is eligible for and assign the LTSS Housing Stabilization RAC (3131).
    a. The case worker may need to select "*I have refused waiver services*" from the "Client is eligible for" drop down to move the assessment to current.
    b. Enter authorization(s) using appropriate LTSS Housing Stabilization Service Code SA284,U4 (Housing Subsidy-Purchasing).
    c. For LTSS Housing Stabilization services such as Community Choice Guide, choose "Community Integration" on the Treatments screen in CARE. Complete the Sustainability Goals in CARE and incorporate as part of the LTSS Housing Stabilization service referral to the provider.
    d. For Housing & Employment Stabilization items or services, such as essential household goods or furnishings or pest eradication select "Other" in treatments and select the appropriate provider type and frequency from the Provider List. List the service type in the comments.
2. Document the client's approval to reduce the number of hours indicated to 0. Note in the SER that the client is utilizing a housing voucher and is eligible for Housing & Employment Stabilization services.

a. For clients who request fewer hours than are indicated on the Care Plan screen, follow the instructions in the LTC Manual Chapter 3 Assessment and Care Planning, under the "Getting approval on the Plan of Care" section.

3. As needed, transfer the case to the local Area Agency on Aging (AAA) office per transfer policy. Program RAC must be opened prior to transfer. Do not transfer a case with an Assessment moved to History to the AAA. Contacts must be documented in the SER.

    a. If client qualifies for the Wellness Education newsletter, you can authorize that service.

4. During the duration of the service period, should Housing & Employment Stabilization services be needed, complete a SER outlining:
    a. The service you are authorizing and/or the items you are purchasing and how they are necessary for the client's service plan.
    b. The Supervisor's approval to authorize WA Roads services.
    c. The goal of services authorized.
5. If there is an immediate service need to prevent the client from losing housing, the HCS/AAA staff assigned must respond to the need promptly.
    a. For example, if the client needs to utilize Emergency Rental Assistance (ERA), the HCS/AAA staff should submit and ERA form to the regional ALTSA Housing Specialist.
    b. Upon approval of ERA, the HCS/AAA staff should authorize a CCG to make the ERA payment.
6. The CM should follow all assessment timelines, including completing an annual assessment.
7. Enter authorization(s) using appropriate LTSS Housing Stabilization Service Code(s).

Note: Assigned HCS Case Manager must open Program RAC prior to transfer to AAA. You can open a Program RAC without then authorizing a service through that RAC.

2. For an individual who is found ineligible for LTSS services, but who is eligible for Housing & Employment Stabilization because ALTSA coordinated their housing voucher/subsidy:

1. Assign the LTSS Housing Stabilization RAC (3131) and move the assessment to History, but do not inactivate the case; you will still be able to authorize Housing & Employment Stabilization services should they be needed as long as the LTSS-Housing Stabilization RAC is assigned.

    a. Per LTC Manual Chapter 27: "When an Annual or Significant Change CARE assessment results in a decrease in residential rate, in-home units or other service, or a termination of a service, the department must provide clients at least 10-days' notice prior to implementing the reduction or termination."
        i. Per policy, the CM should send a termination PAN for LTSS per current protocols (being 10 days before the current plan period).

ii. Add the option of "Other" to the PAN (in CARE) and, dependent on circumstances, enter:
    1. If a GOSH client, on the LTSS termination PAN, include this language:
        a. "Supportive Housing services via GOSH will continue for 90 days. GOSH services will end (xx/xx/xxxx)."
        b. Please note, the GOSH Program Manager is the one to send the GOSH services termination PAN. The GOSH Program Manager will send this PAN after the 90-day period noted above.
        c. The GOSH Program Manager will extend RAC 3131 and the Supportive Housing authorization for the 90-day period.
    2. If the client is an ALTSA Subsidy holder, include this language:
        a. "While your Long-Term Services and Supports are being terminated, your housing subsidy/rent assistance is not being terminated. Your ALTSA Housing Program Manager will mail you a letter with more information about keeping your housing subsidy/rent assistance."

b. The HCS/AAA case manager should hold the case for 90 days.
c. If there is a determination that the individual needs and wants LTSS within the 90-day period, the HCS/AAA case manager should contact the HCS office for an Initial/Reapply assessment. Once the Initial/Reapply assessment is complete, the case is transferred back to the AAA.
d. If there is no determination that the individuals needs and wants LTSS within the 90-day period, after a care conference with the Housing Program Manager, the HCS/AAA case manager may inactivate the case.
    i. For GOSH clients, at this time, the GOSH Program Manager will end the GOSH authorization and end RAC 3131 - LTSS Housing Stabilization.
    ii. The GOSH Program Manager will send the GOSH services PAN.

1. If Housing & Employment Stabilization services are authorized to provide intermittent stabilization, the case manager and supervisor must utilize these services in the most cost-effective way. If the need for stabilization services becomes ongoing, the CM and supervisor should staff the case with the Housing Specialist to see if other service options would best fit the individual's needs.

3. For individuals who are residing in subsidized housing that was coordinated through ALTSA, whether through the state-funded ALTSA Subsidy or a federal voucher through HUD (NED/MSV/RVP and 811 vouchers), and are inactive:

No action is required of the HCS/AAA until individuals are identified. Individuals could be identified in a variety of ways:

1. The public housing authority/landlord could contact the ALTSA Housing Program Manager regarding an issue or crisis, at which point the ALTSA Housing Program Manager will make the referral to the local HCS office; or

2. The individual may contact an office (HCS or AAA) directly if services are being requested.
3. HCS/AAAs can contact the ALTSA Program Manager and request a list of individuals residing in their PSA who are utilizing a housing voucher.
4. Once the individual is identified as a person whose housing was coordinated through ALTSA and there is a need for Housing & Employment Stabilization services:
   i. Activate the case in CARE.
   ii. Housing & Employment Stabilization services can be authorized as soon as the case is activated in CARE.
   iii. If the AAA is the first point of contact and there is need for a new Assessment, per policy, the AAA should contact the HCS office if an Initial or Initial/Reapply assessment is required. Once the Initial or Initial/Reapply assessment is complete, the case is transferred back to the AAA.
   iv. Do not delay authorizing Housing & Employment Stabilization services for an immediate need during completion of the assessment process. If the client does not want to proceed with an assessment, Housing & Employment Stabilization services can still be authorized.

Please note that individuals who are receiving an ALTSA Housing Resource are immediately eligible for Housing and Employment Stabilization Services and the goods and services it provides

RESOURCES

Housing Team Contacts can be found on the **RCL Housing Resources Website.**

Office of Housing and Employment website: Office of Housing and Employment

Brochures and Videos

ALTSA Housing Resources

LTSS One-Pager

Global Leasing One-Pager

Civil Transitions Program One-Pager
Governor's Opportunity for Supportive Housing (GOSH) GOSH-SH-One-Pager
Presumptive Eligibility Supportive Housing
GOSH Interim Setting One-Pager 03.2023
Governor's Opportunity for Supportive Housing (GOSH) GOSH-SH-One-Pager
Zero Income One-Pager
Income Discrimination Flyer Income Discrimination Flyer Tenants: New Legal Protection from Discrimination Based on Source of Income

ALTSA Bridge Subsidy Brochure Governor's Opportunity for Supportive Housing One-Pager

Video: Options for Housing Through Long-Term Care Services

	FUND	LIMIT	SERVICE CODES	SUBJECT TO ETR	
FEDERAL	**Roads to Community Living (RCL)**	$10000	Goods: SA296	✓	***See LTC Chapter 7***
	Community Transition Services	$2500		✓	
	COPES	$1700	Services: SA297	✓	
If Client is not eligible for one of the programs above, see the following:					
STATE	**Housing & Employment Stabilization Services**	$5000	Goods & Services: SA294,U4	✓	***See LTC Chapter 6***

Housing Resource Chart

RAC 3132: Health Related Social Needs - Federal

Motel Interim Stay for Transitions (MIST) SA294u1

Motel Interim Stay for Transitions (MIST): is a service to pay for a short-term motel/hotel stay offered to minimize the number of clients who discharge to and/or experience episodes of homelessness. MIST aims to minimize the time it takes to get vital LTSS in place and increase the client's chances of ending up on services in their own home. The service is authorized for up to a 6-month period at a time. Federal MIST is funded via the 1115 waiver in which the Washington State Health Related Social Needs Services Program (HRSN) will allow Medicaid enrollees to receive evidence-based, non-medical services to address an individual's unmet, adverse social conditions that contribute to poor health. This includes temporary housing.

Who is eligible for federal MIST?	HCS/AAA clients who are receiving Medicaid long-term services who have one of the following qualifications: 1. **ALTSA Subsidy (Bridge & Acute Care Hospital)** • Bridge Subsidy: ALTSA clients who have a Bridge voucher issued and are working with an authorized contracted provider on an independent housing search. • Acute Hospital Care (ACH) Subsidy: ALTSA clients transitioning from an Acute Care Hospital (ACH) setting, when housing is a barrier. 2. **GOSH Program:** ALTSA clients who are enrolled in the Governor's Opportunity for Supportive Housing (GOSH) and are at risk of or experiencing homelessness. 3. **Other Housing Resource:** • ALTSA clients who will be living independently and currently have a resource from a housing agency or program. Examples might include Mainstream, NED, Housing Choice, Apple Health & Homes, HEN, HOPWA, VA, etc. • ALTSA clients who have been approved for a project-based resource and have a move-in-date. Examples might include Tax Credit units, 811 units, or Permanent Supportive Housing Unit from homeless service agency. 4. **In-Home Short-Term Displacement:** ALTSA clients who have their own home **and** a short-term situation that requires them to temporarily vacate. Ex: Pest control or eradication, fire, or flooding. 5. **Experiencing Homelessness:** ALTSA clients experiencing homelessness. Ex: staying in a car, park, abandoned building, tent, shelter, or couch surfing.
What is covered under MIST 294u1?	1. Payment for up to 6-month period for a Medicaid ALTSA client to stay at a motel/hotel. 2. Damages upon HQ approval- Please contact Supportive Housing Program Manager
What is not covered under MIST 294u1?	1. Deposits
How much can I spend?	1. Up to $4000 per month for a total of six months. • Note: not to exceed six month
Do I need to use a contracted provider?	**Yes.**

	1. The HCS/AAA CM will need to coordinate with the Contracted Provider and notify them that the client has been authorized for Motel Interim Stay for Transitions for a period of up to 6 months. 2. The Contracted Provider should be authorized for the duration of the MIST authorization period. 3. The Contracted Provider should make periodic visits to the client to provide support and assist in a housing search, as needed. *This might change if SHA takes this on...*
How do I authorize federal MIST?	1. Upon receiving approval for MIST, the HCS/AAA CM should open RAC 3132. 2. Use Service Code SA294,U1 to reimburse the contracted provider for the expenses incurred. 3. HCS/AAA CM will reimburse contracted provider on a two-week timeline for a period of up to six months. **Note: do not submit authorization to ProviderOne until receipt/s have been received.**
When do I authorize this service?	1. MIST should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager and a hotel/motel have been found.
Are ETRs allowed for federal MIST?	**No.** 1. When the approved MIST amount is above $2000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Emergency Rental Assistance SA298

Emergency Rental Assistance (ERA) can be used as a one-time payment made directly to landlords on behalf of an ALTSA client who is facing an immediate eviction due to non-payment of rent. As part of the assistance request, clients must demonstrate they are able to pay their rent going forward and maintain their independent housing as a part of being stabilized in their community setting. This resource should only be requested when there are no other community options to meet the need fully or partially.

Federal Emergency Rental Assistance is funded via the 1115 waiver, in which the Washington State Health Related Social Needs Services Program (HRSN) will allow Medicaid enrollees to receive evidence-based, non-medical services to address an individual's unmet, adverse social conditions that contribute to poor health. These includes rent.

Who is eligible for federal ERA?	1. An ALTSA client who is experiencing or at risk of experiencing homelessness, including facing an immediate eviction due to non-payment of rent.
What is covered under federal ERA?	1. A one-time payment made directly to landlords on behalf of an ALTSA client who is facing an immediate eviction due to non-payment of rent.
What is not covered under federal ERA?	1. ERA does not include pre-tenancy deposits or move-in costs required at move in. ERA cannot pay in excess of 150% Fair Market Rent per month and can only pay for a total of six months back rent.
When do I need a provider contract?	1. The HCS/AAA case manager will need to authorize a Contracted Provider (Community Choice Guide or GOSH Supportive Housing Provider) to make the ERA payment on the clients' behalf. *Could change dependent on SHA.*
How do I authorize federal ERA	1. Use RAC 3132. 2. Use Service Code SA298 to reimburse the contracted provider for the ERA payment amount approved by the HPM.
When do I authorize this service?	1. ERA should only be authorized after an ERA referral has been submitted and approved by the Housing Program Manager.
Are ETRs allowed for the federal ERA?	**No.** 1. note: When the approved ERA amount is above $4000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

RAC 3131: Long-Term Services and Supports Housing Stabilization – State Funds

Governor's Opportunity for Supportive Housing (GOSH) Pre-Tenancy SA299u1

Governor's Opportunity for Supportive Housing (GOSH) Pre-Tenancy	
Who is eligible for GOSH?	HCS/AAA clients who are receiving Medicaid long-term services who: are choosing In-Home setting and: 1. are willing to work with a Supportive Housing Provider, **and** 2. qualify for ALTSA services (financially & functionally eligible), **and** 3. are discharging or being diverted from Eastern or Western State Hospitals,

	4. An individual with a 90- or 180-day commitment order for further involuntary treatment who is discharging from a local community psychiatric facility into Home and Community Services Long-Term Services and Supports (HCS LTSS); or an individual who is detained through the Involuntary Treatment Act who is stabilized and discharged into HCS LTSS prior to the need to petition for a 90- or 180-day commitment order. 5. ALTSA clients who are currently living in a residential setting who transitioned or were diverted from Western/Eastern State Hospital within the past 18 months, as documented in CARE and counted by SHDD team, and wish to live independently.
What is covered under GOSH SA299u1?	Services that support an individual's ability to prepare for and transition to housing, including direct and collateral services: 1. Screening and housing assessment for individuals' preferences and barriers. 2. Developing an individual housing support plan: identifying goals, addressing barriers, establishing approaches to meet goals, including identifying available services and resources. 3. Assisting with eligibility determination, housing applications, subsidy applications, and housing searches. 4. Identifying resources for modifications and/or one-time move-in needs. 5. Assisting in arranging for and supporting details of moving into housing. 6. Training on roles, responsibilities, and rights of tenant and landlord. 7. Developing housing support crisis plan. 8. Maintaining participant and collateral contacts, and timely completion of supportive housing deliverables as outlined in 'Service Standards for Providers'.
What is not covered under GOSH SA299u1?	1. Rent 2. Move-in-costs 3. Utilities
How much can I spend?	1. 160 units per month
Do I need to use a contracted provider?	**Yes.** 1. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.

How do I authorize GOSH SA299u1?	Once the referral has been accepted by the SHPM: 1. The SHPM will open RAC 3131 – LTSS Housing Stabilization and then the pre-tenancy Supportive Housing service code, SA299-U1, to open the SH authorization in CARE. 2. It is the SHPM's responsibility to open, extend and close authorizations for service code SA299, U1.
When do I authorize this service?	1. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.
Are ETRs allowed for GOSH SA299u1?	**No.**
What about SA299,U1 for Civil Transitions Program?	1. Supportive Housing services are available through GOSH for those who meet Civil Transition Program eligibility (see Chapter 9b). 2. For clients meeting Civil Transition Program (CTP) eligibility only, use the appropriate CTP RAC and then authorize SA299u1 with the Reason Code "Civil Transitions Program". 3. If a Civil Transition Program client ends up eligible for LTSS: • End CTP RAC • End SA299,u1 authorization, then: • Open RAC 3131 LTSS Housing Stabilization • Open SA299u1 and use Reason Code " 5440 FEFE", which stands for 5440 Functionally Eligible Financially Eligible.

Governor's Opportunity for Supportive Housing (GOSH) Tenancy H0044

Governor's Opportunity for Supportive Housing (GOSH) Tenancy	
Who is eligible for GOSH?	1. HCS/AAA clients who are receiving Medicaid long-term services who: are choosing In-Home setting and: 2. are willing to work with a Supportive Housing Provider, and 3. qualify for ALTSA services (financially & functionally eligible), and 4. are discharging or being diverted from Eastern or Western State Hospitals, 5. An individual with a 90- or 180-day commitment order for further involuntary treatment who is discharging from a local community psychiatric facility into Home and Community Services Long-Term Services and Supports (HCS LTSS); or an individual who is detained through the Involuntary Treatment Act who is stabilized and discharged into HCS LTSS prior to the need to petition for a 90- or 180-day commitment order. 6. ALTSA clients who are currently living in a residential setting who transitioned or were diverted from Western/Eastern State Hospital

	within the past 18 months, as documented in CARE and counted by SHDD team, and wish to live independently.
What is covered under GOSH H0044?	Services to support individuals to maintain tenancy once housing is secured, such as: 1. Early intervention for behaviors that might jeopardize housing, e.g., late rent payment, lease violations, etc. 2. Training on responsibilities and rights of tenant and landlord. 3. Coaching on relationship building with landlords, property managers, and neighbors, and assisting in dispute resolution. 4. Linking with community resources to prevent eviction
What is not covered under GOSH H0044?	1. Rent 2. Move-in-costs 3. Utilities
How much can I spend?	1. 1 unit per month (rate $575)
Do I need to use a contracted provider?	**Yes.** 1. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.
How do I authorize GOSH H0044?	Once the client has moved into their own apartment: 1. The SHPM will ensure RAC 3131 – LTSS Housing Stabilization's end date matches the CARE Plan end date. 2. The SHPM will close pre-tenancy service code SA299, U1, and open tenancy service code H0044. 3. It is the responsibility of the SHPM to close the authorization for SA299, U1 and open an authorization for H0044. 4. The SHPM will update the tenancy service code, H0044, on an annual basis. If there are any concerns around client eligibility, staff with the SHPM.
When do I authorize this service?	GOSH Services should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager. Once the client has moved into their own apartment: 1. The SHPM will ensure RAC 3131 – LTSS Housing Stabilization's end date matches the CARE Plan end date. 2. The SHPM will close pre-tenancy service code SA299, U1, and open tenancy service code H0044. Please note, the date when the tenancy service code, H0044, is opened will vary based on the terms of the SHP's contract:

Are ETRs allowed for GOSH H0044?	No.
What about H0044 FOR Civil Transitions program?	1. H0044 should not be used for a client only eligible for the Civil Transition Program. 2. If a Supportive Housing client who was originally Civil Transition Program client ended up eligible for LTSS and secures housing use Reason Code "5440 FEFE", which stands for 5440 Functionally Eligible Financially Eligible.

Motel Interim Stay for Transitions (MIST) SA294u2

Motel Interim Stay for Transitions (MIST): is a service to pay for a short-term motel/hotel stay offered to minimize the number of clients who discharge to and/or experience episodes of homelessness. MIST aims to minimize the time it takes to get vital LTSS in place and increase the client's chances of ending up on services in their own home. The service is authorized for up to a 6-month period at a time	
Who is eligible for state MIST?	HCS/AAA clients who are receiving Medicaid long-term services who have one of the following qualifications: 1. **ALTSA Subsidy (Bridge & Acute Care Hospital)** • Bridge Subsidy: ALTSA clients who have a Bridge voucher issued and are working with an authorized contracted provider on an independent housing search. • Acute Hospital Care (ACH) Subsidy: ALTSA clients transitioning from an Acute Care Hospital (ACH) setting, when housing is a barrier. 2. **GOSH Program:** ALTSA clients who are enrolled in the Governor's Opportunity for Supportive Housing (GOSH) and are at risk of or experiencing homelessness. 3. **Other Housing Resource:** • ALTSA clients who will be living independently and currently have a resource from a housing agency or program. Examples might include Mainstream, NED, Housing Choice, Apple Health & Homes, HEN, HOPWA, VA, etc. • ALTSA clients who have been approved for a project-based resource and have a move-in-date. Examples might include Tax Credit units, 811 units, or Permanent Supportive Housing Unit from homeless service agency. 4. **In-Home Short-Term Displacement:** ALTSA clients who have their own home **and** a short-term situation that requires them to temporarily vacate. Ex: Pest control or eradication, fire, or flooding.

	5. **Experiencing Homelessness:** ALTSA clients experiencing homelessness. Ex: staying in a car, park, abandoned building, tent, shelter, or couch surfing.
What is covered under MIST 294u2?	1. Payment for up to 6-month period for a Medicaid ALTSA client to stay at a motel/hotel. 2. Deposits 3. Damages- (Requires HQ Approval. Please contact the Supportive Housing Program Manager)
What is not covered under MIST 294u2?	1. Monthly payment that exceeds $4,000.
How much can I spend?	1. Up to $4,000 per month for a total of six months.
Do I need to use a contracted provider?	**Yes.** 1. The HCS/AAA CM will need to coordinate with the Contracted Provider and notify them that the client has been authorized for Motel Interim Stay for Transitions for a period of up to 6 months. 2. The Contracted Provider should be authorized for the duration of the MIST authorization period. 3. The Contracted Provider should make periodic visits to the client to provide support and assist in a housing search, as needed. *This might change if SHA takes this on...*
How do I authorize state MIST?	1. Upon receiving approval for MIST, the HCS/AAA CM should open RAC 3131. 2. Use Service Code SA294,U2 to reimburse the contracted provider for the expenses incurred. 3. HCS/AAA CM will reimburse contracted provider on a two-week timeline for a period of up to six months. **Note: do not submit authorization to ProviderOne until receipt/s have been received.** 4. If a client is enrolled in GOSH services, HCS/AAA CM will need to select "2017 Governors Request Supportive Housing" as the reason code. If client is not enrolled in GOSH Service, please select "No reason code needed" as the reason code.
When do I authorize this service?	1. MIST should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager and a hotel/motel have been found.

Are ETRs allowed for state MIST?	**No.** 1. Note: When the approved MIST amount is above $2000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Housing Subsidy - Purchasing SA294u4

Housing & Employment Stabilization Services (H&ES) These state funded services are intended to fill specific gaps to provide transitional or stabilizing supports for clients, who have received a housing or Supported Employment resource or had their housing/employment coordinated through ALTSA to sustain community living.	
Who is eligible for state H&ES?	When an ALTSA client meets these qualifications: 1. Received a housing resource or had their housing coordinated through ALTSA; **or** 2. Enrolled with Supported Employment or had their employment coordinated through ALTSA; **and** 3. Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to your own home, or are living in the community and need stabilization services to remain there; **and** 4. Do not have other programs, services, or resources to assist you with these costs; **and** 5. Are not eligible for federal funding
What is covered under state H&ES?	1. First month's rent, security deposits, safety deposits 2. Utility set-up fees or deposits 3. Health and safety assurances, such as pest eradication, allergen control, or non-recurring cleaning fees prior or upon return to the home. 4. Moving services 5. Background check/application fees 6. Non-recurring rental insurance required for lease up. 7. Furniture, essential furnishings, and basic items essential for basic living outside the institution. 8. The provision of goods that increase independence or substitute for human assistance to the extent that expenditures would have been made for the human assistances, such as purchasing a microwave. 9. Cellphone 10. Household items 11. Bus pass 12. Food 13. Food Handlers card 14. Identification card

	15. Clothes (interview clothes, first set of uniforms to begin work) 16. Etc.
What is not covered under state H&ES?	1. recreational or diversional items such as television, cable or DVD players. 2. Assistive Technology
When do I need a provider contract?	1. A contracted provider (Community Choice Guide or GOSH SHP) will need to be authorized to complete purchases or/and payments on the behalf of the client.
How do I authorize state H&ES?	1. Open RAC 3131-LTSS Housing Stabilization 2. Use Service Code SA294,U4 to authorize the necessary goods and services. 3. Select the appropriate reason code. Options are "In-Home Community Stabilization or Employment Stabilization" 4. Note in the Service Episode Record (SER) that the client is eligible for LTSS Housing Stabilization services and that you have Supervisory approval to authorize state only funds. 5. Complete a SER outlining the service you are authorizing and/or the items you are purchasing and how they are necessary for the client's service plan. 6. Receipts for all purchases must be included in the participant's electronic case record (ECR). Attach all receipts/bids to the Packet Cover Sheet: Social Services Packet Cover Sheet (DSHS Form 02-615)
When do I authorize this service?	When an ALTSA client meets these qualifications: 1. Received a housing resource or had their housing coordinated through ALTSA; **or** 2. Enrolled with FCS Supported Employment or had their employment coordinated through ALTSA; **and** 3. Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to your own home, or are living in the community and need stabilization services to remain there; **and** 4. Do not have other programs, services, or resources to assist you with these costs; **and** 5. Are not eligible for federal funding
Are ETRs allowed for state H&ES?	**Yes.** 1. An ETR will be required if the total amount of goods & services exceeds $5000. 2. Select "other" for both ETR/ETP category & type.

	3. Submit the ETR to "Committee, Housing ETR" and email housingcommitteeetr@dshs.wa.gov to inform us about the ETR requested. 4. Note: If the amount Exceeds $2500, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Emergency Rental Assistance SA298

Emergency Rental Assistance (ERA) can be used as a one-time payment made directly to landlords on behalf of an ALTSA client who is facing an immediate eviction due to non-payment of rent. As part of the assistance request, clients must demonstrate they are able to pay their rent going forward and maintain their independent housing as a part of being stabilized in their community setting. This resource should only be requested when there are no other community options to meet the need fully or partially.	
Who is eligible for state ERA?	1. An ALTSA client who is facing an immediate eviction due to non-payment of rent.
What is covered under state ERA?	1. A one-time payment made directly to landlords on behalf of an ALTSA client who is facing an immediate eviction due to non-payment of rent.
What is not covered under state ERA?	1. ERA does not include pre-tenancy deposits or move-in costs, including first month's rent, required at move in. ERA cannot pay in excess of 150% Fair Market Rent per month and can only pay for a total of six months back rent.
When do I need a provider contract?	1. The HCS/AAA case manager will need to authorize a Contracted Provider (Community Choice Guide or GOSH Supportive Housing Provider) to make the ERA payment on the clients' behalf.
How do I authorize state ERA	1. Use RAC 3131. 2. Use Service Code SA298 to reimburse the contracted provider for the ERA payment amount approved by the HPM.
When do I authorize this service?	1. ERA should only be authorized after an ERA referral has been submitted and approved by the Supportive Housing Program Manager. The HCS/AAA is only allowed to authorize the amount approved by the SHPM.
Are ETRs allowed for the state ERA?	**No.** 1. note: When the approved ERA amount is above $4000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Related WACs:

WAC 388-106-0270: What services are available under Community First Choice (CFC)?

WAC 388-106-0030: Where can I receive services?

WAC 388-106: Long Term Care Services

WAC 388-106-1700 to WAC 388-106-1765: Supportive Housing

Acronyms:

HPM: Housing Program Manager	LTSS: Long-Term Services and Supports	
GOSH: Governor's Opportunity for Supportive Housing	FCS: Foundational Community Supports	SH: Supportive Housing
CCG: Community Choice Guide	SHA: Spokane Housing Authority	PHA: Public Housing Authority
	AMI: Area Median Income	FMR: Fair Market Rent

Forms:

GOSH Referral Form

Tips for Maintaining LTSS

Bridge Subsidy Process & Referral

Hospital Subsidy Referral; ALTSA Subsidy – Acute Care Hospital Referral Form

ALTSA Bridge Subsidy Referral.pdf

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
5/2020		Established	

8/2020		Added Chapter Section hyperlinks, Section 5B.6 GOSH and link to Supportive Housing WACs	
10/2020		Updated GOSH Pre-Tenancy service code and provided clarification around SHPM vs CM responsibility in "GOSH Client Accepted" section. Added Housing Team contacts under section 5b.11. In section 5b.4 added instruction on how to document ALTSA subsidy into CARE and Bridge file transition information. Added *Forms* to section 5b.11 including (2) new forms: ALTSA Bridge Referral and Bridge Referral and Application Process.	
2/2021		Added SA294 subsidy payment authorization information to section 5B.4. Moved GOSH Section from 5B.6 to 5B.5. Added clarification that there is no participation for Supportive Housing services. Added GOSH "Discharge Planning" and "Transition to Independent Housing" sections to 5B.5. Updated hyperlinks.	
5/2021		Deleted SA294 payment authorization process for P1. Added the need for CM support with quarterly Bridge tenancy verifications as well as annual re-certifications. Clarified steps to add "Housing subsidy (HCS/AAA)" and "Supportive Housing (HCS/AAA)" as Treatments on the Medical Screen in CARE. Added new procedure for referring to GOSH, hyperlinked to new DSHS 11-153 GOSH Referral form. Clarified GOSH eligibility and HCS and AAA CMs can refer. Clarified GOSH authorization responsibility. Hyperlinked to Chapter 30d to connect Supportive Housing service consults and consideration. Clarified on-going eligibility for GOSH clients regarding services and subsidy. Hyperlinked to Chapter 30d in the 'How can I use CTS/CTSS/WA Roads section'. Updated PM Roles.	
8/2021		Added new staff contacts for all regions by way of link to RCL Housing Resources website. Updated Bridge Referral form, Participant Agreement and Referral and Application Process form. Added updated ERA form. Updated 811 ALTSA HPM role regarding DDA/DBHR referrals. Added expanded GOSH eligibility criteria.	
2/2022		Updated various links throughout the chapter. Updated ALTSA Subsidy P&P inserted Document. Updated Participant Agreement inserted document. Added *What is needed to transfer an ALTSA subsidy client from*	

		HCS to the AAA? Section. Updated GOSH section to add protocol to staff cases with SHPM prior to closing a GOSH client and protocol related to clients with short term institutional stays (e.g., re-hospitalization or jail).	
8/2022		Added RVP eligibility and availability. Update ERA with Hotel/Motel stay information and Process. Update link to ERA form. Add info from Chapter 5a regarding WA Roads and eligibility from ALTSA housing resources. Updated language around HCS to AAA case transfers and Annual Assessments for GOSH. Added some hyperlinks into the GOSH Section to animated YouTube Videos: What is the Governor's Opportunity for Supportive Housing?; You've Been Referred to GOSH – Now What?; Governor's Opportunity for Supportive Housing (GOSH): Good Discharge Planning	
11/2022		Added more detailed payment/authorization information for ERA SA298. Added in section from Chapter 5a on how to work with individuals on ALTSA Housing Resources who are not currently receiving LTSS. Added language on keeping GOSH participants open who are in jail or institutional stays into the Interim Setting section. General text/grammar corrections throughout document. Added Bellingham/Whatcom and Spokane RVP resource.	
2/2023		Updated Unit Manager titles. Updated "NED" section to "permanent HUD voucher" section and added more process details. Updated Chapter Section list to include new 5b.5. Updated 811 sections with more details regarding application process. Removed old versions of forms and added updated versions (Participant Agreement, Tips for Maintaining LTSS, Chapter Version ALTSA Subsidy P&P and Bridge referral). Added page numbers to footer. Added links to Brochures and Video.	
5/2023		ALTSA subsidy video link. Updates to Section 5b.5. Updated ERA form.	
8/2023		Updated information in the ALTSA Subsidy and GOSH sections related to CARE Changes. Clarified language related to ineligibility for permanent HUD vouchers.	
11/2023		Updated Emergency Rental Assistance Form. Clarified language and updated language in section 5b.5 "Working with individuals on ALTSA housing resources who are not currently receiving ALTSA LTSS". Updated GOSH Section to include new regional referral email addresses.	

1/2024		Chapter Links added and updated ERA form added	
2/2024		Added a green box in pages 14 & 24 & 29 & 34 with a process for possible no longer functionally eligible ALTSA clients who are already enrolled in a housing service. Added on page 33 & 34 Motel Interim Stay for Transitions (MIST) program description. Added MIST to Table of contents Page 2. Replaced Washington Roads RAC info in pages 17 & 21 & 29 with new info (RAC 3131- LTSS Housing Stabilization). Added on page 17 (1 d. and the HCS/AAA CM will extend the WA Roads RAC) & (2 i. GOSH Program Manager will end the GOSH authorization and end RAC 3131- LTSS Housing Stabilization, and HCS/AAA CM will end the WA Roads RAC). Removed from page 30 & 31 under reimbursements "while the Supportive Housing services are authorized by SHPM under the service code SA299,U1 the CM would authorize use of any CFC CTS/CTSS/WA Roads funds under a separate service code, dependent upon eligibility and funds used."	
3/27/2024		Updated Bridge documents at bottom of document with most recent versions. Page 11 &12 amended for ALTSA Bridge Subsidy.	
5/7/2024		Removed Motel/Hotel language from ERA section. Corrected MIST referral email address. Added MIST Request Form. Added bullet on Civil Transition eligibility.	
6/17/2024		Added ERA email address. Updated ERA referral process. Removed "How do I make a referral for a client who I believe is eligible for ERA?" Updated MIST eligibility criteria (Bridge Subsidy, GOSH program, Civil Transitions Program, Other Housing Resource, In-Home Short-Term Displacement, & Limited Residential). Updated MIST referral Process outline. Updated & added "How is payment made for MIST?" process/procedure. Updated MIST Referral Form.	
9/3/2024		Added information regarding Bridge Subsidy waitlist, added information regarding Presumptive Eligibility, added policy information from chapter 9 regarding GOSH client unable to return to residential setting and being admitted to the hospital. Added policy information regarding if a client is incarcerated or hospitalized and how ALTSA pays the subsidy for up to 6 months. Added Stephen Miller contact info. Added Housing and Employment website, updated links to one pager. Updated table of contents to include	

		Presumptive Eligibility. Added Global Leasing info. Updated GOSH eligibility criteria.	
10/2024	**JOANA**	Chapter 5b changed to Chapter 6. Chapter 6 Established	
11/2024	Joana	Added information regarding the ALTSA Acute Care Hospital Subsidy, and the referral/process and referral.	
01/2025	Joana	Edited information regarding the ALTSA Acute Care Hospital Subsidy	
03/2025	Joana	Chapter 6 was divided up into 4 sections and renamed. Chapter 6A- ALTSA Subsidies & GOSH Services established. Update policy & procedure regarding Housing and Employment Stabilization Services. Updated OHAE background and EDAI statement. Added a chart describing all the RACs and Service Codes associated with OHAE.	

Interim Housing Resources (Motel Interim Stay for Transitions & Emergency Rental Assistance)

Chapter 6B outlines the policies and procedures for interim housing resources available to ALTSA clients. These resources include Motel Interim Stay for Transitions (MIST) to support individuals who don't have a place to stay, and Emergency Rental Assistance (ERA) is for those facing immediate housing instability due to non-payment of rent. This chapter provides guidance on eligibility criteria, authorization processes, and case management responsibilities to ensure that clients receive timely and appropriate housing support while working toward long-term stability.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:
Jonnie Matson Rental Assistance Unit Manager
360.628.0183 jonnie.matson2@dshs.wa.gov

If you have questions or need clarification about Motel Interim Stay for Transitions, please contact:
Shawna Sampson Rental Assistance Program Manager
shawna.sampson@dshs.wa.gov

If you have questions or need clarification about Emergency Rental Assistance, please contact:
Michael Lowe Rental Assistance Program Manager
360.972.0265 michael.lowe@dshs.wa.gov

For additional information on ALTSA housing resources please visit our website:
Office of Housing and Employment

TABLE OF CONTENTS

BACKGROUND

The ALTSA Office of Housing and Employment (OHAE) is dedicated to offering housing and supported employment resources that honor client choice. We work to eliminate barriers and expand opportunities that align with an individual's vision for their life regardless of mental health, substance use disorder, race, language, age, ability, or other status.

OHAE brings together federal, state, and local resources to create opportunities and strategies to help clients access independent housing, and in collaboration with our community partners, help build an individualized array of services to support them. This chapter provides specific guidance around interim housing and eviction prevention services and can help you refer clients who are eligible for them.

Whenever possible, we can offer guidance about difficult housing situations you might encounter with your client, including tips about working with clients experiencing homelessness. Affordable housing and tenancy support are complex topics that often do not have easy or quick solutions. Please let us know about other topics or obstacles you would like to see addressed in this chapter.

EMERGENCY RENTAL ASSISTANCE (ERA)

ERA is used as a one-time payment made directly to landlords on behalf of client receiving Long-Term Services and Supports (LTSS) who is facing an eviction due to non-payment of rent. As part of the assistance request, clients must demonstrate they are able to pay their rent going forward and maintain their independent housing as a part of being stabilized in their community setting. This resource should only be requested when there are no other community options to meet the need fully or partially. ERA does not include pre-tenancy deposits or move-in costs, including first month's rent, required at move in. There are other resources that may cover these one-time expenses; please see service codes SA297 or SA291 or SA294,U4.

ERA Referral Process

Complete the ERA Referral Request Form and email to emergencyrentalassistance@dshs.wa.gov The form will ask for a detailed description of the client's current situation, why they require ERA, and what their plan is for paying rent moving forward. It will also ask you to verify the total rent amount due and what is owed specifically for each month. More information or final verification of the amount due may be requested by the Housing Program Manager prior to approval. Obtain local approval from your supervisor prior to submitting the ERA referral. It may take up to 1-2 business days for the Program Manager to determine eligibility and respond. If you have any questions about ERA, please email your questions to emergencyrentalassistance@dshs.wa.gov.

Please note, you can access the ERA referral form via SharePoint at Emergency Rental Assistance Referral.

Once eligibility has been determined an email will be sent with instructions on how to proceed.

The HPM will communicate via email if the client has been determined eligible and will include an ERA Acknowledgment Agreement (AA) for the CM to verbally review with the client. The CM will need to acknowledge they have reviewed the form and initial it and return to the HPM prior to approval.

Upon receipt of ERA AA the HPM will provide an approval email which will include the RAC and authorization code to use for the ERA payment. There is more than one option, so please use the RAC and code provided to you in the specific email approval for each client.

The HPM will enter a SER note stating that the client has been approved for the ERA service.

The HCS/AAA case manager will be responsible for notifying the HPM immediately if the client no longer requires the ERA payment.

ERA Payment Process

1. The HCS/AAA case manager will need to authorize a Contracted Provider (Community Choice Guide (CCG) or GOSH Supportive Housing Provider) to make the ERA payment on the clients' behalf. If there are other tasks needed to stabilize the client's housing situation, the provider can be authorized additional time for those needs.
    - When authorizing a CCG, the HCS/AAA CM will need to utilize service codes SA263 or/and SA266 to reimburse the CCG for the time it took the CCG in making the ERA payment and/or coordinating additional supports for the ALTSA client. A GOSH Supportive Housing provider will not need to be reimbursed additional units to make the payment and/or to coordinate additional support.

2. The HCS/AAA case manager or authorized contracted provider will communicate with the landlord or/and property manager and discuss how the ERA Payment will be completed (ex: credit card, in-person via money order/check, or via mail-sending a check/money order).

3. The HCS/AAA case manager will reimburse the contracted provider for the ERA payment made.

4. Use RAC and authorization code provided by HPM in approval email.

5. Place authorization in "Reviewing" status until a receipt has been received by the HCS/AAA CM. **Please note do not submit authorization to "approval" status until a receipt has been provided by the contracted provider.**

6. Once the HCS/AAA CM receives receipt, they will verify that the amount on the receipt matches the "Reviewing" status authorization. The HCS/AAA CM will update the authorization start and end date to match the receipt's dates of service which would be the months covered by the ERA.

7. If the amount on the receipt is different than what the HPM approved, you must inform the HPM prior to approving authorization. **If you receive a receipt for a higher amount then the ERA approval and the additional cost is related to a check fee/mail fee or etc., please don't use code SA298 to cover this expense. You will need to use SA297, or SA291 or SA294,U4 depending on the client's eligibility for federal or state funds.**

8. The HCS/AAA CM will move the authorization from "Reviewing" status to Approved.

9. Receipts for all purchases must be included in the participant's electronic case record (ECR). Attach all receipts/bids to the Packet Cover Sheet: Social Services Packet Cover Sheet (DSHS Form 02-615)

Note: When using RAC 3131-LTSS Housing Stabilization to make an Emergency Rental Assistance payment, Community Choice Guide Service Codes (SA266 & SA263) can also be authorize under this RAC if the client is eligible for State Funding only.

MOTEL INTERIM STAY FOR TRANSITIONS (MIST)

The Motel Interim Stay for Transitions (MIST) is a service to pay for a short-term motel/hotel stay offered to minimize the number of clients who discharge to and/or experience episodes of homelessness. MIST aims to minimize the time it takes to get vital LTSS in place and increase the client's chances of ending up on services in their own home. The service can be authorized for up to a six-month period at a time.

What is the eligibility for MIST:

At the time of the MIST referral submission, the individual needs to have been assessed and determined both functionally and financially eligible for LTSS.

Who may qualify for MIST?

1. ALTSA Subsidy Holders (Bridge & Acute Care Hospital)
    - Bridge Subsidy: ALTSA clients who have a Bridge voucher issued and are working with an authorized contracted provider on an independent housing search. Please note: MIST should not be used to transition a client out of the SNF unless they cannot stay (ex: insurance stops paying, behaviors, etc.).
    - Acute Hospital Care (ACH) Subsidy: ALTSA clients transitioning from an Acute Care Hospital (ACH) setting and are working with an authorized contracted provider on an independent housing search.

2. GOSH Program: ALTSA clients who are enrolled in the Governor's Opportunity for Supportive Housing (GOSH) and are at-risk of or experiencing homelessness. Civil Transitions Program (5440): ALTSA clients who are referred through the Civil Transitions Program.

3. Other Housing Resource:
   - ALTSA clients who will be living independently and currently have a resource from a housing agency or program. Examples might include Mainstream, NED, Housing Choice, Apple Health & Homes, HEN, HOPWA, VA, etc.
   - ALTSA clients who have been approved for a project-based resource and have a move-in-date. Examples might include Tax Credit units, 811 units, or Permanent Supportive Housing Unit from homeless service agency.

4. In-Home Short-Term Displacement: ALTSA clients who have their own home and a short-term situation that requires them to temporarily vacate. Ex: Pest control or eradication, fire, or flooding. *Approval is at program discretion.*

5. Experiencing Homelessness: ALTSA clients experiencing homelessness or fleeing domestic violence or other unsafe situations. Ex: staying in a car, park, abandoned building, tent, shelter, or couch surfing.

MIST Referral Process

1) The HCS/AAA case manager will need to complete the online request form via MIST Referral

2) Once the referral has been approved by the Housing Program Manager (HPM), the following will occur:

(a.) The HPM will email a pre-approval, providing the HCS/AAA Case Manager with the Participant Agreement form. The HCS/AAA CM or Contracted Provider will review this form with the client and obtain a signature from the client, then return the Participation Agreement to the HPM.

(b.) The HPM will Provide the RAC & Service Code to be used, authorization dates, and other pertinent information via email. There is more than one option, so please use the RAC and Service Code provided to you in the specific email approval for each client.

(c.) The HPM will enter a SER note stating that the client has been approved for Motel Interim Stays for Transitions funds. It will include the RAC/service code and authorization dates.

(d.) The HCS/AAA CM will need to coordinate with the Contracted Provider and notify them that the client has been authorized for Motel Interim Stay for Transitions for a period of up to six months.

(e.) The HCS/AAA CM must notify the HPM immediately if any of the following occur:

- The client has not secured independent housing within the six-month approval period and the authorization is ending.
- The client no longer requires MIST.
- The client has left the hotel and has not returned (whereabouts unknown).
- The client violates the Participant Agreement or has caused damages to the motel.

Please note: The HCS/AAA CM will need to provide the HPM with the service start and end dates and outcome once the client is no longer using MIST.

(f.) If there are any issues or concerns regarding a MIST client, including eligibility concerns, the HCS/AAA Case Manager should staff with the assigned HPM. Do not close a MIST client prior to staffing with the assigned HPM. The client must remain active on LTSS to continue receiving MIST.

How is payment made for MIST?

1) Contracted Provider will submit to an invoice and receipt for the motel/hotel cost to the HCS/AAA Case Manager.
   (a.) HCS/AAA CM will reimburse the contracted provider in increments of up to two weeks; however, this does not mean the full two weeks must be used, as reimbursement can be issued for shorter periods as needed. **Note: do not submit authorization to ProviderOne until receipt and invoice have been received.**
   (b.) Use RAC (provided by HPM in approval email).
   (c.) Use Service Code (provided by HPM in approval email) to reimburse the contracted provider for the expenses incurred. Please note: If a client is enrolled in GOSH services, the HCS/AAA CM will need to select "2017 Governor's Request Supportive Housing" as the reason code. If client is not enrolled in GOSH Service, please select "No reason code needed" as the reason code.
   (d.) HCS/AAA CM will place authorization in "Reviewing" status until an invoice and receipt is received by the HCS/AAA CM.
   (e.) Once HCS/AAA CM receives invoice and receipt, HCS/AAA CM will verify the amount on the receipt matches the "Reviewing" status authorization. If the amount on receipt doesn't match what is in "Reviewing" status, CM will update the amount.
   (f.) HCS/AAA CM will update the authorization start and end date to match the receipt's dates of service, which are the actual dates the client was in the motel/hotel.

(g.) HCS/AAA CM will move the authorization from "Reviewing" status to Approved.
(h.) If the authorization requires HQ force approval, HCS/AAA Case manager can reach out to the assigned HPM to have the authorization forced.
(i.) If you have further questions regarding making a MIST authorization please see the MIST authorization desk guide MIST in CARE Authorization
(j.) If you have any questions about MIST, please email your questions to mistreferral@dshs.wa.gov

MIST Guidelines:

1. **Participation Agreement**:
   - The client must read, agree to, and physically initial and sign the Participant Agreement before MIST is approved. This acknowledges the client understands what is required of them to keep their motel service. Clients must be aware that their MIST service will end when they move into an apartment or other chosen setting, if they leave the motel without notice, or if they violate the terms of the Participant Agreement.
2. **Expectations for providers working with MIST clients:**
   - Contracted providers are expected to stay in regular contact with clients enrolled in MIST. There should be a minimum of weekly room visits as well as phone calls. Contracted providers should also make sure the motel has their contact information for any potential issues. In addition, they should be supporting the client in active housing searches, where applicable. They should inform the LTC CM if the client vacates the room, is asked to leave, or causes damages.
3. **Deposits and damages:**
   - Contracted providers can utilize up to a $300 deposit made to the motel upon arrival to cover damages. It can be paid by bundling it with the initial hotel payment for the first 2 weeks of the stay. Balances of damages above and beyond $300 are the client's responsibility to pay, some clients won't be able to afford this. If the client does not have the funds to pay or the damages are above $300, referring staff should reach out to the assigned HPM for staffing. The contracted provider should not submit an invoice for reimbursement until the damage deposit is resolved (the hold of funds released or credited) to avoid paying for costs not actually charged. Pet deposits or fees are allowable if they fall within the daily room rate. This is in addition to the up to $300 damage deposit per motel allowance.
4. **Client ID:**
   - Clients are usually required to have valid identification (ID) for a motel stay. The referring HCS/AAA CMs should make sure the client has a valid ID or authorize the contracted provider to assist the client in obtaining it. Many apartments also require valid ID when a client applies, so there are other good reasons that it will be helpful to make sure clients have access to their ID. [insert language (and link?) here re: getting discounted ID via "Identicard" DSHS Form 16-029?]
5. **MIST is not a crisis program:**
   - MIST is not an emergency service or crisis program. HPMs have up to two business days

to respond to submitted requests. HCS/AAA Case Managers should take this into account, so they have a clear understanding of the program timeframes and appropriate expectations for responses.

RESOURCES

Housing Team Contacts can be found on the **RCL Housing Resources Website.**

The Office of Housing and Employment SharePoint DSHS-ALT-HCS-Housing-Employment - Home

Office of Housing and Employment website: Office of Housing and Employment

Brochures and Videos

ALTSA Housing Resources

LTSS One-Pager

Zero Income One-Pager

Income Discrimination Flyer Income Discrimination Flyer Tenants: New Legal Protection from Discrimination Based on Source of Income

MIST Field One-Pager

MIST in CARE Authorization

Emergency Rental Assistance (ERA)

Video: Options for Housing Through Long-Term Care Services

Housing Resource Chart

RAC 3132: Health Related Social Needs - Federal

Motel Interim Stay for Transitions (MIST) SA294U1

Motel Interim Stay for Transitions (MIST): is a service to pay for a short-term motel/hotel stay offered to minimize the number of clients who discharge to and/or experience episodes of homelessness. MIST aims to minimize the time it takes to get vital LTSS in place and increase the client's chances of ending up on services in their own home. The service is authorized for up to a 6-month period at a time. Federal MIST is funded via the 1115 waiver in which the Washington State Health Related Social Needs Services Program (HRSN) will allow Medicaid enrollees to receive evidence-based, non-medical services to address an individual's unmet, adverse social conditions that contribute to poor health. This includes temporary housing.

Who is eligible for federal MIST?	HCS/AAA clients who are receiving Medicaid long-term services who have one of the following qualifications: 1. **ALTSA Subsidy (Bridge & Acute Care Hospital)** • Bridge Subsidy: ALTSA clients who have a Bridge voucher issued and are working with an authorized contracted provider on an independent housing search. • Acute Hospital Care (ACH) Subsidy: ALTSA clients transitioning from an Acute Care Hospital (ACH) setting, when housing is a barrier. 2. **GOSH Program:** ALTSA clients who are enrolled in the Governor's Opportunity for Supportive Housing (GOSH) and are at risk of or experiencing homelessness. 3. **Other Housing Resource:** • ALTSA clients who will be living independently and currently have a resource from a housing agency or program. Examples might include Mainstream, NED, Housing Choice, Apple Health & Homes, HEN, HOPWA, VA, etc. • ALTSA clients who have been approved for a project-based resource and have a move-in-date. Examples might include Tax Credit units, 811 units, or Permanent Supportive Housing Unit from homeless service agency. 4. **In-Home Short-Term Displacement:** ALTSA clients who have their own home **and** a short-term situation that requires them to temporarily vacate. Ex: Pest control or eradication, fire, or flooding. 5. **Experiencing Homelessness:** ALTSA clients experiencing homelessness. Ex: staying in a car, park, abandoned building, tent, shelter, or couch surfing.
What is covered under MIST 294u1?	1. Payment for up to 6-month period for a Medicaid ALTSA client to stay at a motel/hotel. 2. Damages upon HQ approval- Please contact Supportive Housing Program Manager
What is not covered under MIST 294u1?	1. Deposits
How much can I spend?	1. Up to $4000 per month for a total of six months. • Note: not to exceed six months
Do I need to use a contracted provider?	**Yes.**

	1. The HCS/AAA CM will need to coordinate with the Contracted Provider and notify them that the client has been authorized for Motel Interim Stay for Transitions for a period of up to 6 months. 2. The Contracted Provider should be authorized for the duration of the MIST authorization period. 3. The Contracted Provider should make periodic visits to the client to provide support and assist in a housing search, as needed. *This might change if SHA takes this on...*
How do I authorize federal MIST?	1. Upon receiving approval for MIST, the HCS/AAA CM should open RAC 3132. 2. Use Service Code SA294,U1 to reimburse the contracted provider for the expenses incurred. 3. HCS/AAA CM will reimburse contracted provider on a two-week timeline for a period of up to six months. **Note: do not submit authorization to ProviderOne until receipt/s have been received.**
When do I authorize this service?	1. MIST should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager and a hotel/motel have been found.
Are ETRs allowed for federal MIST?	**No.** 1. When the approved MIST amount is above $2000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Emergency Rental Assistance SA298

Emergency Rental Assistance (ERA) can be used as a one-time payment made directly to landlords on behalf of an ALTSA client who is facing an immediate eviction due to non-payment of rent. As part of the assistance request, clients must demonstrate they are able to pay their rent going forward and maintain their independent housing as a part of being stabilized in their community setting. This resource should only be requested when there are no other community options to meet the need fully or partially.
Federal Emergency Rental Assistance is funded via the 1115 waiver, in which the Washington State Health Related Social Needs Services Program (HRSN) will allow Medicaid enrollees to receive evidence-based, non-medical services to address an individual's unmet, adverse social conditions that contribute to poor health. These includes rent.

Who is eligible for federal ERA?	1. An ALTSA client who is experiencing or at risk of experiencing homelessness, including facing an immediate eviction due to non-payment of rent.
What is covered under federal ERA?	1. A one-time payment made directly to landlords on behalf of an ALTSA client who is facing an immediate eviction due to non-payment of rent.
What is not covered under federal ERA?	1. ERA does not include pre-tenancy deposits or move-in costs required at move in. ERA cannot pay in excess of 150% Fair Market Rent per month and can only pay for a total of six months back rent.
When do I need a provider contract?	1. The HCS/AAA case manager will need to authorize a Contracted Provider (Community Choice Guide or GOSH Supportive Housing Provider) to make the ERA payment on the clients' behalf. *Could change dependent on SHA.*
How do I authorize federal ERA	1. Use RAC 3132. 2. Use Service Code SA298 to reimburse the contracted provider for the ERA payment amount approved by the HPM.
When do I authorize this service?	1. ERA should only be authorized after an ERA referral has been submitted and approved by the Housing Program Manager.
Are ETRs allowed for the federal ERA?	**No.** 1. note: When the approved ERA amount is above $4000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

RAC 3131: Long-Term Services and Supports Housing Stabilization – State Funds

Governor's Opportunity for Supportive Housing (GOSH) Pre-Tenancy SA299u1

Governor's Opportunity for Supportive Housing (GOSH) Pre-Tenancy	
Who is eligible for GOSH?	HCS/AAA clients who are receiving Medicaid long-term services who: are choosing In-Home setting and: 1. are willing to work with a Supportive Housing Provider, **and** 2. qualify for ALTSA services (financially & functionally eligible), **and** 3. are discharging or being diverted from Eastern or Western State Hospitals,

	4. An individual with a 90- or 180-day commitment order for further involuntary treatment who is discharging from a local community psychiatric facility into Home and Community Services Long-Term Services and Supports (HCS LTSS); or an individual who is detained through the Involuntary Treatment Act who is stabilized and discharged into HCS LTSS prior to the need to petition for a 90- or 180-day commitment order. 5. ALTSA clients who are currently living in a residential setting who transitioned or were diverted from Western/Eastern State Hospital within the past 18 months, as documented in CARE and counted by SHDD team, and wish to live independently.
What is covered under GOSH SA299u1?	Services that support an individual's ability to prepare for and transition to housing, including direct and collateral services: 1. Screening and housing assessment for individuals' preferences and barriers. 2. Developing an individual housing support plan: identifying goals, addressing barriers, establishing approaches to meet goals, including identifying available services and resources. 3. Assisting with eligibility determination, housing applications, subsidy applications, and housing searches. 4. Identifying resources for modifications and/or one-time move-in needs. 5. Assisting in arranging for and supporting details of moving into housing. 6. Training on roles, responsibilities, and rights of tenant and landlord. 7. Developing housing support crisis plan. 8. Maintaining participant and collateral contacts, and timely completion of supportive housing deliverables as outlined in 'Service Standards for Providers'.
What is not covered under GOSH SA299u1?	1. Rent 2. Move-in-costs 3. Utilities
How much can I spend?	1. 160 units per month
Do I need to use a contracted provider?	**Yes.** 1. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.

How do I authorize GOSH SA299u1?	Once the referral has been accepted by the SHPM: 1. The SHPM will open RAC 3131 – LTSS Housing Stabilization and then the pre-tenancy Supportive Housing service code, SA299-U1, to open the SH authorization in CARE. 2. It is the SHPM's responsibility to open, extend and close authorizations for service code SA299, U1.
When do I authorize this service?	1. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.
Are ETRs allowed for GOSH SA299u1?	**No.**
What about SA299,U1 for Civil Transitions Program?	1. Supportive Housing services are available through GOSH for those who meet Civil Transition Program eligibility (see Chapter 9b). 2. For clients meeting Civil Transition Program (CTP) eligibility only, use the appropriate CTP RAC and then authorize SA299u1 with the Reason Code "Civil Transitions Program". 3. If a Civil Transition Program client ends up eligible for LTSS: • End CTP RAC • End SA299,u1 authorization, then: • Open RAC 3131 LTSS Housing Stabilization • Open SA299u1 and use Reason Code " 5440 FEFE", which stands for 5440 Functionally Eligible Financially Eligible.

Governor's Opportunity for Supportive Housing (GOSH) Tenancy H0044

Governor's Opportunity for Supportive Housing (GOSH) Tenancy	
Who is eligible for GOSH?	1. HCS/AAA clients who are receiving Medicaid long-term services who: are choosing In-Home setting and: 2. are willing to work with a Supportive Housing Provider, and 3. qualify for ALTSA services (financially & functionally eligible), and 4. are discharging or being diverted from Eastern or Western State Hospitals, 5. An individual with a 90- or 180-day commitment order for further involuntary treatment who is discharging from a local community psychiatric facility into Home and Community Services Long-Term Services and Supports (HCS LTSS); or an individual who is detained through the Involuntary Treatment Act who is stabilized and discharged into HCS LTSS prior to the need to petition for a 90- or 180-day commitment order. 6. ALTSA clients who are currently living in a residential setting who transitioned or were diverted from Western/Eastern State Hospital

	within the past 18 months, as documented in CARE and counted by SHDD team, and wish to live independently.
What is covered under GOSH H0044?	Services to support individuals to maintain tenancy once housing is secured, such as: 1. Early intervention for behaviors that might jeopardize housing, e.g., late rent payment, lease violations, etc. 2. Training on responsibilities and rights of tenant and landlord. 3. Coaching on relationship building with landlords, property managers, and neighbors, and assisting in dispute resolution. 4. Linking with community resources to prevent eviction
What is not covered under GOSH H0044?	1. Rent 2. Move-in-costs 3. Utilities
How much can I spend?	1. 1 unit per month (rate $575)
Do I need to use a contracted provider?	**Yes.** 1. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.
How do I authorize GOSH H0044?	Once the client has moved into their own apartment: 1. The SHPM will ensure RAC 3131 – LTSS Housing Stabilization's end date matches the CARE Plan end date. 2. The SHPM will close pre-tenancy service code SA299, U1, and open tenancy service code H0044. 3. It is the responsibility of the SHPM to close the authorization for SA299, U1 and open an authorization for H0044. 4. The SHPM will update the tenancy service code, H0044, on an annual basis. If there are any concerns around client eligibility, staff with the SHPM.
When do I authorize this service?	GOSH Services should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager. Once the client has moved into their own apartment: 1. The SHPM will ensure RAC 3131 – LTSS Housing Stabilization's end date matches the CARE Plan end date. 2. The SHPM will close pre-tenancy service code SA299, U1, and open tenancy service code H0044. Please note, the date when the tenancy service code, H0044, is opened will vary based on the terms of the SHP's contract:

Are ETRs allowed for GOSH H0044?	No.
What about H0044 FOR Civil Transitions program?	1. H0044 should not be used for a client only eligible for the Civil Transition Program. 2. If a Supportive Housing client who was originally Civil Transition Program client ended up eligible for LTSS and secures housing use Reason Code "5440 FEFE", which stands for 5440 Functionally Eligible Financially Eligible.

Motel Interim Stay for Transitions (MIST) SA294u2

Motel Interim Stay for Transitions (MIST): is a service to pay for a short-term motel/hotel stay offered to minimize the number of clients who discharge to and/or experience episodes of homelessness. MIST aims to minimize the time it takes to get vital LTSS in place and increase the client's chances of ending up on services in their own home. The service is authorized for up to a 6-month period at a time	
Who is eligible for state MIST?	HCS/AAA clients who are receiving Medicaid long-term services who have one of the following qualifications: 1. **ALTSA Subsidy (Bridge & Acute Care Hospital)** • Bridge Subsidy: ALTSA clients who have a Bridge voucher issued and are working with an authorized contracted provider on an independent housing search. • Acute Hospital Care (ACH) Subsidy: ALTSA clients transitioning from an Acute Care Hospital (ACH) setting, when housing is a barrier. 2. **GOSH Program:** ALTSA clients who are enrolled in the Governor's Opportunity for Supportive Housing (GOSH) and are at risk of or experiencing homelessness. 3. **Other Housing Resource:** • ALTSA clients who will be living independently and currently have a resource from a housing agency or program. Examples might include Mainstream, NED, Housing Choice, Apple Health & Homes, HEN, HOPWA, VA, etc. • ALTSA clients who have been approved for a project-based resource and have a move-in-date. Examples might include Tax Credit units, 811 units, or Permanent Supportive Housing Unit from homeless service agency. 4. **In-Home Short-Term Displacement:** ALTSA clients who have their own home **and** a short-term situation that requires them to temporarily vacate. Ex: Pest control or eradication, fire, or flooding.

	5. **Experiencing Homelessness:** ALTSA clients experiencing homelessness. Ex: staying in a car, park, abandoned building, tent, shelter, or couch surfing.
What is covered under MIST 294u2?	1. Payment for up to 6-month period for a Medicaid ALTSA client to stay at a motel/hotel. 2. Deposits 3. Damages- (Requires HQ Approval. Please contact the Supportive Housing Program Manager)
What is not covered under MIST 294u2?	1. Monthly payment that exceeds $4,000.
How much can I spend?	1. Up to $4,000 per month for a total of six months.
Do I need to use a contracted provider?	**Yes.** 1. The HCS/AAA CM will need to coordinate with the Contracted Provider and notify them that the client has been authorized for Motel Interim Stay for Transitions for a period of up to 6 months. 2. The Contracted Provider should be authorized for the duration of the MIST authorization period. 3. The Contracted Provider should make periodic visits to the client to provide support and assist in a housing search, as needed. *This might change if SHA takes this on...*
How do I authorize state MIST?	1. Upon receiving approval for MIST, the HCS/AAA CM should open RAC 3131. 2. Use Service Code SA294,U2 to reimburse the contracted provider for the expenses incurred. 3. HCS/AAA CM will reimburse contracted provider on a two-week timeline for a period of up to six months. **Note: do not submit authorization to ProviderOne until receipt/s have been received.** 4. If a client is enrolled in GOSH services, HCS/AAA CM will need to select "2017 Governor's Request Supportive Housing" as the reason code. If client is not enrolled in GOSH Service, please select "No reason code needed" as the reason code.
When do I authorize this service?	1. MIST should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager and a hotel/motel have been found.

Are ETRs allowed for state MIST?	**No.** 1. Note: When the approved MIST amount is above $2000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Housing Subsidy - Purchasing SA294u4

Housing & Employment Stabilization Services (H&ES) These state funded services are intended to fill specific gaps to provide transitional or stabilizing supports for clients, who have received a housing or Supported Employment resource or had their housing/employment coordinated through ALTSA to sustain community living.	
Who is eligible for state H&ES?	When an ALTSA client meets these qualifications: 1. Received a housing resource or had their housing coordinated through ALTSA; **or** 2. Enrolled with Supported Employment or had their employment coordinated through ALTSA; **and** 3. Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to your own home, or are living in the community and need stabilization services to remain there; **and** 4. Do not have other programs, services, or resources to assist you with these costs; **and** 5. Are not eligible for federal funding
What is covered under state H&ES?	1. First month's rent, security deposits, safety deposits 2. Utility set-up fees or deposits 3. Health and safety assurances, such as pest eradication, allergen control, or non-recurring cleaning fees prior or upon return to the home. 4. Moving services 5. Background check/application fees 6. Non-recurring rental insurance required for lease up. 7. Furniture, essential furnishings, and basic items essential for basic living outside the institution. 8. The provision of goods that increase independence or substitute for human assistance to the extent that expenditures would have been made for the human assistances, such as purchasing a microwave. 9. Cellphone 10. Household items 11. Bus pass 12. Food 13. Food Handlers card 14. Identification card

	15. Clothes (interview clothes, first set of uniforms to begin work) 16. Etc.
What is not covered under fed state H&ES?	1. recreational or diversional items such as television, cable or DVD players. 2. Assistive Technology
When do I need a provider contract?	1. A contracted provider (Community Choice Guide or GOSH SHP) will need to be authorized to complete purchases or/and payments on the behalf of the client.
How do I authorize state H&ES?	1. Open RAC 3131-LTSS Housing Stabilization 2. Use Service Code SA294,U4 to authorize the necessary goods and services. 3. Select the appropriate reason code. Options are "In-Home Community Stabilization or Employment Stabilization" 4. Note in the Service Episode Record (SER) that the client is eligible for LTSS Housing Stabilization services and that you have Supervisory approval to authorize state only funds. 5. Complete a SER outlining the service you are authorizing and/or the items you are purchasing and how they are necessary for the client's service plan. 6. Receipts for all purchases must be included in the participant's electronic case record (ECR). Attach all receipts/bids to the Packet Cover Sheet: Social Services Packet Cover Sheet (DSHS Form 02-615)
When do I authorize this service?	When an ALTSA client meets these qualifications: 1. Received a housing resource or had their housing coordinated through ALTSA; **or** 2. Enrolled with FCS Supported Employment or had their employment coordinated through ALTSA; **and** 3. Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to your own home, or are living in the community and need stabilization services to remain there; **and** 4. Do not have other programs, services, or resources to assist you with these costs; **and** 5. Are not eligible for federal funding
Are ETRs allowed for state H&ES?	**Yes.** 1. An ETR will be required if the total amount of goods & services exceeds $5000. 2. Select "other" for both ETR/ETP category & type.

	3. Submit the ETR to "Committee, Housing ETR" and email housingcommitteeetr@dshs.wa.gov to inform us about the ETR requested. 4. Note: If the amount Exceeds $2500, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Emergency Rental Assistance SA298

Emergency Rental Assistance (ERA) can be used as a one-time payment made directly to landlords on behalf of an ALTSA client who is facing an immediate eviction due to non-payment of rent. As part of the assistance request, clients must demonstrate they are able to pay their rent going forward and maintain their independent housing as a part of being stabilized in their community setting. This resource should only be requested when there are no other community options to meet the need fully or partially.	
Who is eligible for state ERA?	1. An ALTSA client who is facing an immediate eviction due to non-payment of rent.
What is covered under state ERA?	1. A one-time payment made directly to landlords on behalf of an ALTSA client who is facing an immediate eviction due to non-payment of rent.
What is not covered under state ERA?	1. ERA does not include pre-tenancy deposits or move-in costs, including first month's rent, required at move in. ERA cannot pay in excess of 150% Fair Market Rent per month and can only pay for a total of six months back rent.
When do I need a provider contract?	1. The HCS/AAA case manager will need to authorize a Contracted Provider (Community Choice Guide or GOSH Supportive Housing Provider) to make the ERA payment on the clients' behalf.
How do I authorize state ERA	1. Use RAC 3131. 2. Use Service Code SA298 to reimburse the contracted provider for the ERA payment amount approved by the HPM.
When do I authorize this service?	1. ERA should only be authorized after an ERA referral has been submitted and approved by the Supportive Housing Program Manager. The HCS/AAA is only allowed to authorize the amount approved by the SHPM.
Are ETRs allowed for the state ERA?	**No.** 1. note: When the approved ERA amount is above $4000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Related WACs:

WAC 388-106-0270: What services are available under Community First Choice (CFC)?

WAC 388-106-0030: Where can I receive services?

WAC 388-106: Long Term Care Services

WAC 388-106-1700 to WAC 388-106-1765: Supportive Housing

Acronyms:

HPM: Housing Program Manager	LTSS: Long-Term Services and Supports	ERA: Emergency Rental Assistance
GOSH: Governor's Opportunity for Supportive Housing	FCS: Foundational Community Supports	SH: Supportive Housing
CCG: Community Choice Guide	SHA: Spokane Housing Authority	PHA: Public Housing Authority
PBV: Project Based Voucher	AMI: Area Median Income	FMR: Fair Market Rent

Forms:

Tips for Maintaining LTSS

ERA Referral Request Form

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
5/2020		Established	
8/2020		Added Chapter Section hyperlinks, Section 5B.6 GOSH and link to Supportive Housing WACs	
10/2020		Updated GOSH Pre-Tenancy service code and provided clarification around SHPM vs CM responsibility in "GOSH Client Accepted" section. Added Housing Team contacts under section 5b.11. In section 5b.4 added	

		instruction on how to document ALTSA subsidy into CARE and Bridge file transition information. Added *Forms* to section 5b.11 including (2) new forms: ALTSA Bridge Referral and Bridge Referral and Application Process.	
2/2021		Added SA294 subsidy payment authorization information to section 5B.4. Moved GOSH Section from 5B.6 to 5B.5. Added clarification that there is no participation for Supportive Housing services. Added GOSH "Discharge Planning" and "Transition to Independent Housing" sections to 5B.5. Updated hyperlinks.	
5/2021		Deleted SA294 payment authorization process for P1. Added the need for CM support with quarterly Bridge tenancy verifications as well as annual re-certifications. Clarified steps to add "Housing subsidy (HCS/AAA)" and "Supportive Housing (HCS/AAA)" as Treatments on the Medical Screen in CARE. Added new procedure for referring to GOSH, hyperlinked to new DSHS 11-153 GOSH Referral form. Clarified GOSH eligibility and HCS and AAA CMs can refer. Clarified GOSH authorization responsibility. Hyperlinked to Chapter 30d to connect Supportive Housing service consults and consideration. Clarified on-going eligibility for GOSH clients regarding services and subsidy. Hyperlinked to Chapter 30d in the 'How can I use CTS/CTSS/WA Roads section'. Updated PM Roles.	
8/2021		Added new staff contacts for all regions by way of link to RCL Housing Resources website. Updated Bridge Referral form, Participant Agreement and Referral and Application Process form. Added updated ERA form. Updated 811 ALTSA HPM role regarding DDA/DBHR referrals. Added expanded GOSH eligibility criteria.	
2/2022		Updated various links throughout the chapter. Updated ALTSA Subsidy P&P inserted Document. Updated Participant Agreement inserted document. Added *What is needed to transfer an ALTSA subsidy client from HCS to the AAA?* Section. Updated GOSH section to add protocol to staff cases with SHPM prior to closing a GOSH client and protocol related to clients with short term institutional stays (e.g., re-hospitalization or jail).	
8/2022		Added RVP eligibility and availability. Update ERA with Hotel/Motel stay information and Process. Update link	

		to ERA form. Add info from Chapter 5a regarding WA Roads and eligibility from ALTSA housing resources. Updated language around HCS to AAA case transfers and Annual Assessments for GOSH. Added some hyperlinks into the GOSH Section to animated YouTube Videos: What is the Governor's Opportunity for Supportive Housing?; You've Been Referred to GOSH – Now What?; Governor's Opportunity for Supportive Housing (GOSH): Good Discharge Planning	
11/2022		Added more detailed payment/authorization information for ERA SA298. Added in section from Chapter 5a on how to work with individuals on ALTSA Housing Resources who are not currently receiving LTSS. Added language on keeping GOSH participants open who are in jail or institutional stays into the Interim Setting section. General text/grammar corrections throughout document. Added Bellingham/Whatcom and Spokane RVP resource.	
2/2023		Updated Unit Manager titles. Updated "NED" section to "permanent HUD voucher" section and added more process details. Updated Chapter Section list to include new 5b.5. Updated 811 sections with more details regarding application process. Removed old versions of forms and added updated versions (Participant Agreement, Tips for Maintaining LTSS, Chapter Version ALTSA Subsidy P&P and Bridge referral). Added page numbers to footer. Added links to Brochures and Video.	
5/2023		ALTSA subsidy video link. Updates to Section 5b.5. Updated ERA form.	
8/2023		Updated information in the ALTSA Subsidy and GOSH sections related to CARE Changes. Clarified language related to ineligibility for permanent HUD vouchers.	
11/2023		Updated Emergency Rental Assistance Form. Clarified language and updated language in section 5b.5 "Working with individuals on ALTSA housing resources who are not currently receiving ALTSA LTSS". Updated GOSH Section to include new regional referral email addresses.	
1/2024		Chapter Links added and updated ERA form added	
2/2024		Added a green box in pages 14 & 24 & 29 & 34 with a process for possible no longer functionally eligible ALTSA clients who are already enrolled in a housing service. Added on page 33 & 34 Motel Interim Stay for Transitions (MIST) program description. Added MIST to	

		Table of contents Page 2. Replaced Washington Roads RAC info in pages 17 & 21 & 29 with new info (RAC 3131- LTSS Housing Stabilization). Added on page 17 (1 d. and the HCS/AAA CM will extend the WA Roads RAC) & (2 i. GOSH Program Manager will end the GOSH authorization and end RAC 3131- LTSS Housing Stabilization, and HCS/AAA CM will end the WA Roads RAC). Removed from page 30 & 31 under reimbursements "while the Supportive Housing services are authorized by SHPM under the service code SA299,U1 the CM would authorize use of any CFC CTS/CTSS/WA Roads funds under a separate service code, dependent upon eligibility and funds used."	
3/27/2024		Updated Bridge documents at bottom of document with most recent versions. Page 11 &12 amended for ALTSA Bridge Subsidy.	
5/7/2024		Removed Motel/Hotel language from ERA section. Corrected MIST referral email address. Added MIST Request Form. Added bullet on Civil Transition eligibility.	
6/17/2024		Added ERA email address. Updated ERA referral process. Removed "How do I make a referral for a client who I believe is eligible for ERA?" Updated MIST eligibility criteria (Bridge Subsidy, GOSH program, Civil Transitions Program, Other Housing Resource, In-Home Short-Term Displacement, & Limited Residential). Updated MIST referral Process outline. Updated & added "How is payment made for MIST?" process/procedure. Updated MIST Referral Form.	
9/3/2024		Added information regarding Bridge Subsidy waitlist, added information regarding Presumptive Eligibility, added policy information from chapter 9 regarding GOSH client unable to return to residential setting and being admitted to the hospital. Added policy information regarding if a client is incarcerated or hospitalized and how ALTSA pays the subsidy for up to 6 months. Added Stephen Miller contact info. Added Housing and Employment website, updated links to one pager. Updated table of contents to include Presumptive Eligibility. Added Global Leasing info. Updated GOSH eligibility criteria.	
10/2024	joana	Chapter 5b changed to Chapter 6. Chapter 6 Established	
11/2024	joana	Added information regarding the ALTSA Acute Care Hospital Subsidy, and the referral/process and referral.	

01/2025	joana	Edited information regarding the ALTSA Acute Care Hospital Subsidy	
03/2025	joana	Chapter 6 was divided up into 4 sections and renamed. Chapter 6B- Interim Housing Resources (Motel Interim Stay for Transitions & Emergency Rental Assistance) established. Update policy & procedure regarding ERA. Updated OHAE background and EDAI statement. Added a chart describing all the RACs and Service Codes associated with OHAE. Updated criteria, policy & procedure for MIST.	

Permanent Federal Vouchers

Chapter 6C outlines the policies and procedures for administering permanent housing vouchers including the 811 Project Rental Assistance (PRA) program for ALTSA clients. These long-term housing resources provide stable, affordable housing for individuals. This chapter details eligibility criteria, the application and referral process, case management responsibilities, and ongoing compliance requirements to ensure that clients receive and maintain appropriate housing support.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Jonnie Matson Rental Assistance Unit Manager
360.628.0183 jonnie.matson2@dshs.wa.gov

If you have questions or need clarification regarding Permanent Federal Vouchers, please contact:

Ian Harpole Housing Integration Unit Manager
509.992.5007 ian.harpole@dshs.wa.gov

For additional information please visit our website: Office of Housing and Employment

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BACKGROUND

The ALTSA Office of Housing and Employment (OHAE) is dedicated to offering housing and supported employment resources that honor client choice. We work to eliminate barriers and expand opportunities that align with an individual's vision for their life regardless of mental health, substance use disorder, race, language, age, ability, or other status.

OHAE brings together federal, state, and local resources to create opportunities and strategies to help clients access independent housing, and in collaboration with our community partners, help build an individualized array of services to support them. This chapter provides specific guidance around Housing and Urban Development (HUD)permanent federal vouchers and can help you refer clients who are eligible for them.

Whenever possible, we can offer guidance about difficult housing situations you might encounter with your client, including tips about working with clients experiencing homelessness. Affordable housing and tenancy support are complex topics that often do not have easy or quick solutions. Please let us know about other topics or obstacles you would like the see addressed in this chapter.

PERMANENT FEDERAL HUD VOUCHERS

Starting in 2011, the ALTSA Housing Team began collaborating with local Public Housing Authorities (PHAs) to make Housing Choice Vouchers (HCVs) available to DSHS clients. For background, the Housing and Urban Development (HUD) agency awards these vouchers (formerly known as Section 8) to the PHAs through a competitive process called "Notice of Funding Allocations" (or NOFAs). The voucher pays for a portion of the individual's rent and the individual is responsible for paying 30% of their monthly household toward rent.

The different types of HCVs the ALTSA Housing Team administers are the Non-Elderly Disabled (NED1, NED2, Mainstream Voucher [MSV]) and the Referral Voucher Program (RVP). Your regional ALTSA Housing Program Manager can help you understand the eligibility criteria for these vouchers and let you know where there is current availability.

What is a "Non-Elderly Disabled" (NED) voucher?

HUD defines a "Non-Elderly Disabled Family" as a family whose head of household, or sole member, is 18-61 years of age at the time of lease signing, and the qualifying person has a disability. There are three subcategories of NED vouchers that target specific groups of people with disabilities:

- **NED Category 1** vouchers are available to the qualifying person (and their family, if applicable) regardless of their current living situation.
- **NED Category 2** vouchers are available to the qualifying person (and their family, if applicable) who is currently living in an institutional setting such as Skilled Nursing Facilities, hospitals, Residential Habilitation Centers for individuals with developmental disabilities, and Psychiatric Hospitals (Eastern and Western State). The institutional settings, though, **exclude** board and

care facilities (e.g., adult homes, adult day care, adult congregate living), residential services, and community-based congregate settings. Prison is also excluded.

- **NED Mainstream** vouchers (MSV) are available to the qualifying person (and their family, if applicable) who are institutionalized (see definition above), or at risk of institutionalization, or homeless, or at risk of homelessness. Please ask your regional Housing Program Manager for more information on what are the definitions of *at risk* and *homeless*, as these may vary depending on the PHA.

What Is the Referral Voucher Program (RVP)?

The RVP is a Housing Choice Voucher (HCV) and is not considered a NED voucher. It is available to individuals regardless of setting who are receiving ALTSA LTSS. There is a service component for this voucher and applicants should be agreeable to receiving LTSS. This voucher is available to applicants over the age of 18.

Where are permanent HUD vouchers available?

- Region 1:
  - City of Yakima: NED2 and MSV
  - Spokane, Ferry, Stevens, Pend Oreille, Lincoln, and Whitman Counties: NED 1 and Mainstream and RVP
  - City of Kennewick: NED1 and MSV
  - Okanogan County: MSV
- Region 2:
  - Snohomish County: NED2
  - Whatcom County: RVP
- Region 3:
  - City of Tacoma/Pierce County: NED2 and MSV
  - Jefferson and Clallam Counties: NED2
  - Cowlitz, Lewis, Pacific and Wahkiakum Counties: NED2

Does an individual have to reside in the area where the voucher is available?

The current location of a client is not a barrier to applying for federal vouchers. Public Housing Authorities (PHAs) allow anyone to apply for vouchers or public housing, and eligibility is not based on the current location or residence of the applicant. Applicants currently living within the service area of the PHA, however, may be given preference.

What are the basic eligibility requirements for permanent HUD vouchers?

A household must:

- Be very low-income. A household's income must be at, or below, 50 percent of the Area Median Income as determined by HUD. Each year, HUD publishes these income limits for every housing market across the nation:
  - https://www.huduser.gov/portal/datasets/il.html

- Be a citizen or a non-citizen with "eligible immigration status," and
- Be in good standing with federal housing programs. Specifically, a household must not have:
  - Been evicted from federally assisted housing for illegal drug activity within the past 3 years.
  - Be required to register as a lifetime sex offender.
  - Been convicted of producing methamphetamine in federally assisted housing.
- A criminal history may disqualify an applicant from the voucher. On a case-by-case basis, a denial can be appealed except for the above three categories.

What are the roles and responsibilities in the eligibility process?

There is a multi-level process for determining eligibility for and processing of permanent HUD vouchers. ALTSA, contracted providers and Housing Authorities all have a role in the process.

- **ALTSA Housing Program Managers (HPMs):** Are responsible for screening and referring applicants from case managers that expressed their client's need for affordable housing. All referrals are made through ALTSA Housing Program Managers to Public Housing Authorities; individuals contacting Public Housing Authorities outside of this process will be directed to ALTSA Housing Program Managers.
- **HCS Case Managers:** Make referrals for ALTSA housing resources, create transition plans, and authorize transition goods and services.
- **Contracted Providers** (Community Choice Guides or Supportive Housing Providers): Complete tasks and purchases authorized by the HCS Case Manager to support the client in reaching transition and/or stabilization goals.

Public Housing Authorities: After receiving the initial application packet from ALTSA, they will screen the applicants on their prior tenant history, conduct criminal background checks, rental history, and, and screen for other criteria. Each PHA is then responsible for administering their program in accordance with their housing plan.

What is the process to refer a client for permanent HUD vouchers?

- **Contact your Regional ALTSA Housing Program Manager (HPM) with the client's name and ACES ID**
  - HPM will prescreen the client and determine if the client is eligible to apply.
  - If client is found eligible, HPM will email the housing application to the NFCM and cc supervisor.
  - This is the time to make a CCG referral -- if one hasn't been made yet.
- **Complete the application and provide supporting documentation**

  - If the client needs support completing the application and gathering documents, this can be provided by the NFCM, SNF Social Worker, or contracted provider.
- **Submit completed application to HPM**
  - HPM will review the documents and submit to the PHA.
  - PHAs will schedule briefing appointment with client and/or contact.
- **HPM will work with contracted provider and PHA on housing search and lease up process.**
- **Clients must remain in the SNF until the voucher is issued by the PHA. Once client has signed the lease, a transition date can be set, and client can move.**

What is the required documentation for my client to apply?

Depending on the PHA, the required application materials can vary. However, the following is a list of common items required. Ask your Regional Housing Program Manager about the specific documents required for your client's application:

- Current state issued photo ID. PHAs will not accept expired ID.
- Copies of Social Security card(s).
- Copies of current year Social Security award letters or other first-party income verification. In some circumstances, HPM may be able to provide income verification via ACES.
- Copies of bank statements if clients have checking or savings accounts.
- Disability verification if client is not receiving income based on their disability.

How will I know if there are permanent HUD vouchers available?

At times, there may be immediate availability of vouchers, and when those situations arise, the announcements about openings are distributed statewide via regular emails to HCS supervisors, Program Managers and RCL Specialists so the information can be dispersed to HCS Case Managers.

Is there a waitlist for permanent HUD vouchers?

Regional HPMs maintain short waitlists of eligible applicants. When there are enough applicants on a waitlist, the HPM will no longer accept additional applications. Because the turnover in vouchers is not predictable, the HPMs will not be able to predict how long a person may need to wait for an available voucher.

811 UNITS: PROJECT BASED RENTAL ASSISTANCE (PRA)

Funding for the 811 Project Based Rental Assistance (PRA) apartment units were created by a grant from HUD. The grant provides project-based subsidies for newly built or converted housing units statewide, providing an increase in the number of permanent, affordable housing units for non-elderly clients with disabilities. HUD administers this grant through the Washington State Department of Commerce, which partners with DSHS-ALTSA to make referrals to the units and coordinate services for residents.

What is the definition of an "811 PRA unit"?

An 811 Project Based Rental Assistance (PRA) unit is created through a contract between the Washington State Department of Commerce and a housing provider. The subsidy is paid to the housing provider and cannot be transferred to another apartment or otherwise follow a client when they move. When a client moves from an 811 unit, the rental assistance does not move with them to the new location. The 811 PRA units are permanent housing, and tenants may live there if they continue to meet the annual eligibility criteria and remain in compliance with their lease agreement.

What locations in Washington State have 811 PRA units?

The following areas have 811 units:

- Region 1:
  - Spokane County: Spokane and Spokane Valley
  - Chelan County: Wenatchee
  - Benton County: Kennewick and Richland
  - Franklin County: Pasco
- Region 2:
  - King County: Seattle, Renton and Auburn
- Region 3:
  - Thurston County: Olympia
  - Clark County: Vancouver
  - Clallam County: Port Angeles

Does an individual have to live in the city or county where the 811 PRA unit is located?

The current location of a client is not a barrier to applying to any of the properties that have 811 PRA units. Property managers allow eligible applicants to apply for available units regardless of an applicant's current location or residence.

What are the basic eligibility standards for 811 PRA units?

A household must:

- Be extremely low-income. A household's income must be at or below 30 percent of the area-wide median income as determined by HUD. Each year, HUD publishes these income limits for every housing market across the nation: https://www.huduser.gov/portal/datasets/il.html
- Applicant must be between the ages of 18-61 at the time of lease signing.
- Be a citizen or a non-citizen with "eligible immigration status," and
- Be in good standing with federal housing programs. Specifically, a household must not have:

- Been evicted from federally assisted housing for illegal drug activity within 3 years.
- Been required to register as a sex offender.
- A felony conviction for the manufacturing or production of methamphetamine.

- A criminal history may disqualify an applicant from an 811 unit. Denials can be appealed on a case-by-case basis except for the above three categories.
- Applicant must be active on a DSHS caseload upon move into the unit but are not required to maintain LTSS to retain the housing.

What settings do people need to be transitioning from to be eligible for 811 PRA units?

The 811 program follows an eligibility priority:

- 1st priority: People living in institutional settings and those that are homeless.
- 2nd priority: Individuals wishing to move from residential settings.
- 3rd priority: In-home clients needing other housing due to safety, accessibility or rent burden issue/s.

The Housing Program Managers will process 811 client applications in the order received, and when there are multiple applications for limited units, the above priorities will apply.

What are ALTSA's and the Property Management agency's responsibilities in the 811 PRA units' eligibility process?

There is a multi-level process for determining eligibility for 811 units. Both ALTSA and Property Managers are responsible for determining client eligibility. Due to the complex funding strategies used to create the tax credit properties that 811 units are in, eligibility criteria may also vary by property.

- **ALTSA Housing Program Managers:** Are responsible for screening and referring applicants from case managers who expressed their client's need for affordable housing. All referrals are made through ALTSA Housing Program Managers to 811 Property Managers; individuals contacting these agencies outside of this process will be directed to ALTSA Housing Program Managers.
- **HCS Case Managers:** Make referrals for ALTSA housing resources, create transition plans, and authorize transition goods and services.
- **Contracted Providers** (Community Choice Guides or Supportive Housing Providers): Complete tasks and purchases authorized by the HCS Case Manager to support the client in reaching transition and/or stabilization goals.
- **Property Management Agencies**: After receiving initial application packets from ALTSA, Property Managers will screen the applicants on their prior tenant history, conduct criminal background checks, rental history, and credit history checks, and screen for other criteria. Each agency is then responsible for administering the 811 program in accordance with its tenant selection plan.

How do I make a client referral for an 811 unit?

- **Contact your Regional ALTSA Housing Program Manager (HPM) with the client's name and ACES ID**.
    - HPM will prescreen the client and determine if the client is eligible to apply.
    - If client is found eligible, HPM will email the housing application to the NFCM and cc Supervisor.
    - This is the time to make a CCG referral -- if one hasn't been made yet.
- **Complete the application and provide supporting documentation.**
    - If the client needs support completing the application and gathering documents, this can be provided by the HCS CM, AAA CM, SNF Social Worker, or contracted provider.
- **Submit completed application to HPM.**
    - HPM will review the documents and submit to the Property Manager.
    - Property Managers will schedule briefing appointment with client and/or contact. Once client has signed the lease, a move-in date can be set and client can move.

What is the required documentation for my client to apply?

Depending on the Property Management agency, the required application materials can vary. However, the following is a list of commonly items required. Ask your regional HPM for specific documents required for your client's application:

- Current state-issued photo ID. Expired ID will not be accepted.
- Copies of Social Security Card(s)
- Copies of current years Social Security award letters or other first party income verification
- Copies of bank statements if clients have checking or savings accounts.

How will I know when there is an 811 unit available?

At times, there may be immediate 811-unit availability, and when those situations arise, the openings will be announced to the field via email notifications.

Is there a waitlist for 811 units?

Regional HPMs maintain short waitlists of eligible applicants. When there are enough applicants on a waitlist, the HPM will no longer accept additional applications. Because the turnover in 811 PRA units is not predictable, the HPMs will not be able to predict how long a person may need to wait for an available 811 PRA unit.

INACTIVATE CLIENTS WHO ARE RECEIVING PERMANENT FEDERAL VOUCHERS COORDINATED THROUGH ALTSA

Clients who originally had their housing resource coordinated through ALTSA but were inactivated from LTSS can still access LTSS housing and employment stabilization services when needed.

No action is required of the HCS/AAA until individuals are identified. Individuals could be identified in a variety of ways:

1. The public housing authority/landlord could contact the ALTSA Housing Program Manager regarding an issue or crisis, at which point the ALTSA Housing Program Manager will make the referral to the local HCS office; or
2. The individual may contact an office (HCS or AAA) directly if services are being requested.
3. HCS/AAAs can contact the ALTSA Program Manager and request a list of individuals residing in their PSA who are utilizing a housing voucher.
4. Once the individual is identified as a person whose housing was coordinated through ALTSA and there is a need for Housing & Employment Stabilization Services:
5. Activate the case in CARE.
6. Housing & Employment Stabilization Services can be authorized as soon as the case is activated in CARE.
7. If the AAA is the first point of contact and there is need for a new Assessment, per policy, the AAA should contact the HCS office if an Initial or Initial/Reapply assessment is required. Once the Initial or Initial/Reapply assessment is complete, the case is transferred back to the AAA.

Do not delay authorizing Housing & Employment Stabilization Services for an immediate need during completion of the assessment process. If the client does not want to proceed with an assessment, Housing & Employment Stabilization Services can still be authorized.

RESOURCES

Housing Team Contacts can be found on the **RCL Housing Resources Website.**

Office of Housing and Employment website: Office of Housing and Employment

Brochures and Videos

ALTSA Housing Resources

Federal Vouchers One-Pager

811 Units One-Pager

LTSS One-Pager

Zero Income One-Pager

Income Discrimination Flyer Income Discrimination Flyer Tenants: New Legal Protection from Discrimination Based on Source of Income

Video: Options for Housing Through Long-Term Care Services

	FUND	LIMIT	SERVICE CODES	SUBJECT TO ETR	
FEDERAL	**Roads to Community Living (RCL)**	$10000	Goods: SA296	✓	***See LTC Chapter 7***
	Community Transition Services	$2500		✓	
	COPES	$1700	Services: SA297	✓	
If Client is not eligible for one of the programs above, see the following:					
STATE	**Housing & Employment Stabilization Services**	$5000	Goods & Services: SA294,U4	✓	***See LTC Chapter 6***

Housing Resource Chart

RAC 3132: Health Related Social Needs - Federal

Motel Interim Stay for Transitions (MIST) SA294u1

Motel Interim Stay for Transitions (MIST): is a service to pay for a short-term motel/hotel stay offered to minimize the number of clients who discharge to and/or experience episodes of homelessness. MIST aims to minimize the time it takes to get vital LTSS in place and increase the client's chances of ending up on services in their own home. The service is authorized for up to a 6-month period at a time. Federal MIST is funded via the 1115 waiver in which the Washington State Health Related Social Needs Services Program (HRSN) will allow Medicaid enrollees to receive evidence-based, non-medical services to address an individual's unmet, adverse social conditions that contribute to poor health. This includes temporary housing.	
Who is eligible for federal MIST?	HCS/AAA clients who are receiving Medicaid long-term services who have one of the following qualifications: 1. **ALTSA Subsidy (Bridge & Acute Care Hospital)**

	• Bridge Subsidy: ALTSA clients who have a Bridge voucher issued and are working with an authorized contracted provider on an independent housing search. • Acute Hospital Care (ACH) Subsidy: ALTSA clients transitioning from an Acute Care Hospital (ACH) setting, when housing is a barrier. 2. **GOSH Program:** ALTSA clients who are enrolled in the Governor's Opportunity for Supportive Housing (GOSH) and are at risk of or experiencing homelessness. 3. **Other Housing Resource:** • ALTSA clients who will be living independently and currently have a resource from a housing agency or program. Examples might include Mainstream, NED, Housing Choice, Apple Health & Homes, HEN, HOPWA, VA, etc. • ALTSA clients who have been approved for a project-based resource and have a move-in-date. Examples might include Tax Credit units, 811 units, or Permanent Supportive Housing Unit from homeless service agency. 4. **In-Home Short-Term Displacement:** ALTSA clients who have their own home **and** a short-term situation that requires them to temporarily vacate. Ex: Pest control or eradication, fire, or flooding. 5. **Experiencing Homelessness:** ALTSA clients experiencing homelessness. Ex: staying in a car, park, abandoned building, tent, shelter, or couch surfing.
What is covered under MIST 294u1?	1. Payment for up to 6-month period for a Medicaid ALTSA client to stay at a motel/hotel. 2. Damages upon HQ approval- Please contact Supportive Housing Program Manager
What is not covered under MIST 294u1?	1. Deposits
How much can I spend?	1. Up to $4000 per month for a total of six months. • Note: not to exceed six month
Do I need to use a contracted provider?	**Yes.** 1. The HCS/AAA CM will need to coordinate with the Contracted Provider and notify them that the client has been authorized for Motel Interim Stay for Transitions for a period of up to 6 months. 2. The Contracted Provider should be authorized for the duration of the MIST authorization period.

	3. The Contracted Provider should make periodic visits to the client to provide support and assist in a housing search, as needed. *This might change if SHA takes this on...*
How do I authorize federal MIST?	1. Upon receiving approval for MIST, the HCS/AAA CM should open RAC 3132. 2. Use Service Code SA294,U1 to reimburse the contracted provider for the expenses incurred. 3. HCS/AAA CM will reimburse contracted provider on a two-week timeline for a period of up to six months. **Note: do not submit authorization to ProviderOne until receipt/s have been received.**
When do I authorize this service?	1. MIST should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager and a hotel/motel have been found.
Are ETRs allowed for federal MIST?	**No.** 1. When the approved MIST amount is above $2000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Emergency Rental Assistance SA298

Emergency Rental Assistance (ERA) can be used as a one-time payment made directly to landlords on behalf of an ALTSA client who is facing an immediate eviction due to non-payment of rent. As part of the assistance request, clients must demonstrate they are able to pay their rent going forward and maintain their independent housing as a part of being stabilized in their community setting. This resource should only be requested when there are no other community options to meet the need fully or partially. Federal Emergency Rental Assistance is funded via the 1115 waiver, in which the Washington State Health Related Social Needs Services Program (HRSN) will allow Medicaid enrollees to receive evidence-based, non-medical services to address an individual's unmet, adverse social conditions that contribute to poor health. These includes rent.

Who is eligible for federal ERA?	1. An ALTSA client who is experiencing or at risk of experiencing homelessness, including facing an immediate eviction due to non-payment of rent.
What is covered under federal ERA?	1. A one-time payment made directly to landlords on behalf of an ALTSA client who is facing an immediate eviction due to non-payment of rent.

What is not covered under federal ERA?	1. ERA does not include pre-tenancy deposits or move-in costs required at move in. ERA cannot pay in excess of 150% Fair Market Rent per month and can only pay for a total of six months back rent.
When do I need a provider contract?	1. The HCS/AAA case manager will need to authorize a Contracted Provider (Community Choice Guide or GOSH Supportive Housing Provider) to make the ERA payment on the clients' behalf. *Could change dependent on SHA.*
How do I authorize federal ERA	1. Use RAC 3132. 2. Use Service Code SA298 to reimburse the contracted provider for the ERA payment amount approved by the HPM.
When do I authorize this service?	1. ERA should only be authorized after an ERA referral has been submitted and approved by the Housing Program Manager.
Are ETRs allowed for the federal ERA?	**No.** 1. note: When the approved ERA amount is above $4000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

RAC 3131: Long-Term Services and Supports Housing Stabilization – State Funds

Governor's Opportunity for Supportive Housing (GOSH) Pre-Tenancy SA299u1

Governor's Opportunity for Supportive Housing (GOSH) Pre-Tenancy	
Who is eligible for GOSH?	HCS/AAA clients who are receiving Medicaid long-term services who: are choosing In-Home setting and: 1. are willing to work with a Supportive Housing Provider, **and** 2. qualify for ALTSA services (financially & functionally eligible), **and** 3. are discharging or being diverted from Eastern or Western State Hospitals, 4. An individual with a 90- or 180-day commitment order for further involuntary treatment who is discharging from a local community psychiatric facility into Home and Community Services Long-Term Services and Supports (HCS LTSS); or an individual who is detained through the Involuntary Treatment Act who is stabilized and discharged into HCS LTSS prior to the need to petition for a 90- or 180-day commitment order. 5. ALTSA clients who are currently living in a residential setting who transitioned or were diverted from Western/Eastern State Hospital

	within the past 18 months, as documented in CARE and counted by SHDD team, and wish to live independently.
What is covered under GOSH SA299u1?	Services that support an individual's ability to prepare for and transition to housing, including direct and collateral services: 1. Screening and housing assessment for individuals' preferences and barriers. 2. Developing an individual housing support plan: identifying goals, addressing barriers, establishing approaches to meet goals, including identifying available services and resources. 3. Assisting with eligibility determination, housing applications, subsidy applications, and housing searches. 4. Identifying resources for modifications and/or one-time move-in needs. 5. Assisting in arranging for and supporting details of moving into housing. 6. Training on roles, responsibilities, and rights of tenant and landlord. 7. Developing housing support crisis plan. 8. Maintaining participant and collateral contacts, and timely completion of supportive housing deliverables as outlined in 'Service Standards for Providers'.
What is not covered under GOSH SA299u1?	1. Rent 2. Move-in-costs 3. Utilities
How much can I spend?	1. 160 units per month
Do I need to use a contracted provider?	**Yes.** 1. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.
How do I authorize GOSH SA299u1?	Once the referral has been accepted by the SHPM: 1. The SHPM will open RAC 3131 – LTSS Housing Stabilization and then the pre-tenancy Supportive Housing service code, SA299-U1, to open the SH authorization in CARE. 2. It is the SHPM's responsibility to open, extend and close authorizations for service code SA299, U1.

When do I authorize this service?	1. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.
Are ETRs allowed for GOSH SA299u1?	**No.**
What about SA299,U1 for Civil Transitions Program?	1. Supportive Housing services are available through GOSH for those who meet Civil Transition Program eligibility (see Chapter 9b). 2. For clients meeting Civil Transition Program (CTP) eligibility only, use the appropriate CTP RAC and then authorize SA299u1 with the Reason Code "Civil Transitions Program". 3. If a Civil Transition Program client ends up eligible for LTSS: • End CTP RAC • End SA299,u1 authorization, then: • Open RAC 3131 LTSS Housing Stabilization • Open SA299u1 and use Reason Code "5440 FEFE", which stands for 5440 Functionally Eligible Financially Eligible.

Governor's Opportunity for Supportive Housing (GOSH) Tenancy H0044

Governor's Opportunity for Supportive Housing (GOSH) Tenancy	
Who is eligible for GOSH?	1. HCS/AAA clients who are receiving Medicaid long-term services who: are choosing In-Home setting and: 2. are willing to work with a Supportive Housing Provider, and 3. qualify for ALTSA services (financially & functionally eligible), and 4. are discharging or being diverted from Eastern or Western State Hospitals, 5. An individual with a 90- or 180-day commitment order for further involuntary treatment who is discharging from a local community psychiatric facility into Home and Community Services Long-Term Services and Supports (HCS LTSS); or an individual who is detained through the Involuntary Treatment Act who is stabilized and discharged into HCS LTSS prior to the need to petition for a 90- or 180-day commitment order. 6. ALTSA clients who are currently living in a residential setting who transitioned or were diverted from Western/Eastern State Hospital within the past 18 months, as documented in CARE and counted by SHDD team, and wish to live independently.
What is covered under GOSH H0044?	Services to support individuals to maintain tenancy once housing is secured, such as: 1. Early intervention for behaviors that might jeopardize housing, e.g., late rent payment, lease violations, etc.

	2. Training on responsibilities and rights of tenant and landlord. 3. Coaching on relationship building with landlords, property managers, and neighbors, and assisting in dispute resolution. 4. Linking with community resources to prevent eviction
What is not covered under GOSH H0044?	1. Rent 2. Move-in-costs 3. Utilities
How much can I spend?	1. 1 unit per month (rate $575)
Do I need to use a contracted provider?	**Yes.** 1. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.
How do I authorize GOSH H0044?	Once the client has moved into their own apartment: 1. The SHPM will ensure RAC 3131 – LTSS Housing Stabilization's end date matches the CARE Plan end date. 2. The SHPM will close pre-tenancy service code SA299, U1, and open tenancy service code H0044. 3. It is the responsibility of the SHPM to close the authorization for SA299, U1 and open an authorization for H0044. 4. The SHPM will update the tenancy service code, H0044, on an annual basis. If there are any concerns around client eligibility, staff with the SHPM.
When do I authorize this service?	GOSH Services should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager. Once the client has moved into their own apartment: 1. The SHPM will ensure RAC 3131 – LTSS Housing Stabilization's end date matches the CARE Plan end date. 2. The SHPM will close pre-tenancy service code SA299, U1, and open tenancy service code H0044. Please note, the date when the tenancy service code, H0044, is opened will vary based on the terms of the SHP's contract:
Are ETRs allowed for GOSH H0044?	No.
What about H0044 FOR Civil Transitions program?	1. H0044 should not be used for a client only eligible for the Civil Transition Program. 2. If a Supportive Housing client who was originally Civil Transition Program client ended up eligible for LTSS and secures housing use

	Reason Code "5440 FEFE", which stands for 5440 Functionally Eligible Financially Eligible.

Motel Interim Stay for Transitions (MIST) SA294u2

Motel Interim Stay for Transitions (MIST): is a service to pay for a short-term motel/hotel stay offered to minimize the number of clients who discharge to and/or experience episodes of homelessness. MIST aims to minimize the time it takes to get vital LTSS in place and increase the client's chances of ending up on services in their own home. The service is authorized for up to a 6-month period at a time	
Who is eligible for state MIST?	HCS/AAA clients who are receiving Medicaid long-term services who have one of the following qualifications: 1. **ALTSA Subsidy (Bridge & Acute Care Hospital)** • Bridge Subsidy: ALTSA clients who have a Bridge voucher issued and are working with an authorized contracted provider on an independent housing search. • Acute Hospital Care (ACH) Subsidy: ALTSA clients transitioning from an Acute Care Hospital (ACH) setting, when housing is a barrier. 2. **GOSH Program:** ALTSA clients who are enrolled in the Governor's Opportunity for Supportive Housing (GOSH) and are at risk of or experiencing homelessness. 3. **Other Housing Resource:** • ALTSA clients who will be living independently and currently have a resource from a housing agency or program. Examples might include Mainstream, NED, Housing Choice, Apple Health & Homes, HEN, HOPWA, VA, etc. • ALTSA clients who have been approved for a project-based resource and have a move-in-date. Examples might include Tax Credit units, 811 units, or Permanent Supportive Housing Unit from homeless service agency. 4. **In-Home Short-Term Displacement:** ALTSA clients who have their own home **and** a short-term situation that requires them to temporarily vacate. Ex: Pest control or eradication, fire, or flooding. 5. **Experiencing Homelessness:** ALTSA clients experiencing homelessness. Ex: staying in a car, park, abandoned building, tent, shelter, or couch surfing.
What is covered under MIST 294u2?	1. Payment for up to 6-month period for a Medicaid ALTSA client to stay at a motel/hotel.

	2. Deposits 3. Damages- (Requires HQ Approval. Please contact the Supportive Housing Program Manager)
What is not covered under MIST 294u2?	1. Monthly payment that exceeds $4,000.
How much can I spend?	1. Up to $4,000 per month for a total of six months.
Do I need to use a contracted provider?	**Yes.** 1. The HCS/AAA CM will need to coordinate with the Contracted Provider and notify them that the client has been authorized for Motel Interim Stay for Transitions for a period of up to 6 months. 2. The Contracted Provider should be authorized for the duration of the MIST authorization period. 3. The Contracted Provider should make periodic visits to the client to provide support and assist in a housing search, as needed. *This might change if SHA takes this on...*
How do I authorize state MIST?	1. Upon receiving approval for MIST, the HCS/AAA CM should open RAC 3131. 2. Use Service Code SA294,U2 to reimburse the contracted provider for the expenses incurred. 3. HCS/AAA CM will reimburse contracted provider on a two-week timeline for a period of up to six months. **Note: do not submit authorization to ProviderOne until receipt/s have been received.** 4. If a client is enrolled in GOSH services, HCS/AAA CM will need to select "2017 Governor's Request Supportive Housing" as the reason code. If client is not enrolled in GOSH Service, please select "No reason code needed" as the reason code.
When do I authorize this service?	1. MIST should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager and a hotel/motel have been found.
Are ETRs allowed for state MIST?	**No.** 1. Note: When the approved MIST amount is above $2000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Housing Subsidy - Purchasing SA294u4

Housing & Employment Stabilization Services (H&ES) These state funded services are intended to fill specific gaps to provide transitional or stabilizing supports for clients, who have received a housing or Supported Employment resource or had their housing/employment coordinated through ALTSA to sustain community living.	
Who is eligible for state H&ES?	When an ALTSA client meets these qualifications: 1. Received a housing resource or had their housing coordinated through ALTSA; **or** 2. Enrolled with Supported Employment or had their employment coordinated through ALTSA; **and** 3. Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to your own home, or are living in the community and need stabilization services to remain there; **and** 4. Do not have other programs, services, or resources to assist you with these costs; **and** 5. Are not eligible for federal funding
What is covered under state H&ES?	1. First month's rent, security deposits, safety deposits 2. Utility set-up fees or deposits 3. Health and safety assurances, such as pest eradication, allergen control, or non-recurring cleaning fees prior or upon return to the home. 4. Moving services 5. Background check/application fees 6. Non-recurring rental insurance required for lease up. 7. Furniture, essential furnishings, and basic items essential for basic living outside the institution. 8. The provision of goods that increase independence or substitute for human assistance to the extent that expenditures would have been made for the human assistances, such as purchasing a microwave. 9. Cellphone 10. Household items 11. Bus pass 12. Food 13. Food Handlers card 14. Identification card 15. Clothes (interview clothes, first set of uniforms to begin work) 16. Etc.
What is not covered under state H&ES?	1. recreational or diversional items such as television, cable or DVD players. 2. Assistive Technology

When do I need a provider contract?	1. A contracted provider (Community Choice Guide or GOSH SHP) will need to be authorized to complete purchases or/and payments on the behalf of the client.
How do I authorize state H&ES?	1. Open RAC 3131-LTSS Housing Stabilization 2. Use Service Code SA294,U4 to authorize the necessary goods and services. 3. Select the appropriate reason code. Options are "In-Home Community Stabilization or Employment Stabilization" 4. Note in the Service Episode Record (SER) that the client is eligible for LTSS Housing Stabilization services and that you have Supervisory approval to authorize state only funds. 5. Complete a SER outlining the service you are authorizing and/or the items you are purchasing and how they are necessary for the client's service plan. 6. Receipts for all purchases must be included in the participant's electronic case record (ECR). Attach all receipts/bids to the Packet Cover Sheet: Social Services Packet Cover Sheet (DSHS Form 02-615)
When do I authorize this service?	When an ALTSA client meets these qualifications: 1. Received a housing resource or had their housing coordinated through ALTSA; **or** 2. Enrolled with FCS Supported Employment or had their employment coordinated through ALTSA; **and** 3. Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to your own home, or are living in the community and need stabilization services to remain there; **and** 4. Do not have other programs, services, or resources to assist you with these costs; **and** 5. Are not eligible for federal funding
Are ETRs allowed for state H&ES?	**Yes.** 1. An ETR will be required if the total amount of goods & services exceeds $5000. 2. Select "other" for both ETR/ETP category & type. 3. Submit the ETR to "Committee, Housing ETR" and email housingcommitteeetr@dshs.wa.gov to inform us about the ETR requested. 4. Note: If the amount Exceeds $2500, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Emergency Rental Assistance SA298

Emergency Rental Assistance (ERA) can be used as a one-time payment made directly to landlords on behalf of an ALTSA client who is facing an immediate eviction due to non-payment of rent. As part of the assistance request, clients must demonstrate they are able to pay their rent going forward and maintain their independent housing as a part of being stabilized in their community setting. This resource should only be requested when there are no other community options to meet the need fully or partially.	
Who is eligible for state ERA?	1. An ALTSA client who is facing an immediate eviction due to non-payment of rent.
What is covered under state ERA?	1. A one-time payment made directly to landlords on behalf of an ALTSA client who is facing an immediate eviction due to non-payment of rent.
What is not covered under state ERA?	1. ERA does not include pre-tenancy deposits or move-in costs, including first month's rent, required at move in. ERA cannot pay in excess of 150% Fair Market Rent per month and can only pay for a total of six months back rent.
When do I need a provider contract?	1. The HCS/AAA case manager will need to authorize a Contracted Provider (Community Choice Guide or GOSH Supportive Housing Provider) to make the ERA payment on the clients' behalf.
How do I authorize state ERA	1. Use RAC 3131. 2. Use Service Code SA298 to reimburse the contracted provider for the ERA payment amount approved by the HPM.
When do I authorize this service?	1. ERA should only be authorized after an ERA referral has been submitted and approved by the Supportive Housing Program Manager. The HCS/AAA is only allowed to authorize the amount approved by the SHPM.
Are ETRs allowed for the state ERA?	**No.** 1. note: When the approved ERA amount is above $4000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Related WACs:

WAC 388-106-0270: What services are available under Community First Choice (CFC)?

WAC 388-106-0030: Where can I receive services?

WAC 388-106: Long Term Care Services

WAC 388-106-1700 to WAC 388-106-1765: Supportive Housing

Acronyms:

HPM: Housing Program Manager	**LTSS: Long-Term Services and Supports**
CCG: Community Choice Guide	**SHA: Spokane Housing Authority**
PBV: Project Based Voucher	**AMI: Area Median Income**

Forms:

Video: Options for Housing Through Long-Term Care Services

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
5/2020		Established	
8/2020		Added Chapter Section hyperlinks, Section 5B.6 GOSH and link to Supportive Housing WACs	
10/2020		Updated GOSH Pre-Tenancy service code and provided clarification around SHPM vs CM responsibility in "GOSH Client Accepted" section. Added Housing Team contacts under section 5b.11. In section 5b.4 added instruction on how to document ALTSA subsidy into CARE and Bridge file transition information. Added *Forms* to section 5b.11 including (2) new forms: ALTSA Bridge Referral and Bridge Referral and Application Process.	
2/2021		Added SA294 subsidy payment authorization information to section 5B.4. Moved GOSH Section from 5B.6 to 5B.5. Added clarification that there is no participation for Supportive Housing services. Added GOSH "Discharge Planning" and "Transition to	

		Independent Housing" sections to 5B.5. Updated hyperlinks.	
5/2021		Deleted SA294 payment authorization process for P1. Added the need for CM support with quarterly Bridge tenancy verifications as well as annual re-certifications. Clarified steps to add "Housing subsidy (HCS/AAA)" and "Supportive Housing (HCS/AAA)" as Treatments on the Medical Screen in CARE. Added new procedure for referring to GOSH, hyperlinked to new DSHS 11-153 GOSH Referral form. Clarified GOSH eligibility and HCS and AAA CMs can refer. Clarified GOSH authorization responsibility. Hyperlinked to Chapter 30d to connect Supportive Housing service consults and consideration. Clarified on-going eligibility for GOSH clients regarding services and subsidy. Hyperlinked to Chapter 30d in the 'How can I use CTS/CTSS/WA Roads section'. Updated PM Roles.	
8/2021		Added new staff contacts for all regions by way of link to RCL Housing Resources website. Updated Bridge Referral form, Participant Agreement and Referral and Application Process form. Added updated ERA form. Updated 811 ALTSA HPM role regarding DDA/DBHR referrals. Added expanded GOSH eligibility criteria.	
2/2022		Updated various links throughout the chapter. Updated ALTSA Subsidy P&P inserted Document. Updated Participant Agreement inserted document. Added *What is needed to transfer an ALTSA subsidy client from HCS to the AAA?* Section. Updated GOSH section to add protocol to staff cases with SHPM prior to closing a GOSH client and protocol related to clients with short term institutional stays (e.g., re-hospitalization or jail).	
8/2022		Added RVP eligibility and availability. Update ERA with Hotel/Motel stay information and Process. Update link to ERA form. Add info from Chapter 5a regarding WA Roads and eligibility from ALTSA housing resources. Updated language around HCS to AAA case transfers and Annual Assessments for GOSH. Added some hyperlinks into the GOSH Section to animated YouTube Videos: What is the Governor's Opportunity for Supportive Housing?; You've Been Referred to GOSH – Now What?; Governor's Opportunity for Supportive Housing (GOSH): Good Discharge Planning	
11/2022		Added more detailed payment/authorization information for ERA SA298. Added in section from Chapter 5a on how to work with individuals on ALTSA Housing Resources who are not currently receiving	

		LTSS. Added language on keeping GOSH participants open who are in jail or institutional stays into the Interim Setting section. General text/grammar corrections throughout document. Added Bellingham/Whatcom and Spokane RVP resource.	
2/2023		Updated Unit Manager titles. Updated "NED" section to "permanent HUD voucher" section and added more process details. Updated Chapter Section list to include new 5b.5. Updated 811 sections with more details regarding application process. Removed old versions of forms and added updated versions (Participant Agreement, Tips for Maintaining LTSS, Chapter Version ALTSA Subsidy P&P and Bridge referral). Added page numbers to footer. Added links to Brochures and Video.	
5/2023		ALTSA subsidy video link. Updates to Section 5b.5. Updated ERA form.	
8/2023		Updated information in the ALTSA Subsidy and GOSH sections related to CARE Changes. Clarified language related to ineligibility for permanent HUD vouchers.	
11/2023		Updated Emergency Rental Assistance Form. Clarified language and updated language in section 5b.5 "Working with individuals on ALTSA housing resources who are not currently receiving ALTSA LTSS". Updated GOSH Section to include new regional referral email addresses.	
1/2024		Chapter Links added and updated ERA form added	
2/2024		Added a green box in pages 14 & 24 & 29 & 34 with a process for possible no longer functionally eligible ALTSA clients who are already enrolled in a housing service. Added on page 33 & 34 Motel Interim Stay for Transitions (MIST) program description. Added MIST to Table of contents Page 2. Replaced Washington Roads RAC info in pages 17 & 21 & 29 with new info (RAC 3131- LTSS Housing Stabilization). Added on page 17 (1 d. and the HCS/AAA CM will extend the WA Roads RAC) & (2 i. GOSH Program Manager will end the GOSH authorization and end RAC 3131- LTSS Housing Stabilization, and HCS/AAA CM will end the WA Roads RAC). Removed from page 30 & 31 under reimbursements "while the Supportive Housing services are authorized by SHPM under the service code SA299,U1 the CM would authorize use of any CFC	

		CTS/CTSS/WA Roads funds under a separate service code, dependent upon eligibility and funds used."	
3/27/2024		Updated Bridge documents at bottom of document with most recent versions. Page 11 &12 amended for ALTSA Bridge Subsidy.	
5/7/2024		Removed Motel/Hotel language from ERA section. Corrected MIST referral email address. Added MIST Request Form. Added bullet on Civil Transition eligibility.	
6/17/2024		Added ERA email address. Updated ERA referral process. Removed "How do I make a referral for a client who I believe is eligible for ERA?" Updated MIST eligibility criteria (Bridge Subsidy, GOSH program, Civil Transitions Program, Other Housing Resource, In-Home Short-Term Displacement, & Limited Residential). Updated MIST referral Process outline. Updated & added "How is payment made for MIST?" process/procedure. Updated MIST Referral Form.	
9/3/2024		Added information regarding Bridge Subsidy waitlist, added information regarding Presumptive Eligibility, added policy information from chapter 9 regarding GOSH client unable to return to residential setting and being admitted to the hospital. Added policy information regarding if a client is incarcerated or hospitalized and how ALTSA pays the subsidy for up to 6 months. Added Stephen Miller contact info. Added Housing and Employment website, updated links to one pager. Updated table of contents to include Presumptive Eligibility. Added Global Leasing info. Updated GOSH eligibility criteria.	
10/2024	**JOANA**	Chapter 5b changed to Chapter 6. Chapter 6 Established	
11/2024	joana	Added information regarding the ALTSA Acute Care Hospital Subsidy, and the referral/process and referral.	
01/2025	joana	Edited information regarding the ALTSA Acute Care Hospital Subsidy	
04/2025	joana	Chapter 6 was divided up into 4 sections and renamed. Chapter 6C- Permanent Federal Vouchers established. Update policy & procedure regarding Housing and Employment Stabilization Services when using with clients who have been inactivated from LTSS. Updated OHAE background and EDAI statement. Added a chart	

		describing all the RACs and Service Codes associated with OHAE.	

Housing & Service Coordination

Chapter 6D provides guidance on working with clients experiencing homelessness, documenting housing resources in CARE, and effectively pairing Long-Term Services and Supports (LTSS) with housing assistance. This chapter outlines when the LTSS RAC can be used to authorize Goods & Services for clients accessing housing resources through ALTSA. Additionally, it covers best practices for integrating supportive services with housing solutions and highlights community-based housing resources that can further assist clients in achieving long-term stability.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Jonnie Matson — Rental Assistance Unit Manager
360.628.0183 jonnie.matson2@dshs.wa.gov

Whitney Joy Howard — Housing Integration Unit Manager
360.791.2358 whitney.howard@dshs.wa.gov

Stephen Miller — Supportive Housing Unit Manager
564.200.3510 stephen.miller@dshs.wa.gov

For additional information please visit our website: Office of Housing and Employment

TABLE OF CONTENTS

BACKGROUND

The ALTSA Office of Housing and Employment (OHAE) is dedicated to offering housing and supported employment resources that honor client choice. We work to eliminate barriers and expand opportunities that align with an individual's vision for their life regardless of mental health, substance use disorder, race, language, age, ability, or other status.

OHAE brings together federal, state, and local resources to create opportunities and strategies to help clients access independent housing, and in collaboration with our community partners, help build an individualized array of services to support them. This chapter provides specific guidance around Housing and Urban Development (HUD)permanent federal vouchers and can help you refer clients who are eligible for them.

Whenever possible, we can offer guidance about difficult housing situations you might encounter with your client, including tips about working with clients experiencing homelessness. Affordable housing and tenancy support are complex topics that often do not have easy or quick solutions. Please let us know about other topics or obstacles you would like the see addressed in this chapter.

GUIDANCE ON WORKING WITH CLIENTS WHO ARE HOMELESS

The following information will assist case management staff in determining options for working with clients who are eligible for Long Term Services and Supports (LTSS) and are currently homeless or facing housing instability.

May a client receive personal care or other LTSS in a shelter, RV or other location that is outside the typical in-home setting?

Yes, *in-home* refers to settings other than institutional or licensed residential and does not require that a person reside in a house or apartment. LTSS may be provided in an alternative setting when there is a provider available to meet the client's request. If you have questions, please consult with your HPM.

WAC 388-106-0270: What services are available under community first choice (CFC)?

WAC 388-106-0030: Where can I receive services?

The Challenging Cases Protocol can also be used, and is often necessary, when working with clients who are experiencing homelessness.

What can I do when I have assessed a client who is homeless and there are no possible in-home locations to provide personal care?

- Look into eligibility for Foundational Community Supports (FCS) - Supportive Housing (SH) or GOSH
- Consider eligibility for FCS-Supported Employment
- If the client has access to any housing opportunities and is not FCS-SH eligible, consider referring the client to Community Supports Transition Services, COPES or LTSS Housing Stabilization to work with a Community Choice Guide to find housing
- If the client has behavioral challenges that are affecting the establishment of LTSS, consider making a Behavioral Supports H2019 (Chapter 5a) referral
- If a client is initially declining personal care services, it is allowable to use the COPES Wellness Newsletter to keep a client open while working on a different Care Plan
- Before closing a case for a client who is homeless but open to accepting services, consult the Challenging Cases Protocol and consider contacting your regional HPM to see if they are aware of any resources that may be available
- Also see section 5.B9 for Community Resources for Housing

How do I document working with a client who is experiencing homelessness and declines all services?

Some clients experiencing homelessness go through the ALTSA assessment process multiple times as referrals for an intake are made by community providers (hospitals, shelters, etc.). It is important to document through a SER the reason the client is declining services, and the strategies used to engage the client in accepting services or locating a reasonable setting for the client to receive those services. It is also important to list any information given by collateral contacts so that the information can be referred to in future contacts with the client.

DOCUMENTING ALTSA HOUSING RESOURCES IN CARE

What are the changes or additions I need to make in CARE when I refer a client to an ALTSA housing resource?

It is important to document that your client will be receiving an ALTSA housing resource so that if/when the case transitions, the information can be communicated to the new case manager. When a client has been offered an ALTSA housing resource, the following additions can be made in CARE:

All SERs regarding housing should be entered using the ***Housing*** **purpose code**.

For clients utilizing the ALTSA Subsidy, the HCS CM must enter the following into the CARE assessment:

- Add "Housing subsidy (HCS/AAA)" as a Treatment for ALTSA Bridge and ALTSA GOSH subsidy recipients
  - On the Medical Screen in CARE, choose the Program "Housing Subsidy (HCS/AAA)"
  - Check "No" for Received in the Last 14 days?
  - Check "Yes" for Need
  - Choose "Agency" for the Provider
  - Choose "PRN" for Frequency
  - For Comments, type: "*Client will be receiving the ALTSA Housing Subsidy administered by Spokane Housing Authority."*
- Add Spokane Housing Authority as a Paid Provider in the Care Planning section under the Supports Screen and assign the provider the task of "Housing subsidy (HCS/AAA)"

For clients utilizing a **NED voucher or 811 unit**, the CM must:

- Adding or updating the Housing Program Manager in the collateral contact screen.

For clients utilizing **Foundational Community Supports or GOSH Supportive Housing**, the CM must:

- Add Supportive Housing (HCS/AAA) as a Treatment in the Medical Screen and in the Care Planning section, and under supports assign the authorized Supportive Housing Provider the task of Supportive Housing (HCS/AAA) and Other (for Community Transition Services).

WHEN TO USE HOUSING & EMPLOYMENT STABILIZATION SERVICES

For ALTSA clients who have received a housing resource or had their housing coordinated through ALTSA **and** are only eligible for state funding, the HCS/AAA case manager will authorize Housing & Employment Stabilization services under RAC 3131- LTSS Housing Stabilization.

1. Use Service Code SA294,U4 (Housing Subsidy-Purchasing) to authorize the necessary goods and services (background screening to aid housing search, paying for rental deposit and first month's rent, utility hookup fees, purchase of furniture, purchase of essential items including needed clothing, or/and assistive technology) needed to transition or/and stabilize the client safely back to the community. Please note, an ETR will be required if the total amount of goods & services exceeds $5000.
2. Select the appropriate reason code. Options are "In-Home Community Stabilization or Employment Stabilization"
3. When submitting an ETR, select "other" for both ETR/ETP category & type.
4. Submit the ETR for approval/denial to "Committee, Housing ETR" and email housingcommitteeetr@dshs.wa.gov to inform us about the ETR request.
5. Note in the Service Episode Record (SER) that the client is eligible for Housing & Employment Stabilization services and that you have Supervisory approval to authorize state only funds.

6. Complete a SER outlining the service you are authorizing and/or the items you are purchasing and how they are necessary for the client's service plan.
7. Receipts for all purchases must be included in the participant's electronic case record (ECR). Attach all receipts/bids to the Packet Cover Sheet: Social Services Packet Cover Sheet (DSHS Form 02-615)

PAIRING SERVICES WITH HOUSING RESOURCES

Whether a client is using an ALTSA Housing Resource or a community housing resource, they may need Community Transition and/or Stabilization supports and/or services to be able to access or maintain housing. When a client has an opportunity to utilize a subsidy, or move into other affordable housing, these services and supports can be utilized. The following resources may be used to facilitate the moving process with the client. These resources can also be used to stabilize and sustain housing for a client to prevent a loss of affordable housing.

How can I use Supportive Housing services to assist my client with a housing resource?

Supportive Housing services are available in two ways for ALTSA recipients:

- Individuals who are currently residing in the community may be eligible for Supportive Housing services under "Healthier Washington Medicaid Transformation: Foundational Community Supports (FCS): Supportive Housing services."
- Individuals with challenging or complex needs who are currently residing at Eastern or Western State Hospital or can be diverted from these institutions may access Supportive Housing Services through the Governor's Opportunity for Supportive Housing (GOSH). For more information on GOSH, please see Section 6.6.

Supportive Housing is a housing support service that can serve a client in assisting with pre-and-post tenancy tasks. The service is intended to support a client for as long as they need and want the service.

Supportive Housing services may be an option for individuals who want to live independently and have a history of unsuccessful housing episodes without coordinated, focused support services. ALTSA seeks to provide person-centered, responsive, low-barrier services for these individuals.

To learn more about the full spectrum of services that FCS Supportive Housing can provide, and the eligibility criteria and referral process for these services, please see Chapter 30d.

How do I use Community Transition Services (CTS) or Housing & Employment Stabilization services to assist my client with a housing resource?

Clients may access ALTSA CTS and H&ES, depending on their eligibility criteria. To determine which services to use, please see the corresponding LTC Manual Chapters:

- Community Transition Services (CTS) through Community First Choice, see Chapter 7b.
- Community Transition Services (CTS) through COPES, see Chapter 7d.
- Housing & Employment Stabilization Services through RAC 3131- LTSS Housing Stabilization is for clients that are only eligible for state funding and have an ALTSA subsidy. All goods and services can be authorized using service code SA294,U4.
- To find out more about working with Community Choice Guides or Supportive Housing Providers to provide Community Transition or Sustainability Services for clients, please see the Community Choice Guides and FCS-SH Providers section of LTC Manual Chapter 30d: Foundational Community Supports – Supportive Housing Services.

Please note that individuals who are receiving an ALTSA Housing Resource are immediately eligible for Housing & Employment Stabilization Services and the goods and services it provides.

All clients receiving an ALTSA Housing Resource (NED, 811, ALTSA Subsidy) have access to transition/stabilization services through the duration of their subsidy. Clients can access CTS/Housing & Employment Stabilization Services repeatedly for housing transition or stabilization needs. Regardless of the program through which your client can receive the transition/stabilization services, the goal of supporting clients in accessing and maintaining housing is the same. Pairing services and supports with a housing resource can provide the client a highly successful community transition and contribute to the person's housing stabilization.

*__Please note__: Community First Choice and COPES services are always the priority programs for transition services. Housing & Employment Stabilization Services, in contrast, need supervisor approval because the services are paid for using state-only funding and may only be used when a waiver/state plan service does not address the client's need. The links above to Chapters 7b, & 7d provide details on what the supports and services are, but here are a few case scenarios to help you understand how you could use the resources and services:

Scenario 1:
Doug lives in a subsidized apartment for seniors and received an eviction notice for non-payment of rent. This is the 3rd time recently that Doug has called for help with the same issue, but all the other times he was able to access a different community resource for help. This time, he has been turned down and needs $168 to pay his portion of the rent, or he will be evicted. Doug admits to having problems with his neighbors and feels like his landlord does not like him. Doug is also having a hard time keeping caregivers, and the last agency he was with has recently said they can no longer serve him.
How can CTS/Housing & Employment Stabilization Services?

- Emergency Rental Assistance can be used to pay the $168 and prevent eviction. A CCG is used to make the payment directly to the landlord.
- Since there is a history of not paying his portion of the rent, and also some other tenancy issues with neighbors and the landlord, consider making a Foundational Community Supports - Supportive Housing referral (see Chapter 30d for eligibility criteria). A Supportive Housing provider could assist Doug with his longer-term housing stabilization needs as well as assist him with budgeting and possibly recommending a Payee and/or other community resources. A Supportive Housing provider may also be able to support Doug in caregiver retention strategies.

Scenario 2:
Louise has been rehabilitating in a SNF for the past year and is ready to transition into a community setting with in-home services. Louise lost her past housing due to a family situation and does not have a home to transition to. Louise meets the eligibility criteria for category 2 NED and has been offered an available voucher. Louise cannot remember the last time she held a lease in her name but does have some household items stored along with her personal belongings at a friend's house. Since Louise has been in the SNF, she has not received any of her monthly Supplemental Security Income and does not have any money saved, nor anyone with funds that can assist her. However, Louise knows that her friend will help her move her belongings and may be able to help her with some household furnishings. Louise does not have any other friends or family that can help her with paperwork or looking for an apartment and she feels overwhelmed at the idea of managing this transition on her own. Louise also admits that she does not know where her identification is.
How can CTS/Housing & Employment Stabilization Services?

- Louise can be referred to work with a Community Choice Guide (CCG), who can help her complete the NED2 application packet and gather the supporting documentation. The CCG can also assist her with obtaining a new identification card, including paying the fee*. Since Louise cannot remember her housing history and in order to prepare for the housing search, the CCG can also assist her in obtaining a Tenancy Background Screening and pay for that fee as well.
- The CCG can also assist Louise with her housing search by finding apartments and taking her to view them. Once Louise has found a unit that suits her, the CCG can assist her with the apartment application and pay the processing fee to the landlord. Once approved, the CCG can also pay the deposit and pro-rated 1st month's rent so the client can sign the lease and get a move-in date. With her move-in date established, the CCG can also assist Louise with setting up her electricity account and paying her required $100 utility deposit since Louise has never had an account in her name.
- Louise was able to go through her stored items and she feels she has most things she needs to live independently. Her friend is helping her with a bed and dresser as well. The only basic items that Louise is missing are a lamp, bath towels and cookware. Upon CM authorization, the CCG can purchase these items for the client.
- Since Louise has not lived independently for some time, the CCG can also be tasked with helping her to create a monthly budget, and assist her in finding community resources for assistance with food and utilities. The CCG can also assist Louise in determining what bus routes are close to her for her non-medical transportation needs.

*CCGs pay for approved items and then submit for reimbursement.

CAN A CIVIL TRANSITIONS PROGRAM RECIPIENT ACCESS A HOUSING RESOURCE THROUGH ALTSA

The Civil Transitions Program relates to individuals deemed by the court not competent to stand trial and not restorable due to a diagnosis of dementia, traumatic brain injury (TBI), or an intellectual or development disability (IDD).

Eligibility Criteria:

A Civil Transitions Program recipient that is referred for a housing resources, are eligible to access a housing resource without having to be functionally, or/and financially eligible for LTSS.

Which housing resources can a Civil Transitions Program Recipients Access:

They can access the following resources:

- Motel Interim Stay for Transitions (See chapter 6B)
- Housing and Employment Stabilization Services (See chapter 6D)
- Supportive Housing Services (see chapter 6A)

COMMUNITY RESOURCES FOR HOUSING

There are other community resources for housing that may be available to your client. The Roads to Community Living internet site contains regional information for community housing resources.

Additional Housing Resources are available for clients. Please visit Housing Openings to learn about waitlist openings for Project Based/ Mainstream/Housing Choice Vouchers.

RESOURCES

Housing Team Contacts can be found on the **RCL Housing Resources Website.**

Office of Housing and Employment website: Office of Housing and Employment

Brochures and Videos

ALTSA Housing Resources

Federal Vouchers One-Pager

811 Units One-Pager

LTSS One-Pager

Global Leasing One-Pager

Civil Transitions Program One-Pager

Zero Income One-Pager

Income Discrimination Flyer Income Discrimination Flyer Tenants: New Legal Protection from Discrimination Based on Source of Income

ALTSA Bridge Subsidy Brochure Governor's Opportunity for Supportive Housing One-Pager

MIST Field One-Pager

Video: Options for Housing Through Long-Term Care Services

	FUND	LIMIT	SERVICE CODES	SUBJECT TO ETR	
FEDERAL	**Roads to Community Living (RCL)**	$10000	Goods: SA296	✓	***See LTC Chapter 7***
	Community Transition Services	$2500		✓	
	COPES	$1700	Services: SA297	✓	
If Client is not eligible for one of the programs above, see the following:					
STATE	**Housing & Employment Stabilization Services**	$5000	Goods & Services: SA294,U4	✓	***See LTC Chapter 6***

Housing Resource Chart:

RAC 3132: Health Related Social Needs - Federal

Motel Interim Stay for Transitions (MIST) SA294u1

Motel Interim Stay for Transitions (MIST): is a service to pay for a short-term motel/hotel stay offered to minimize the number of clients who discharge to and/or experience episodes of homelessness. MIST aims to minimize the time it takes to get vital LTSS in place and increase the client's chances of ending up on services in their own home. The service is authorized for up to a 6-month period at a time. Federal MIST is funded via the 1115 waiver in which the Washington State Health Related Social Needs Services Program (HRSN) will allow Medicaid enrollees to receive evidence-based, non-medical services to address an individual's unmet, adverse social conditions that contribute to poor health. This includes temporary housing.

Who is eligible for federal MIST?	HCS/AAA clients who are receiving Medicaid long-term services who have one of the following qualifications: 1. **ALTSA Subsidy (Bridge & Acute Care Hospital)** • Bridge Subsidy: ALTSA clients who have a Bridge voucher issued and are working with an authorized contracted provider on an independent housing search. • Acute Hospital Care (ACH) Subsidy: ALTSA clients transitioning from an Acute Care Hospital (ACH) setting, when housing is a barrier. 2. **GOSH Program:** ALTSA clients who are enrolled in the Governor's Opportunity for Supportive Housing (GOSH) and are at risk of or experiencing homelessness. 3. **Other Housing Resource:** • ALTSA clients who will be living independently and currently have a resource from a housing agency or program. Examples might include Mainstream, NED, Housing Choice, Apple Health & Homes, HEN, HOPWA, VA, etc. • ALTSA clients who have been approved for a project-based resource and have a move-in-date. Examples might include Tax Credit units, 811 units, or Permanent Supportive Housing Unit from homeless service agency. 4. **In-Home Short-Term Displacement:** ALTSA clients who have their own home **and** a short-term situation that requires them to temporarily vacate. Ex: Pest control or eradication, fire, or flooding. 5. **Experiencing Homelessness:** ALTSA clients experiencing homelessness. Ex: staying in a car, park, abandoned building, tent, shelter, or couch surfing.
What is covered under MIST 294u1?	1. Payment for up to 6-month period for a Medicaid ALTSA client to stay at a motel/hotel. 2. Damages upon HQ approval- Please contact Supportive Housing Program Manager
What is not covered under MIST 294u1?	1. Deposits
How much can I spend?	1. Up to $4000 per month for a total of six months. • Note: not to exceed six months
Do I need to use a contracted provider?	**Yes.**

	1. The HCS/AAA CM will need to coordinate with the Contracted Provider and notify them that the client has been authorized for Motel Interim Stay for Transitions for a period of up to 6 months. 2. The Contracted Provider should be authorized for the duration of the MIST authorization period. 3. The Contracted Provider should make periodic visits to the client to provide support and assist in a housing search, as needed. *This might change if SHA takes this on...*
How do I authorize federal MIST?	1. Upon receiving approval for MIST, the HCS/AAA CM should open RAC 3132. 2. Use Service Code SA294,U1 to reimburse the contracted provider for the expenses incurred. 3. HCS/AAA CM will reimburse contracted provider on a two-week timeline for a period of up to six months. **Note: do not submit authorization to ProviderOne until receipt/s have been received.**
When do I authorize this service?	1. MIST should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager and a hotel/motel have been found.
Are ETRs allowed for federal MIST?	**No.** 1. When the approved MIST amount is above $2000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Emergency Rental Assistance SA298

Emergency Rental Assistance (ERA) can be used as a one-time payment made directly to landlords on behalf of an ALTSA client who is facing an immediate eviction due to non-payment of rent. As part of the assistance request, clients must demonstrate they are able to pay their rent going forward and maintain their independent housing as a part of being stabilized in their community setting. This resource should only be requested when there are no other community options to meet the need fully or partially.
Federal Emergency Rental Assistance is funded via the 1115 waiver, in which the Washington State Health Related Social Needs Services Program (HRSN) will allow Medicaid enrollees to receive evidence-based, non-medical services to address an individual's unmet, adverse social conditions that contribute to poor health. These includes rent.

Who is eligible for federal ERA?	1. An ALTSA client who is experiencing or at risk of experiencing homelessness, including facing an immediate eviction due to non-payment of rent.
What is covered under federal ERA?	1. A one-time payment made directly to landlords on behalf of an ALTSA client who is facing an immediate eviction due to non-payment of rent.
What is not covered under federal ERA?	1. ERA does not include pre-tenancy deposits or move-in costs required at move in. ERA cannot pay in excess of 150% Fair Market Rent per month and can only pay for a total of six months back rent.
When do I need a provider contract?	1. The HCS/AAA case manager will need to authorize a Contracted Provider (Community Choice Guide or GOSH Supportive Housing Provider) to make the ERA payment on the clients' behalf. *Could change dependent on SHA.*
How do I authorize federal ERA	1. Use RAC 3132. 2. Use Service Code SA298 to reimburse the contracted provider for the ERA payment amount approved by the HPM.
When do I authorize this service?	1. ERA should only be authorized after an ERA referral has been submitted and approved by the Housing Program Manager.
Are ETRs allowed for the federal ERA?	**No.** 1. note: When the approved ERA amount is above $4000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

RAC 3131: Long-Term Services and Supports Housing Stabilization – State Funds

Governor's Opportunity for Supportive Housing (GOSH) Pre-Tenancy SA299u1

Governor's Opportunity for Supportive Housing (GOSH) Pre-Tenancy	
Who is eligible for GOSH?	HCS/AAA clients who are receiving Medicaid long-term services who: are choosing In-Home setting and: 1. are willing to work with a Supportive Housing Provider, **and** 2. qualify for ALTSA services (financially & functionally eligible), **and** 3. are discharging or being diverted from Eastern or Western State Hospitals,

	4. An individual with a 90- or 180-day commitment order for further involuntary treatment who is discharging from a local community psychiatric facility into Home and Community Services Long-Term Services and Supports (HCS LTSS); or an individual who is detained through the Involuntary Treatment Act who is stabilized and discharged into HCS LTSS prior to the need to petition for a 90- or 180-day commitment order. 5. ALTSA clients who are currently living in a residential setting who transitioned or were diverted from Western/Eastern State Hospital within the past 18 months, as documented in CARE and counted by SHDD team, and wish to live independently.
What is covered under GOSH SA299u1?	Services that support an individual's ability to prepare for and transition to housing, including direct and collateral services: 1. Screening and housing assessment for individuals' preferences and barriers. 2. Developing an individual housing support plan: identifying goals, addressing barriers, establishing approaches to meet goals, including identifying available services and resources. 3. Assisting with eligibility determination, housing applications, subsidy applications, and housing searches. 4. Identifying resources for modifications and/or one-time move-in needs. 5. Assisting in arranging for and supporting details of moving into housing. 6. Training on roles, responsibilities, and rights of tenant and landlord. 7. Developing housing support crisis plan. 8. Maintaining participant and collateral contacts, and timely completion of supportive housing deliverables as outlined in 'Service Standards for Providers'.
What is not covered under GOSH SA299u1?	1. Rent 2. Move-in-costs 3. Utilities
How much can I spend?	1. 160 units per month
Do I need to use a contracted provider?	**Yes.** 1. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.

How do I authorize GOSH SA299u1?	Once the referral has been accepted by the SHPM: 1. The SHPM will open RAC 3131 – LTSS Housing Stabilization and then the pre-tenancy Supportive Housing service code, SA299-U1, to open the SH authorization in CARE. 2. It is the SHPM's responsibility to open, extend and close authorizations for service code SA299, U1.
When do I authorize this service?	1. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.
Are ETRs allowed for GOSH SA299u1?	**No.**
What about SA299,U1 for Civil Transitions Program?	1. Supportive Housing services are available through GOSH for those who meet Civil Transition Program eligibility (see Chapter 9b). 2. For clients meeting Civil Transition Program (CTP) eligibility only, use the appropriate CTP RAC and then authorize SA299u1 with the Reason Code "Civil Transitions Program". 3. If a Civil Transition Program client ends up eligible for LTSS: • End CTP RAC • End SA299,u1 authorization, then: • Open RAC 3131 LTSS Housing Stabilization • Open SA299u1 and use Reason Code " 5440 FEFE", which stands for 5440 Functionally Eligible Financially Eligible.

Governor's Opportunity for Supportive Housing (GOSH) Tenancy H0044

Governor's Opportunity for Supportive Housing (GOSH) Tenancy	
Who is eligible for GOSH?	1. HCS/AAA clients who are receiving Medicaid long-term services who: are choosing In-Home setting and: 2. are willing to work with a Supportive Housing Provider, and 3. qualify for ALTSA services (financially & functionally eligible), and 4. are discharging or being diverted from Eastern or Western State Hospitals, 5. An individual with a 90- or 180-day commitment order for further involuntary treatment who is discharging from a local community psychiatric facility into Home and Community Services Long-Term Services and Supports (HCS LTSS); or an individual who is detained through the Involuntary Treatment Act who is stabilized and discharged into HCS LTSS prior to the need to petition for a 90- or 180-day commitment order. 6. ALTSA clients who are currently living in a residential setting who transitioned or were diverted from Western/Eastern State Hospital

	within the past 18 months, as documented in CARE and counted by SHDD team, and wish to live independently.
What is covered under GOSH H0044?	Services to support individuals to maintain tenancy once housing is secured, such as: 1. Early intervention for behaviors that might jeopardize housing, e.g., late rent payment, lease violations, etc. 2. Training on responsibilities and rights of tenant and landlord. 3. Coaching on relationship building with landlords, property managers, and neighbors, and assisting in dispute resolution. 4. Linking with community resources to prevent eviction
What is not covered under GOSH H0044?	1. Rent 2. Move-in-costs 3. Utilities
How much can I spend?	1. 1 unit per month (rate $575)
Do I need to use a contracted provider?	**Yes.** 1. After a referral has been submitted and approved for GOSH Services, the SHPM will contract a GOSH SHP to work with the client.
How do I authorize GOSH H0044?	Once the client has moved into their own apartment: 1. The SHPM will ensure RAC 3131 – LTSS Housing Stabilization's end date matches the CARE Plan end date. 2. The SHPM will close pre-tenancy service code SA299, U1, and open tenancy service code H0044. 3. It is the responsibility of the SHPM to close the authorization for SA299, U1 and open an authorization for H0044. 4. The SHPM will update the tenancy service code, H0044, on an annual basis. If there are any concerns around client eligibility, staff with the SHPM.
When do I authorize this service?	GOSH Services should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager. Once the client has moved into their own apartment: 1. The SHPM will ensure RAC 3131 – LTSS Housing Stabilization's end date matches the CARE Plan end date. 2. The SHPM will close pre-tenancy service code SA299, U1, and open tenancy service code H0044. Please note, the date when the tenancy service code, H0044, is opened will vary based on the terms of the SHP's contract:

Are ETRs allowed for GOSH H0044?	No.
What about H0044 FOR Civil Transitions program?	1. H0044 should not be used for a client only eligible for the Civil Transition Program. 2. If a Supportive Housing client who was originally Civil Transition Program client ended up eligible for LTSS and secures housing use Reason Code "5440 FEFE", which stands for 5440 Functionally Eligible Financially Eligible.

Motel Interim Stay for Transitions (MIST) SA294u2

Motel Interim Stay for Transitions (MIST): is a service to pay for a short-term motel/hotel stay offered to minimize the number of clients who discharge to and/or experience episodes of homelessness. MIST aims to minimize the time it takes to get vital LTSS in place and increase the client's chances of ending up on services in their own home. The service is authorized for up to a 6-month period at a time	
Who is eligible for state MIST?	HCS/AAA clients who are receiving Medicaid long-term services who have one of the following qualifications: 1. **ALTSA Subsidy (Bridge & Acute Care Hospital)** • Bridge Subsidy: ALTSA clients who have a Bridge voucher issued and are working with an authorized contracted provider on an independent housing search. • Acute Hospital Care (ACH) Subsidy: ALTSA clients transitioning from an Acute Care Hospital (ACH) setting, when housing is a barrier. 2. **GOSH Program:** ALTSA clients who are enrolled in the Governor's Opportunity for Supportive Housing (GOSH) and are at risk of or experiencing homelessness. 3. **Other Housing Resource:** • ALTSA clients who will be living independently and currently have a resource from a housing agency or program. Examples might include Mainstream, NED, Housing Choice, Apple Health & Homes, HEN, HOPWA, VA, etc. • ALTSA clients who have been approved for a project-based resource and have a move-in-date. Examples might include Tax Credit units, 811 units, or Permanent Supportive Housing Unit from homeless service agency. 4. **In-Home Short-Term Displacement:** ALTSA clients who have their own home **and** a short-term situation that requires them to temporarily vacate. Ex: Pest control or eradication, fire, or flooding.

	5. **Experiencing Homelessness:** ALTSA clients experiencing homelessness. Ex: staying in a car, park, abandoned building, tent, shelter, or couch surfing.
What is covered under MIST 294u2?	1. Payment for up to 6-month period for a Medicaid ALTSA client to stay at a motel/hotel. 2. Deposits 3. Damages- (Requires HQ Approval. Please contact the Supportive Housing Program Manager)
What is not covered under MIST 294u2?	1. Monthly payment that exceeds $4,000.
How much can I spend?	1. Up to $4,000 per month for a total of six months.
Do I need to use a contracted provider?	**Yes.** 1. The HCS/AAA CM will need to coordinate with the Contracted Provider and notify them that the client has been authorized for Motel Interim Stay for Transitions for a period of up to 6 months. 2. The Contracted Provider should be authorized for the duration of the MIST authorization period. 3. The Contracted Provider should make periodic visits to the client to provide support and assist in a housing search, as needed. *This might change if SHA takes this on...*
How do I authorize state MIST?	1. Upon receiving approval for MIST, the HCS/AAA CM should open RAC 3131. 2. Use Service Code SA294,U2 to reimburse the contracted provider for the expenses incurred. 3. HCS/AAA CM will reimburse contracted provider on a two-week timeline for a period of up to six months. **Note: do not submit authorization to ProviderOne until receipt/s have been received.** 4. If a client is enrolled in GOSH services, HCS/AAA CM will need to select "2017 Governors Request Supportive Housing" as the reason code. If client is not enrolled in GOSH Service, please select "No reason code needed" as the reason code.
When do I authorize this service?	1. MIST should only be authorized after a referral has been submitted and approved by the Supportive Housing Program Manager and a hotel/motel have been found.

Are ETRs allowed for state MIST?	**No.** 1. Note: When the approved MIST amount is above $2000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Housing Subsidy - Purchasing SA294u4

Housing & Employment Stabilization Services (H&ES) These state funded services are intended to fill specific gaps to provide transitional or stabilizing supports for clients, who have received a housing or Supported Employment resource or had their housing/employment coordinated through ALTSA to sustain community living.	
Who is eligible for state H&ES?	When an ALTSA client meets these qualifications: 1. Received a housing resource or had their housing coordinated through ALTSA; **or** 2. Enrolled with Supported Employment or had their employment coordinated through ALTSA; **and** 3. Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to your own home, or are living in the community and need stabilization services to remain there; **and** 4. Do not have other programs, services, or resources to assist you with these costs; **and** 5. Are not eligible for federal funding
What is covered under state H&ES?	1. First month's rent, security deposits, safety deposits 2. Utility set-up fees or deposits 3. Health and safety assurances, such as pest eradication, allergen control, or non-recurring cleaning fees prior or upon return to the home. 4. Moving services 5. Background check/application fees 6. Non-recurring rental insurance required for lease up. 7. Furniture, essential furnishings, and basic items essential for basic living outside the institution. 8. The provision of goods that increase independence or substitute for human assistance to the extent that expenditures would have been made for the human assistances, such as purchasing a microwave. 9. Cellphone 10. Household items 11. Bus pass 12. Food 13. Food Handlers card 14. Identification card

	15. Clothes (interview clothes, first set of uniforms to begin work) 16. Etc.
What is not covered under fed state H&ES?	1. recreational or diversional items such as television, cable or DVD players. 2. Assistive Technology
When do I need a provider contract?	1. A contracted provider (Community Choice Guide or GOSH SHP) will need to be authorized to complete purchases or/and payments on the behalf of the client.
How do I authorize state H&ES?	1. Open RAC 3131-LTSS Housing Stabilization 2. Use Service Code SA294,U4 to authorize the necessary goods and services. 3. Select the appropriate reason code. Options are "In-Home Community Stabilization or Employment Stabilization" 4. Note in the Service Episode Record (SER) that the client is eligible for LTSS Housing Stabilization services and that you have Supervisory approval to authorize state only funds. 5. Complete a SER outlining the service you are authorizing and/or the items you are purchasing and how they are necessary for the client's service plan. 6. Receipts for all purchases must be included in the participant's electronic case record (ECR). Attach all receipts/bids to the Packet Cover Sheet: Social Services Packet Cover Sheet (DSHS Form 02-615)
When do I authorize this service?	When an ALTSA client meets these qualifications: 1. Received a housing resource or had their housing coordinated through ALTSA; **or** 2. Enrolled with FCS Supported Employment or had their employment coordinated through ALTSA; **and** 3. Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to your own home, or are living in the community and need stabilization services to remain there; **and** 4. Do not have other programs, services, or resources to assist you with these costs; **and** 5. Are not eligible for federal funding
Are ETRs allowed for state H&ES?	**Yes.** 1. An ETR will be required if the total amount of goods & services exceeds $5000. 2. Select "other" for both ETR/ETP category & type.

	3. Submit the ETR to "Committee, Housing ETR" and email housingcommitteeetr@dshs.wa.gov to inform us about the ETR requested. 4. Note: If the amount Exceeds $2500, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Emergency Rental Assistance SA298

Emergency Rental Assistance (ERA) can be used as a one-time payment made directly to landlords on behalf of an ALTSA client who is facing an immediate eviction due to non-payment of rent. As part of the assistance request, clients must demonstrate they are able to pay their rent going forward and maintain their independent housing as a part of being stabilized in their community setting. This resource should only be requested when there are no other community options to meet the need fully or partially.	
Who is eligible for state ERA?	1. An ALTSA client who is facing an immediate eviction due to non-payment of rent.
What is covered under state ERA?	1. A one-time payment made directly to landlords on behalf of an ALTSA client who is facing an immediate eviction due to non-payment of rent.
What is not covered under state ERA?	1. ERA does not include pre-tenancy deposits or move-in costs, including first month's rent, required at move in. ERA cannot pay in excess of 150% Fair Market Rent per month and can only pay for a total of six months back rent.
When do I need a provider contract?	1. The HCS/AAA case manager will need to authorize a Contracted Provider (Community Choice Guide or GOSH Supportive Housing Provider) to make the ERA payment on the clients' behalf.
How do I authorize state ERA	1. Use RAC 3131. 2. Use Service Code SA298 to reimburse the contracted provider for the ERA payment amount approved by the HPM.
When do I authorize this service?	1. ERA should only be authorized after an ERA referral has been submitted and approved by the Supportive Housing Program Manager. The HCS/AAA is only allowed to authorize the amount approved by the SHPM.
Are ETRs allowed for the state ERA?	**No.** 1. note: When the approved ERA amount is above $4000, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Housing Program Manager to force the error.

Related WACs:

WAC 388-106-0270: What services are available under Community First Choice (CFC)?

WAC 388-106-0030: Where can I receive services?

WAC 388-106: Long Term Care Services

WAC 388-106-1700 to WAC 388-106-1765: Supportive Housing

Acronyms:

HPM: Housing Program Manager	LTSS: Long-Term Services and Supports	ERA: Emergency Rental Assistance
GOSH: Governor's Opportunity for Supportive Housing	FCS: Foundational Community Supports	SH: Supportive Housing
CCG: Community Choice Guide	SHA: Spokane Housing Authority	PHA: Public Housing Authority
PBV: Project Based Voucher	AMI: Area Median Income	FMR: Fair Market Rent

Forms:

GOSH Referral Form

Tips for Maintaining LTSS

Bridge Subsidy Process & Referral

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
5/2020		Established	
8/2020		Added Chapter Section hyperlinks, Section 5B.6 GOSH and link to Supportive Housing WACs	
10/2020		Updated GOSH Pre-Tenancy service code and provided clarification around SHPM vs CM responsibility in "GOSH Client Accepted" section. Added Housing Team	

		contacts under section 5b.11. In section 5b.4 added instruction on how to document ALTSA subsidy into CARE and Bridge file transition information. Added *Forms* to section 5b.11 including (2) new forms: ALTSA Bridge Referral and Bridge Referral and Application Process.	
2/2021		Added SA294 subsidy payment authorization information to section 5B.4. Moved GOSH Section from 5B.6 to 5B.5. Added clarification that there is no participation for Supportive Housing services. Added GOSH "Discharge Planning" and "Transition to Independent Housing" sections to 5B.5. Updated hyperlinks.	
5/2021		Deleted SA294 payment authorization process for P1. Added the need for CM support with quarterly Bridge tenancy verifications as well as annual re-certifications. Clarified steps to add "Housing subsidy (HCS/AAA)" and "Supportive Housing (HCS/AAA)" as Treatments on the Medical Screen in CARE. Added new procedure for referring to GOSH, hyperlinked to new DSHS 11-153 GOSH Referral form. Clarified GOSH eligibility and HCS and AAA CMs can refer. Clarified GOSH authorization responsibility. Hyperlinked to Chapter 30d to connect Supportive Housing service consults and consideration. Clarified on-going eligibility for GOSH clients regarding services and subsidy. Hyperlinked to Chapter 30d in the 'How can I use CTS/CTSS/WA Roads section'. Updated PM Roles.	
8/2021		Added new staff contacts for all regions by way of link to RCL Housing Resources website. Updated Bridge Referral form, Participant Agreement and Referral and Application Process form. Added updated ERA form. Updated 811 ALTSA HPM role regarding DDA/DBHR referrals. Added expanded GOSH eligibility criteria.	
2/2022		Updated various links throughout the chapter. Updated ALTSA Subsidy P&P inserted Document. Updated Participant Agreement inserted document. Added *What is needed to transfer an ALTSA subsidy client from HCS to the AAA?* Section. Updated GOSH section to add protocol to staff cases with SHPM prior to closing a GOSH client and protocol related to clients with short term institutional stays (e.g., re-hospitalization or jail).	

8/2022		Added RVP eligibility and availability. Update ERA with Hotel/Motel stay information and Process. Update link to ERA form. Add info from Chapter 5a regarding WA Roads and eligibility from ALTSA housing resources. Updated language around HCS to AAA case transfers and Annual Assessments for GOSH. Added some hyperlinks into the GOSH Section to animated YouTube Videos: What is the Governor's Opportunity for Supportive Housing?; You've Been Referred to GOSH – Now What?; Governor's Opportunity for Supportive Housing (GOSH): Good Discharge Planning	
11/2022		Added more detailed payment/authorization information for ERA SA298. Added in section from Chapter 5a on how to work with individuals on ALTSA Housing Resources who are not currently receiving LTSS. Added language on keeping GOSH participants open who are in jail or institutional stays into the Interim Setting section. General text/grammar corrections throughout document. Added Bellingham/Whatcom and Spokane RVP resource.	
2/2023		Updated Unit Manager titles. Updated "NED" section to "permanent HUD voucher" section and added more process details. Updated Chapter Section list to include new 5b.5. Updated 811 sections with more details regarding application process. Removed old versions of forms and added updated versions (Participant Agreement, Tips for Maintaining LTSS, Chapter Version ALTSA Subsidy P&P and Bridge referral). Added page numbers to footer. Added links to Brochures and Video.	
5/2023		ALTSA subsidy video link. Updates to Section 5b.5. Updated ERA form.	
8/2023		Updated information in the ALTSA Subsidy and GOSH sections related to CARE Changes. Clarified language related to ineligibility for permanent HUD vouchers.	
11/2023		Updated Emergency Rental Assistance Form. Clarified language and updated language in section 5b.5 "Working with individuals on ALTSA housing resources who are not currently receiving ALTSA LTSS". Updated GOSH Section to include new regional referral email addresses.	
1/2024		Chapter Links added and updated ERA form added	
2/2024		Added a green box in pages 14 & 24 & 29 & 34 with a process for possible no longer functionally eligible ALTSA clients who are already enrolled in a housing	

		service. Added on page 33 & 34 Motel Interim Stay for Transitions (MIST) program description. Added MIST to Table of contents Page 2. Replaced Washington Roads RAC info in pages 17 & 21 & 29 with new info (RAC 3131- LTSS Housing Stabilization). Added on page 17 (1 d. and the HCS/AAA CM will extend the WA Roads RAC) & (2 i. GOSH Program Manager will end the GOSH authorization and end RAC 3131- LTSS Housing Stabilization, and HCS/AAA CM will end the WA Roads RAC). Removed from page 30 & 31 under reimbursements "while the Supportive Housing services are authorized by SHPM under the service code SA299,U1 the CM would authorize use of any CFC CTS/CTSS/WA Roads funds under a separate service code, dependent upon eligibility and funds used."	
3/27/2024		Updated Bridge documents at bottom of document with most recent versions. Page 11 &12 amended for ALTSA Bridge Subsidy.	
5/7/2024		Removed Motel/Hotel language from ERA section. Corrected MIST referral email address. Added MIST Request Form. Added bullet on Civil Transition eligibility.	
6/17/2024		Added ERA email address. Updated ERA referral process. Removed "How do I make a referral for a client who I believe is eligible for ERA?" Updated MIST eligibility criteria (Bridge Subsidy, GOSH program, Civil Transitions Program, Other Housing Resource, In-Home Short-Term Displacement, & Limited Residential). Updated MIST referral Process outline. Updated & added "How is payment made for MIST?" process/procedure. Updated MIST Referral Form.	
9/3/2024	**JOANA**	Added information regarding Bridge Subsidy waitlist, added information regarding Presumptive Eligibility, added policy information from chapter 9 regarding GOSH client unable to return to residential setting and being admitted to the hospital. Added policy information regarding if a client is incarcerated or hospitalized and how ALTSA pays the subsidy for up to 6 months. Added Stephen Miller contact info. Added Housing and Employment website, updated links to one pager. Updated table of contents to include Presumptive Eligibility. Added Global Leasing info. Updated GOSH eligibility criteria.	
10/2024	joana	Chapter 5b changed to Chapter 6. Chapter 6 Established	

11/2024	joana	Added information regarding the ALTSA Acute Care Hospital Subsidy, and the referral/process and referral.	
01/2025	joana	Edited information regarding the ALTSA Acute Care Hospital Subsidy	
03/2025	joana	Chapter 6 was divided up into 4 sections and renamed. Chapter 6D- Housing & Service Coordination established. Update policy & procedure regarding Housing and Employment Stabilization Services. Updated OHAE background and EDAI statement. Added a chart describing all the RACs and Service Codes associated with OHAE. Added information regarding the Civil Transitions Program and relation to Housing Resources.	

Introduction to Medicaid, State Plans, and 1915c Waivers

Chapter 7 provides an overview of Medicaid, the Medicaid State Plan, and 1915c Waivers. It will also introduce the core Home and Community Services (HCS) programs that enable individuals to remain in or return to their own communities through the provision of coordinated, comprehensive and economical home and community-based services.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Anne Moua HCBS Waiver Program Manager
509.590.3909 Anne.Moua@dshs.wa.gov

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BACKGROUND

The purpose of the HCS Division is to promote, plan, develop, and provide long-term care services responsive to the needs of adults with disabilities and the elderly with priority attention to low-income individuals and families. We help people with disabilities and their families obtain appropriate quality services to maximize independence, dignity, and quality of life.

HCS programs are funded by Medicaid and/or state funds and administered by the Aging and Long-Term Support Administration (ALTSA). To be eligible for all ALTSA-funded programs, the applicant must meet the target population, functional, and financial criteria.

MEDICAID

Medicaid, Title XIX of the Social Security Act (SSA), is a needs-based entitlement program that provides medical assistance for certain individuals and families with low incomes and few resources. The Medicaid program became law in 1965 as a jointly funded, cooperative venture between the Federal and State governments to assist states in the provision of adequate medical care to eligible needy persons.

Medicaid is the foundation on which HCS and the Developmental Disabilities Administration (DDA) build home and community based programs. Most of the core programs are funded through either the Medicaid State Plan or a Medicaid 1915(c) waiver. The costs of providing Medicaid services are shared between the Federal and State government.

The portion paid by the Federal government is known as the Federal Medical Assistance Percentage or FMAP. Each state's FMAP is determined annually using a formula that compares the state's average per capita income with the national average. FMAP cannot be lower than 50% or higher than 83%. States with a higher per capita income receive a lower FMAP. Washington State's FMAP is about 50%.

Rules and policies that govern Medicaid are found in the SSA, the Code of Federal Regulations (CFR), and the Centers for Medicare and Medicaid Services (CMS) Medicaid Manual.

Medicaid State Plan

Section 1905 of the SSA requires States that administer the Medicaid program to describe how they will meet the mandatory Medicaid requirements and the optional services they will provide. This is done through the development of a Medicaid State Plan (also known as the State Plan). It is Washington's agreement with CMS that our state will adhere to the requirements of the SSA and the official issuances of the Department of Health and Human Services (DHHS).

The State Plan is "owned" by the Health Care Authority which is Washington's Medicaid State Agency. HCS and DDA are considered operating agencies for some of the state plan services such as Medicaid Personal Care (MPC) and Community First Choice (CFC).

State Plan Approval

Once approved by CMS, the State Plan deems Washington eligible to receive federal funding or federal matching funds for providing Medicaid services. State Plan services must be offered statewide, and the state cannot set limits on the number of people who will be served or the dollar amount that will be spent. Federal rules require that state plan services should be used before using 1915(c) waiver funds. This is why state plan programs are considered priority programs. By utilizing State Plan services first, Home and Community Based Services (HCBS) waiver capacity is reserved for clients whose amount, duration, or scope of service need is beyond what the state plan programs can provide.

Components

All state plans are different. Each state defines Medicaid eligibility differently and not all states offer some of the optional Medicaid services (like MPC). The State Plan describes:

- Who is eligible;
- What services will be offered including the:
  - amount (how often),
  - duration (for how long), and
  - scope (exact nature of what is provided);
- Who are the qualified providers for each service and what are the specific qualifications for each type of provider;
- How the state sets the rate of payment for services and how payment is made; and
- How the program is administered.

Below is a list of State Plan programs operated by HCS and DDA:

- Community First Choice (CFC)
- Medicaid Personal Care (MPC)
- Program of All-Inclusive Care for the Elderly (PACE) – HCS Only
- Private Duty Nursing

HCBS 1915c Waiver

Section 1915(c) of the Social Security Act describes the regulations for obtaining and operating a 1915(c) HCBS waiver. These waivers are Medicaid's alternative to providing long-term care in institutional settings. HCBS waiver rules allow states to "waive" Medicaid State Plan rules in order to provide services to individuals in their local communities instead of in an institution such as a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/ID).

The state plan rules that can be waived include:

- Income and Resources (the financial eligibility criteria)
- Comparability (targeting a specific population)
- Statewideness (targeting a specific geographic are)

States also have more flexibility in adding additional, optional services to a 1915(c) waiver than to a State Plan.
HCBS waivers operated by HCS include:

- Community Options Program Entry System (COPES)
- New Freedom
- Residential Support Waiver (RSW)

DDA operates the following HCBS waivers:

- Basic Plus
- Core
- Community Protection (CP)
- Children with Intensive In-home Behavioral Supports (CIIBS)
- Individual and Family Services (IFS)

PROGRAM DETERMINATION

Before authorizing initial services or reauthorize ongoing services, clients must be determined both financially and functionally eligible for the program that provides the services they need. For information about financial eligibility for services, see Chapter 7a of the LTC manual.

Initial determination for HCS-funded services is made by the HCS Division. Program eligibility for our target population (aged, blind or physically disabled per SSA criteria) is based on a CARE assessment of an individual's functional unmet needs and a Medicaid financial determination. Functional and financial determinations occur at the same time.

Upon completion of a CARE assessment, the case manager determines program eligibility based on functional eligibility for the programs listed in the drop-down menu on the care plan screen in CARE. Program selection is based on the following items:

- Financial and functional program eligibility;
- Program rules; and
- Client's choice of eligible programs and providers.

Hierarchy

Determine the appropriate program selection based on the following general hierarchy:

- Roads To Community Living (RCL); then
  - ↳ Medicaid State Plan programs – CFC or
    – MPC; then
    - ↳ Home and Community-Based Services (HCBS) waivers; then
      - ↳ State-funded Medical Care Services (MCS); then
        - ↳ State-funded LTC for Non-Citizens; then
          - ↳ Washington Roads

Required Form

Clients who are functionally and financially eligible for the waiver programs can choose to receive their care in an institution or in the community. The Acknowledgment of Services form DSHS 14-225 for CFC and HCS waiver programs is the documentation that all of the program choices have been explained to the client and the client has acknowledged their choice of CFC or waiver services instead of nursing home care. DDA uses the Voluntary Participation Form DSHS 10-424.

1. This form is a federal requirement.
    a) CFC and waiver services cannot be authorized without the client's signature and signature date on this form.
    b) This document indicates the client's choice of Home & Community-based waiver and CFC services (CFC and/or COPES, New Freedom, or Residential Support Waiver).
2. If the client enters the nursing facility, home and community based services are terminated on that date.
    a) A new 14-225 is not required if the stay is short-term (e.g. 30 days or less, recipient is attending rehabilitation and will be returning to place of residence.)
    b) If the stay in the nursing home is more than 30 days, a new Acknowledgment of Services form is required if the client wants to return to the community on CFC and/or waiver services. The 14-225 is documentation of the client's choice to receive services outside of the nursing home.
3. Two signed copies are required - one copy is given to the client and one copy is placed in the client record by sending it to the HCS Imaging Unit.

Excluded Services

Assess and document client goals and services within CARE regardless of funding source. When service planning, you may need to look at funding resources other than HCS and DDA. Excluded services are found in WAC 388-106-0020. For example, core programs do not cover the following services:

1. For Chore and MPC only:
    - Teaching, including teaching how to perform personal care tasks;
    - Development of social, behavioral, recreational, communication, or other types of community living skills;
    - Nursing care.
2. Personal care services provided outside of the client's residence in your place of employment or while accessing community services, that are NOT identified and authorized in your written service plan;
3. Respite (HCS/AAA only);
4. Child care;
5. Animal care, unless for service animals when receiving services through New Freedom;
6. Sterile procedures, administration of medications, or other tasks requiring a licensed health professional, unless authorized as an approved nursing delegation task, client self-directed care task (excludes agency providers), or provided by a family member;
7. Services provided over the telephone;
8. Chore services provided outside the state of Washington;

9. Any services provided outside of the United States;
10. Services to any person who has not been authorized by the department to receive them;
11. Yard care;
12. Assistance with managing finances unless receiving services through New Freedom.

RESOURCES

Related WAC

WAC 388-106-0020 Excluded Services

Acronyms

AAA	Area Agency on Aging
ALTSA	Aging and Long-Term Support Administration
CFC	Community First Choice
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
COPES	Community Options Program Entry System
DDA	Developmental Disability Administration
DHHS	Department of Health and Human Services
FMAP	Federal Medical Assistance Percentage
HCBS	Home and Community Based Services
HCS	Home and Community Services
MCS	Medical Care Services
MPC	Medicaid Personal Care
SSA	Social Security Act

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
10/1/2023	Anne Moua	Update contact	TBD
	Beth Adams	Moved to new template; rearranged content order	

Financial Eligibility for Core Programs

Chapter 7a describes the financial eligibility for HCS programs that provide services that enable individuals to remain in, or return to, their own communities through the provision of coordinated, comprehensive, and economical home and community-based services.
HCS programs are funded by Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), or by the state, and administered by the Aging and Long-Term Support Administration (ALTSA). To be eligible for all ALTSA-funded programs, the applicant must meet the target population, functional, and financial criteria.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Amanda Aseph Office Chief- Financial Eligibility and Policy
360.725.3406 amanda.aseph@dshs.wa.gov

TABLE OF CONTENTS

BACKGROUND

Medicaid, Title XIX of the Social Security Act (the Act), is a program that provides medical assistance for certain individuals and families that meet categorical and financial eligibility requirements. The Medicaid program became law in 1965 as a jointly funded, cooperative venture between the Federal and State governments to assist states in the provision of adequate medical care to eligible, needy persons.
LTSS is an umbrella term that includes both services provided through institutional rules and waivers, and services provided under the State Plan. A subset of LTSS is called long-term care (LTC). LTC refers to programs that use institutional Medicaid rules to determine financial eligibility.

State Plan

Section 1902 of the Act requires states that administer the Medicaid program to describe how they will meet the mandatory Medicaid requirements and the optional services they will provide. This is what we call our state plan. The state plan:

- Establishes eligibility standards;
- Determines the amount (how often), duration (for how long), and scope (exact nature of what is provided) of services;
- Sets the rate of payment for services; and
- Defines program administration.

The State Plan is Washington's agreement that our state will adhere to the requirements of the Act and the official issuances of the Department of Health and Human Services (HHS). The State Plan deems Washington eligible to receive federal funding or federal matching funds for providing Medicaid services.
All state plans are different – each state defines Medicaid eligibility differently and eligibility is not the same across state lines.

Home & Community Based Services (HCBS) Waivers

Granted under Section 1915(c) of the Act, an HCBS waiver is Medicaid's alternative to providing long-term care in institutional settings. The terms waiver, HCBS waiver, 1915(c) waiver, and HCS waiver all refer to HCS waivers granted under Section 1915(c) of the Act. The Developmental Disabilities Administration (DDA) also has 1915(c) waivers.

Programs that Use HCBS Waiver Rules for Financial Eligibility

Program of All-Inclusive Care for the Elderly

Medicaid manual link
Program of all-inclusive care for the elderly (PACE) is a managed care LTSS option to persons living within the PACE service area. Though PACE is a state plan option, HCBS waiver rules are used to determine both eligibility and post eligibility. There is one exception, however – PACE eligible clients are not subject to transfer of asset rules. For all other financial eligibility criteria, see the HCBS Waiver section.

Roads to Community Living

Medicaid manual link

Roads to Community Living (RCL) is a demonstration project funded by the Money Follows the Person grant. It is meant to transition Medicaid eligible persons out of institutions into the community. Eligibility for RCL is dependent on institutional Medicaid eligibility – if a person is receiving Medicaid on the day of discharge from an institution, after a qualifying stay, that person is eligible for RCL. RCL guarantees 365 days of categorically needy (CN) medical. However, for post eligibility, RCL uses the same rules as HCBS waivers (unless the client is eligible under a MAGI-based program). See the HCBS Waiver Post Eligibility section information regarding this.

> NOTE: although HCBS waiver post eligibility is used throughout the RCL demonstration period, many RCL persons will be placed on non-RCL services at the end of the demonstration period. Eligibility for RCL does not necessarily guarantee eligibility for these services. Be sure to contact your Public Benefits Specialist (PBS) if it is anticipated a RCL recipient will transition to non-RCL HCBS services.

State-Funded Long-Term Care for Non-Citizens

Medicaid manual link

The State-funded LTC program for non-Citizens is for individuals in need of LTSS, but not eligible for federally funded Medicaid or Medical Care Services (MCS). This program is funding limited and currently has a limited number of "slots." Eligibility for residential or at-home settings follows HCBS waiver rules. Availability of a slot is coordinated with ALTSA headquarters. See the HCBS Waivers eligibility section for financial eligibility.

FINANCIAL FUNDAMENTALS FOR CLASSIC MEDICAID RECIPIENTS

Timeframes & Responsibilities

The PBS has 45 days from receipt of application to determine eligibility, and 60 days where a disability determination is needed, unless there is good cause to extend the timeline.
HCS PBS staff are responsible for the medical eligibility for non-MAGI based programs when the person is applying or receiving HCS services.
DDA LTC specialty PBS staff are responsible for the medical eligibility for non-MAGI based programs when the person is applying or receiving DDA services, hospice, children and family institutional medical, and behavioral health organization (BHO) alternate living facility (ALF) placements.
An overview of what agency is responsible for Medicaid eligibility determinations is found here.

Communicating with HCS Public Benefits Specialists (PBS)

- The HCS Financial / Social Services Communication form (14-443) is used to communicate with Public Benefits Specialists when initially authorizing HCBS services and at each annual review or significant change if services are extended for a year.
- The 14-443 is available in an electronic format through DMS within the Barcode system.
- Once submitted, the electronic 14-443 is automatically assigned to the PBS of record.

Communicating with DDA LTC Specialty Unit PBS

- The Public Benefits Specialist / DDA Case Resource Manager Communication form (15-345) is used to communicate with PBSs when initially authorizing HCBS services and at each annual review or significant change if services are extended for a year.
- The 15-345 is no longer a paper form but is available in an electronic format through DMS within the Barcode system.
- Once submitted, the electronic 15-345 is automatically assigned to the PBS of record.

Medical Income and Resource Standards

The Health Care Authority (HCA) updates and distributes the Washington Apple Health Income and Resource Standards document. This document lists most financial income and resource standards, plus standards used in determining institutional eligibility and participation such as: personal needs allowance (PNA), maintenance needs, community spouse allocation, and housing maximum amounts. Most standards change annually, but changes are staggered at each calendar quarter.

SSI Recipients Applying for HCBS Waiver, or HCBS Waiver-Rule-Based Services

The Act requires all LTC applicants, including SSI recipients, to submit an application for programs that use institutional financial eligibility rules. Those programs include services in a medical institution, a HCBS waiver service, or services based on HCBS waiver rules. SSI recipients in Washington are categorically eligible for Medicaid but may not be financially eligible for these services. To be eligible for those services, a recipient must:

- Not have transferred an asset for less than fair market value (does not apply to PACE or hospice as a program);
- Not have equity interest in a home that is greater than the standard (this also applies to Community First Choice (CFC) services). See WAC 182-513-1350; and
- Have annuities that meet the requirements in Chapter 182-516 WAC, if any annuities are owned.

SSI recipients or their representatives must complete the Eligibility Review for Long-term Care Benefits (DSHS 14-416) when requesting LTC services unless a signed application less than one year old is in the client's Electronic Client Record (ECR). This form contains a question about annuities, transfer of assets, and home equity. They may also apply online at https://www.washingtonconnection.org/home/. Once a signed application or eligibility review is received, another one will not be required, even if there is a break in LTC services. **Do not delay services while obtaining the application or eligibility review**.

An eligibility review or application is required if SSI eligibility ends. Generally, DSHS is responsible to redetermine Medicaid eligibility when a person's SSI stops. If you have any questions about SSI eligibility, talk with your Public Benefits Specialist.

Fast Track

Fast Track is a process that allows the authorization of HCS services prior to a financial eligibility determination when staff can reasonably conclude that the client will be financially eligible. Clients

receiving services during the Fast Track period will not receive a Medicaid Services Card until financial eligibility is established. Fast Track is available for CFC, Community Options Program Entry System (COPES), and Medicaid Personal Care (MPC), when authorized by HCS. Further, CFC together with COPES can also be Fast Tracked. Do not use Fast Track for non-citizens unless you know that they will qualify for a CN or MN program.
If a client is found not financially eligible during a Fast Track service month, the services are state-funded, and there is no overpayment responsibility. Any expenditures are recovered through the Estate Recovery process. If the client is found financially eligible, the Fast Track services are federally funded once the Medicaid program is in place.
Ensure you communicate with the PBS regarding a person's potential for Fast Track services.
For specific instructions on the fast track process please refer to the Social Service Authorization Manual.

Presumptive Eligibility (PE)

Presumptive Eligibility (PE) allows individuals in need of long-term care services and supports, under the Medicaid state plan and 1915(c) waiver authorities, Medicaid medical coverage at discharge from an acute or community psychiatric hospital stay or diversion from these facilities and provides expedited access to home and community-based services at home. PE will allow clients access to specific benefits quickly, in the most appropriate and least restrictive setting, while full functional and/or financial eligibility are determined. The population already determined financially eligible for Medicaid state plan medical benefits will only require a functional PE determination. A limited benefit package during a PE period for individuals discharging home from an acute care or community psychiatric hospital setting or diversion from these facilities who plan to enroll in one of the following Washington State programs: Community First Choice, COPES, or Medicaid Personal Care.

Clients who receive PE services will have a medical coverage group established while full financial and functional eligibility are determined. PE financial eligibility for the 1915 (c) and 1915 (k) programs will be determined by a financial screen, based on self-attestation to determine if the client meets the requirements as described in **LTC Chapter 30e.**

The Application Assistance Unit (AAU) will attempt to capture a telephonic signature for application on clients approved for PE.

For specific instructions on the presumptive eligibility process please refer to the Social Service Authorization Manual and Apple Health Manual.

Third Party Resources

Generally, if a person has a third-party resource (TPR), they are required to contribute this resource toward their cost of care. Generally, a TPR is a source of funds that does not meet the definition of income (anything a person receives that can be used for food or shelter). Some sources of TPR are veteran's pensions, LTC insurance, or other third-party insurance. More information on financial eligibility and TPR can be found in the Medicaid Manual.

SERVICES

Community First Choice

Medicaid manual link

Community First Choice (CFC) is a state plan option granted under 1915(k) of the Act. Persons are financially eligible for CFC if they are eligible for categorically needy (CN) or Alternate Benefit Plan (ABP) scope of care in the community. This includes both non-institutional medical coverage groups and CN coverage through an HCBS waiver. The financial eligibility rules are located in WAC 182-513-1210 through WAC 182-513-1220.

An SSI recipient is financially eligible for CFC as long as their equity interest in their home is less than the standard.

One benefit of CFC is if an SSI-related married person is found functionally eligible for CFC, and their spouse is not in a medical institution, the CFC eligible person can utilize the financial benefits of spousal impoverishment protections in eligibility for non-institutional Medicaid. Essentially, this means that for both single and married persons (where the spouse is not in a medical institution):

- Countable income in the name of the CFC eligible person must be at or below the 1-person categorically needy income level (CNIL); and
- Combined resources must be at or below the state resource standard plus $2000.00.

In the case of a functionally CFC eligible SSI-related person residing in an alternate living facility (ALF), as defined in WAC 182-500-0050, contact the PBS to determine whether non-institutional Medicaid or HCBS waiver rules will be used for financial eligibility. A person residing in an ALF has a different income standard for non-institutional Medicaid.

NOTE: If a CFC eligible person lives in an ALF, and their countable income is above the CNIL for their household size, this person not only pays Room & Board, but also contributes their remaining income after their PNA and Room & Board are deducted. The combination of Room & Board and their remaining income is considered “total client responsibility.”

In the case of a functionally CFC eligible SSI-related person who is working, and between the age 16 to 64, contact the PBS to determine whether the Healthcare for Workers with Disabilities (HWD) program is more beneficial than other SSI-related programs. The HWD program has a higher income limit and no asset test.

In the case of MAGI-based methodologies, there are no spousal impoverishment protections, and persons must be eligible for a federally funded CN or ABP scope of care medical program. There is no asset test for MAGI-based methodologies.

For a complete list of medical coverage groups eligible for CFC, see the Medical Programs – LTSS Chart located at the end of this document.

CFC Financial Eligibility

Use the steps below in ACES Online to verify CFC financial eligibility. You are looking for an *active* medical coverage group where the person is a *recipient*. If you are unsure of the information in ACES, check with your PBS.

1) Look for any of the non-institutional CN or ABP coverage groups listed on the Medical Programs – LTSS Chart;

a) If a person is a recipient in an active assistance unit (AU) where CFC is available, this person is eligible for CFC services;

2) If the person is not eligible under (1), and the person receives SSI, the person is eligible for CFC. The PBS will update the medical coverage group upon notification from you. Examples include:
   a) Persons discharging from institutions (L01 or L41 – PACE/hospice in an institution);
   b) Persons ending their Roads to Community Living (RCL) demonstration (L41); and
   c) Persons withdrawing from PACE (L31);
3) If the person is not eligible under (2), but is in a medical institution, coordinate with your PBS to establish eligibility;
4) If the person is not eligible under (3), and the person lives in an ALF, coordinate with your PBS to establish eligibility. A financial application may be needed;
5) If the person is not eligible under (4), and the person needs to use HCBS waiver rules to access CFC in any setting, coordinate with your PBS to establish eligibility. Also see the HCBS Waiver section. A financial application will be needed;
6) If the person is not eligible under (5), or you are unsure of a person's Medicaid status, contact the PBS;
7) If the person is not an active recipient in any AU, a financial application is required.
   NOTE: If you determine a Medicare-entitled SSI-related person is eligible for CFC without using HCBS waiver rules, there could be financial advantages to accessing an HCBS waiver service anyway. One such advantage is that a Medicare-Medicaid entitled person has their Medicare Part D prescription copayments waived when receiving HCBS waiver services, whereas a CFC-only person does not. Be sure to ask the PBS if you have questions about CFC only versus HCBS waiver plus CFC.

CFC Post Eligibility

- A CFC-only person (i.e., without HCBS waiver services) does not participate towards their cost of care. If living in an ALF, they pay only Room & Board. However, if SSI-related, living in an ALF, and their income is above the CNIL for their household size, they contribute their total client responsibility towards their cost of care. This does not apply to HWD – see last bullet below.
- A CFC eligible person who also receives HCBS waiver services participates towards their cost of care. If living in an ALF, they pay participation along with Room & Board.
- A CFC eligible person who used HCBS waiver rules to access hospice services participates towards their cost of care. If living in an ALF, they pay participation along with Room & Board.
- A CFC eligible person who is CN eligible through the HWD program continues to pay their HWD premium, along with Room & Board if in an ALF.

HCBS Waivers (COPES, New Freedom, Residential Support)

Medicaid manual link

HCBS waivers allow clients the choice of receiving institutional services in the community instead of in a medical institution. These waivers are granted under section 1915(c) of the Act. All HCS HCBS waivers follow the same financial eligibility rules described in Chapter 182-515 WAC. However, some HCBS waivers may only be offered in certain settings. See LTC Manual Chapter 7 for more information regarding settings.

DDA HCBS waivers also follow the same financial eligibility rules in Chapter 182-515 WAC; however, there is one key difference in financial eligibility between HCS and DDA HCBS waivers:

> Income eligibility for DDA HCBS waivers is capped at the special income level (SIL), whereas HCS HCBS waiver recipients can have income above the SIL.

HCBS Waiver Eligibility

Core eligibility: a person must either be receiving SSI or be SSI-related. MAGI-based medical coverage groups are not eligible for HCBS waiver services, though they may apply, and be related to SSI via a non-grant medical assistance (NGMA) determination (a disability / blindness determination).

HCBS Waiver Eligibility by Medical Coverage Group

Generally, an HCBS waiver recipient will always be placed on the L21 or L22 medical coverage group once financial eligibility and functional eligibility are established. For persons in a medical institution active on Medicaid (L01 or L02), they are financially eligible for HCBS waiver services upon transition to the community. For persons on L95 or L99, coordinate with the PBS because their income may be too high for HCBS waiver services.

There are a few other medical coverage groups that a person will be an active recipient on where they can receive HCBS waiver services. These medical coverage groups are:

Group	Description
S08	HWD
D01/D02*/D26*	Foster Care

*Coordinate HCBS waiver eligibility with your PBS and HCA

For all other SSI and SSI-related medical coverage groups, if an active recipient, a person has met most financial eligibility criteria, but the PBS will need to verify the following three criteria:

- No uncompensated transfers that may incur a penalty period;
- No equity interest in a home that exceeds the standard. See WAC 182-513-1350; and
- All annuities owned by the client or spouse meet the annuity requirements of Chapter 182-516 WAC.

> Persons active only on a Medicare savings program (MSP) – S03, S04, S05, or S06 – are not eligible under the group discussed above. Coordinate with the PBS to determine these persons' eligibility.

HCSB Waiver Eligibility via Application

Financial and functional eligibility for HCBS waiver is completed concurrently. Consider Fast Track where it is reasonably determined that a person may be financially eligible for HCBS waiver. Coordinate Fast Track with the PBS. Please note – Fast Track for New Freedom or DDA HCBS waivers is not allowed. Refer to the Fast Track discussion for services that can be Fast Tracked.

Income – For both single and married persons, income eligibility is only based on income in the name of the HCBS waiver applicant, and one-half of any community income (if married).
Generally, a person's income can be significant, and they are still income eligible for HCBS waiver. The monthly state nursing facility rate, medically needy income disregards, along with recurring medical expenses are subtracted from a person's income before comparing it to the 1-person medically needy income level (MNIL).

For example, this means that as of 01/01/2025, a person can have countable income approximately as high as $10,621 and still be income eligible for HCS HCBS waiver.

Note: This calculation does not apply to DDA HCBS waivers.

Resources - For both single and married persons, the resource limit is $2000.00 However, if married, a person can allocate up to the state spousal resource standard to their spouse before counting resources towards this $2000.00 limit. This can only occur when the spouse is not in a medical institution. Further, any resources above the standard can be reduced by medical expenses.
Other resource considerations –

- A person with an equity interest in their home above the standard is not eligible for HCBS waiver. See WAC 182-513-1350;
- A person (and their spouse if married) must disclose their interest in any annuities, and the annuities must meet the requirements of Chapter 182-516 WAC; and
- HCBS waiver services are subject to transfer of asset considerations. If the person, or their spouse, has transferred an asset in the five years prior to their application, coordinate with your PBS to determine whether eligibility, or a transfer penalty, will be established.

HCBS Waiver Post Eligibility

A person otherwise eligible for non-institutional CN in the community, described in WAC 182-515-1507, does not participate towards their cost of care. If living in an ALF, the person is responsible for Room & Board. If eligible for HWD, a person continues to pay their HWD premium, along with Room & Board if in an ALF.
A person eligible for HCBS waiver under WAC 182-515-1508 does participate towards their cost of care. If living in an ALF, the person is responsible for Room & Board in addition to participation.
A person only participates up to their total cost of care for services that month. If HCBS waiver rules are required to determine eligibility for CFC, a person participates towards the cost of both their HCBS waiver services and CFC services.

The rules regarding post eligibility and participation are found in WAC 182-515-1509 for HCS HCBS waivers and WAC 182-515-1514 for DDA HCBS waivers.
If a person is Fast Tracked, participation must be estimated. Coordinate with the PBS to complete this.

Medicaid Personal Care

Medicaid manual link
MPC is a state plan entitlement similar to CFC. However, access to MPC services is through a non-institutional CN or ABP medical program. Unlike CFC, persons who access CN through an HCBS waiver are not eligible for MPC. Financial eligibility for MPC is described in WAC 182-513-1225.
An SSI recipient is financially eligible for MPC.
Generally, for SSI-related persons, the income and resource standards for non-institutional CN are as follows:

- Countable income for a one-person household no greater than the 1-person CNIL. Countable income for a married person living with their spouse is no greater than the 2-person CNIL.
- Countable resources for a one-person household are no greater than $2000.00. Countable resources for a married person living with their spouse are no greater than $3000.00.

In the case of a functionally MPC eligible SSI-related person residing in an Alternate Living Facility (ALF), contact the PBS to determine whether the person is eligible for non-institutional CN. A person residing in an ALF has a different income standard for non-institutional CN.

NOTE: If an MPC eligible person lives in an ALF, and their countable income is above the CNIL for their household size, this person not only pays Room & Board, but also contributes their remaining income after their PNA and Room & Board are deducted. The combination of Room & Board and their remaining income is considered "total client responsibility."

In the case of a functionally MPC eligible SSI-related person who is working, and between the age 16 to 64, contact the PBS to determine whether the HWD program will get the person access to non-institutional CN. The HWD program has a higher income limit and no asset test.
In the case of MAGI-based methodologies, persons must be eligible for a federally funded CN or ABP scope of care. There is no asset test for MAGI-based methodologies.
For a complete list of medical coverage groups eligible for MPC, see the Medical Programs – LTSS Chart located at the end of this document.

MPC Eligibility

Use the steps below in ACES Online to verify MPC financial eligibility. You are looking for an *active* medical coverage group where the person is a *recipient*. If you are unsure of the information in ACES, check with your PBS.

1) Look for any of the non-institutional CN or ABP coverage groups listed on the Medical Programs – LTSS Chart;

a) If a person is a recipient in an active AU where MPC is available, this person is eligible for MPC services;

2) If the person is not eligible under (1), and the person receives SSI, the person is eligible for MPC. The PBS will update the medical coverage group upon notification from you. Examples include:
   a) Persons discharging from institutions (L01 or L41 – PACE/hospice in an institution);
   b) Persons ending their Roads to Community Living (RCL) demonstration (L41); and
   c) Persons withdrawing from PACE (L31);
3) If the person is not eligible under (2), but is in a medical institution, coordinate with your PBS to establish eligibility;
4) If the person is not eligible under (3), and the person lives in an ALF, coordinate with your PBS to establish eligibility. A financial application may be needed;
5) If the person is not eligible under (4), or you are unsure of a person's Medicaid status, contact the PBS;
6) If the person is not an active recipient in any AU, a financial application is required.

MPC Post Eligibility

A person on MPC does not participate towards their cost of care. If living in an ALF, they pay only Room & Board. However, if SSI-related, living in an ALF, and their income is above the CNIL for their household size, they contribute their total client responsibility towards their cost of care.

An MPC eligible person who is CN eligible through the HWD program continues to pay their HWD premium, along with Room & Board if in an ALF.

Medical Care Services

Medicaid manual link

Medical Care Services (MCS) is a state-funded medical program where eligibility is driven by a person's eligibility for the aged, blind, disabled (ABD) cash program; or eligibility for the housing and essential needs (HEN) program.

In order to be eligible for MCS, a person must be eligible for ABD cash or a HEN referral (but not necessarily receiving a cash grant). Further, the person must not be eligible for any federally funded medical assistance solely due to their citizenship or immigration status. In essence, MCS serves the population of individuals who are qualified aliens that are subject to and within their five-year bar for Medicaid eligibility; and those persons who are lawfully present, but never able to become eligible for Medicaid (i.e., "nonqualified alien").

Eligibility for Residential Services under MCS

Use the steps below in ACES Online to verify residential services eligibility under MCS. You are looking for a medical coverage group where the person is a *recipient*. If you are unsure of the information in ACES, check with your PBS.

1) Look for an *active recipient* of an A01 or A05 medical coverage group. See the Medical Programs – LTSS Chart for information on these medical coverage groups;

2) If not eligible under (1), but eligible in a medical coverage group that is specific to non-citizens, or another state-funded program, coordinate eligibility with your PBS. An application for cash through DSHS is required;
3) If not eligible under (2), an application for cash through DSHS is required.

Post Eligibility for Residential Services under MCS

No cost of care letters are sent to persons eligible for residential services under the MCS program. Persons are responsible for Room & Board. To calculate Room & Board, subtract a person's PNA from their countable income. The remaining income is contributed up to the Room & Board standard.

Chore

Chore is an HCS program using state-only funds. Chore is not available to new applicants as of August 2001. Current Chore clients have been grandfathered into the program. If terminated from Chore, persons will never be financially eligible for Chore again.
HCS financial does not determine financial eligibility for Chore. Financial eligibility for Chore is in WAC 388-106-0610.

Chore Eligibility

Financial eligibility is determined by the social services case worker at least annually, or at an income change. This is accomplished by:

- Completing a CHORE PROGRAM INCOME AND RESOURCES DECLARATION form (DSHS 14-404) to determine financial eligibility and calculate participation;
- Giving a copy to the client
- Placing the original signed copy in the file through DMS

NOTE: If the client does not have an ACES number you will need to work with HCS HQ staff to create a "negative" ACES number which will enable you to create an electronic client record in Barcode.

To remain financially eligible for Chore, a person must:

- Have income that does not exceed the cost of Chore services and not exceed 100% of the Federal Poverty Level (FPL) for their household size;
- Have resources no greater than $10,000 (one person), $15,000 (two-person family). An additional $1,000 is added to the two-person standard for each additional family member; and
- Have not transferred an asset for less than fair market value on or after November 1, 1995.

Chore Post Eligibility

HCS financial does not determine Chore post eligibility. A person's contribution toward their cost of care for Chore services is very different than for HCBS waivers and is calculated by the case manager/social services specialist. For post eligibility, see WAC 388-106-0625.

Healthcare for Workers with Disabilities

Medicaid manual link

HWD is a unique program, in that it is SSI-related, however:

- There is no asset test like other SSI and SSI-related programs;
- Disability determinations are not subject to substantial gainful activity concerns;
- Income limits are much higher than other SSI-related program; and
- An HWD eligible person is financially eligible for CFC, HCBS waiver, and MPC;
    - For CFC or CFC plus HCBS waiver, coordinate with your PBS to ensure the person meets the home equity requirements in WAC 182-513-1350, and the person disclosed interest in any annuities; and
    - For HCBS waiver, coordinate with your PBS to ensure the person is not subject to a transfer of asset penalty.

HWD Eligibility

Determine if a person is an active recipient of an S08 AU. If not, and the person meets (or may meet) the following criteria, contact your local HCS HWD specialist:

a) Be at least age 16;
b) Meet the federal disability requirements; and
c) Be employed full or part-time (including self-employment);

Your local HCS HWD specialist can be found here.

HWD Post Eligibility

A person on HWD does not participate, regardless of service or setting. In all cases, the person must continue to pay their HWD premium to remain eligible for HWD. If living in an ALF, the person is responsible for Room & Board along with their HWD premium.

Note: HWD premiums for American Indians or Alaska Natives are waived.

Children's Health Insurance Program (CHIP)

CHIP is healthcare coverage for children funded under Title XXI of the Act. It provides coverage to children up to the age of 19 who are not eligible for Medicaid (Title XIX) because family income exceeds the Medicaid standard (210% FPL). Once a child is determined eligible for CHIP, the child remains continuously eligible for 12 full months of coverage unless the family fails to pay a required premium.

Income eligibility for CHIP

Families pay a premium for coverage in CHIP that is based on net income of the medical assistance unit that includes the child. The maximum income limit is 317% FPL. Coverage is based on MAGI methodologies and families apply for coverage through the Health Benefit Exchange.

Premium requirements

Households with income between 215% and 265% FPL pay a premium of $20 per child per month (maximum $40 per month) and households with income between 265% FPL and 317% pay a premium of $30 per child per month (maximum $60 per month). Premiums are waived for American Indian/Alaskan Native clients and pregnant women.

Eligibility for HCS/DDA services

DDA provides services to children; however, HCS does not provide services until a child turns 18. Since CHIP provides coverage through a child's 19th birthday, it is possible that a CHIP eligible child will qualify for HCS services. HCS can authorize services, which are equivalent to Medicaid's MPC and CFC, to a child on CHIP coverage – the difference is the funding source used to pay for the services. A child on CHIP is eligible under the ACES coverage group N13 and has special CHIP functional RACs which must be used for correct authorizations.

Service	HCS	DDA
Personal Care (CFC-lookalike)	3251	3521
Personal Care (MPC-lookalike)	3250	3520

Children on CHIP coverage are not eligible for HCBS waiver services. A child on CHIP who needs waiver services must be transitioned to the L22 coverage group and disability must be established.

State-Funded CHIP

Washington State also administers a state-funded CHIP program for children who do not meet the citizenship criteria for the federal program. The eligibility for the program mirrors the federal program; however, eligibility will be under the ACES coverage group N33. These children are eligible for state-funded services that mirror the Medicaid's MPC and CFC services. The functional RACs that must be approved to authorize state-funded services are below.

Service	HCS	DDA
Personal Care (CFC-lookalike)	3350	3910
Personal Care (MPC-lookalike)	3351	3911

EMBEDDED DOCUMENTS

The documents here are not authoritative and should only be used as a guide for eligibility considerations. If you have any questions about a person's financial eligibility, ask your PBS.

Medicaid Programs - LTSS Chart 7.2023.do

Medicaid 101.pptx

RESOURCES

Apple Health Medicaid Manual
Eligibility A-Z Manual (Cash & Food)
ACES Manual - Inquiry Search Information
Title 182 WAC (Health Care Authority)
Chapter 182-500 WAC Definitions
LTSS Definitions WAC
Financial Eligibility & Policy SharePoint (Available to State Employees Only)

Acronyms

AAU	Application Assistance Unit
ABD	Aged, Blind, Disabled
ABP	Alternate Benefit Plan
ALF	Alternate Living Facility
ALTSA	Aging and Long-Term Support Administration
AU	Assistance Unit
BHO	Behavioral Health Organization
CFC	Community First Choice
CHIP	Children's Health Insurance Program
CN	Categorically Needy
CNIL	Categorically Needy Income Level
COPES	Community Options Program Entry System
DDA	Developmental Disabilities Administration
DMS	Document Management System
ECR	Electronic Case Record
FPL	Federal Poverty Level
HCA	Health Care Authority
HCBS	Home and Community Bases Services
HCS	Home and Community Services
HEN	Housing and Essential Needs
HHS	Health and Human Services
HWD	Healthcare for Workers with Disabilities

LTC	Long-term Care
LTSS	Long Term Services and Supports
MCS	Medical Care Services
MNIL	Medically Needy Income Level
MPC	Medicaid Personal Care
MSP	Medicare Savings Program
NGMA	Non-Grant Medical Assistance
PACE	Program of All-Inclusive Care for the Elderly
PBS	Public Benefits Specialist
PE	Presumptive Eligibility
PNA	Personal Needs Allowance
RCL	Roads to Community Living
SIL	Special Income Level
TPR	Third-Party Resource

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
5/20/2025	T Gariano	Updated formatting	

Community First Choice (CFC)

Chapter 7b describes the Community First Choice (CFC) program which provides assistance with personal care and other services that enable individuals to remain in, or return to, their own communities through the provision of coordinated, comprehensive and economical home and community-based services (HCBS).

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Victoria Nuesca CFC Program Manager ALTSA/HCS
360.725.2393 victoria.nuesca@dshs.wa.gov

Sue Halle CFC Program Manager DDA
360.764.3561 suzan.halle@dshs.wa.gov

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WHAT IS COMMUNITY FIRST CHOICE (CFC)?

Community First Choice (CFC) is a Medicaid State Plan option granted under 1915(k) of the Social Security Act. Level of care eligibility for CFC includes those who, without home and community-based attendant services and supports that are provided under CFC, would require the level of care provided in a/an:

- Hospital;
- Skilled Nursing Facility (SNF);
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID);
- Institution providing psychiatric services for individuals under age 21; or
- Institution for Mental Diseases (IMD) for individuals age 65 or over.

Home and Community Services (HCS)	Nursing Facility Level of Care (NFLOC)
Developmental Disabilities Administration (DDA)	Intermediate Care Facility for individuals with Intellectual Disabilities (ICF/IID) Level of Care or Nursing Facility Level of Care (NFLOC)

One of the services provided under CFC includes personal care, which is assistance with the following Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and health-related tasks (for example, nurse delegation and PERS units). Assistance for IADLs is available only when the client also needs assistance with ADLs.

ADLs and IADLs as listed in Washington Administrative Code (WAC) 388-106-0010 include:

ADLs	Bathing Body Care Dressing Eating Personal hygiene Toilet use	Medication management Transfer Bed mobility Locomotion outside room Locomotion in room & immediate living environment Walk in room & immediate living environment
IADLs	Meal preparation Ordinary housework Essential shopping	Wood supply *(when sole source of heat)* Travel to medical services Telephone use

Clients may receive other services available through the CFC program when they meet all the eligibility and sub-eligibility requirements. Other services available through CFC include:

- Relief Care
- Nurse Delegation (ND)
- Personal Emergency Response Systems (PERS)
- Assistive Technology (AT) benefit
- Skills Acquisition Training (SAT)
- Community Transition Services (CTS)
- Caregiver Management Training (how to select, manage, and dismiss personal care providers)

Clients may need other services in addition to those available under CFC,

- HCS/Area Agency on Aging (AAA) Clients:
  - May also receive services through the Community Options Program Entry System (COPES) waiver. If they qualify for CFC and are both functionally and financially eligible for COPES waiver services, they can be on both programs simultaneously in order to access additional needed COPES services.
    - In CARE on the Care Plan screen, the dropdown selection of the Client's chosen program would be CFC + COPES.

      Note: The "+" means "and". When a client is on CFC + COPES, they are enrolled in both the CFC program and in the COPES waiver program.
- DDA Clients:
  - May also receive services through CFC and either the Basic Plus, Core, Children's Intensive In-Home Behavioral Support (CIIBS), or Individual and Family Service (IFS) waivers.
  - Clients must receive prior approval from DDA Headquarters to enroll on a waiver program.

Medicaid Personal Care (MPC) is also a Medicaid State Plan program. MPC is available to those clients who do not meet institutional level of care noted above. See Long-Term Care (LTC) Manual Chapter 7c for information on MPC.

CFC ELIGIBLITY

Before CFC services can be authorized by HCS/AAA or DDA, the client must meet **ALL** the following eligibility criteria:

Age

- For services through HCS/AAA, an individual must be 18 years of age or older.

- For services through DDA, an individual:
  - who meets DDA's determination of a developmental disability may be any age.
  - under age 18 who does not meet DDA's determination of a developmental disability but has functional disabilities may be served by DDA until age 18.
    - DDA will refer young adults age 18 and over to HCS.

Functional Eligibility

To determine functional eligibility, a personal care assessment, also known as your Comprehensive Assessment Reporting & Evaluation (CARE) assessment, must be completed. To be functionally eligible for CFC, a client must:

- Meet NFLOC as outlined in WAC 388-106-0355(1), ***or***
- Meet ICF/IID as outlined in WAC 388-828-3080 and 388-828-4400, ***or***

- Likely need institutional level of care within 30 days unless services are provided.

Financial Eligibility

To be financially eligible for CFC, a client must be eligible for Categorically Needy (CN) or Alternate Benefit Plan (ABP) scope of care in the community. See LTC Manual Chapter 7a for more information regarding financial eligibility for LTC programs.

CFC CARE SETTINGS

Clients enrolled in CFC may choose to receive services in one of the following Home and Community Based Settings:

- The client's own home
- Adult Family Home (AFH)
- Assisted Living (AL) facility
- Adult Residential Care (ARC) facility
- Enhanced Adult Residential Care (EARC) facility
- In community settings, personal care tasks specified on the CARE plan may be provided outside the client's home:
  - To support clients in community activities or to access other services in the community.
  - To assist a person to function in the workplace or as an adjunct to the provision of employment services.

CFC SERVICES

In addition to personal care services, clients can receive other CFC services if they have a documented need and the item or service is applicable, not covered by another source, and is cost-effective. A CFC client may receive any CFC service or item they are eligible for, with or without personal care. As an example, a CFC client who is eligible for and needs/wants a PERS unit, does not need to receive or be authorized personal care services to receive the CFC benefit of PERS service. At the client's re-assessment, the client must meet functional eligibility by having an unmet or partially unmet with ADL task(s) in order to continue to receive CFC services for the next CARE plan.

A CFC client may receive any CFC service or item they are eligible for, with or without personal care.

Personal Care is a service under CFC. The CFC program and a waiver are two separate programs. An ALTSA client can choose to access CFC services or COPES services (if financially eligible for COPES) without choosing personal care. However, it is not common since most clients need assistance with ADLs/IADLs. For DDA clients, if eligible for a DDA waiver (i.e., B+, IFS, Core, etc.), the DDA client can access an eligible waiver service without choosing personal care. Please note, this is not a common situation.

While not a common situation, here are some examples of an ALTSA client being on services without an IP or home care agency CG providing personal care are:

- A CFC eligible client discharging from a Skilled Nursing Facility (SNF) and needs/wants help getting resituated in the community, so they access CFC Community Transition Services (CTS). Once in their own home, they are able to take care of themselves independently and do not need/want any other services, so they choose to end/withdraw their CFC services.
- A CFC+COPES client chooses to only attend Adult Day Health (ADH) or Adult Day Care (ADC) which are COPES services. See Chapter 7d for more information on these services.

Other Funding Sources

Federal rules require that CFC services not replace other services that clients are able to access under Medicaid, Medicare, health insurance, Long-Term Care (LTC) insurance, and/or other community or informal resources available to them.

- If a client has other insurances or resources, those resources should be used prior to authorizing CFC services.
  - If another resource is identified but denies the service, document this denial in a SER note, ***and***
  - Submit any paper documentation of the denial in the client's:
    - electronic case record (ECR) in Document Management Services (DMS) for HCS/AAA client.
    - hard file for DDA client.
- CFC services may not supplement the reimbursement rate from other resources or be used to pay for something that is covered by another resource to pay a higher rate.
- Requesting an Exception to Rule (ETR) is not allowed for the above circumstances.

Providers of CFC services must meet certain qualifications and be contracted through the Department of Social and Health Services (DSHS) or the local AAA prior to services being authorized.

Each local AAA maintains a list of eligible contracted providers for use by HCS, AAA and DDA staff.

Prior to authorizing any service, verify that the client's need for this service is documented/described/identified in the client's CARE assessment which will then reflect the need in the client's CARE service plan and printed on the Assessment Details/Service Summary.

Personal Care Services

WAC 388-106-0010 – **"Personal care services"** means physical or verbal assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) due to functional limitations. Assistance is evaluated with the use of assistive devices.

Personal Care Services

- Personal care assistance enables clients to accomplish tasks that they would normally do for themselves if they did not have a disability/functional limitation. Assistance may:
  - Include hands-on assistance (actually performing a task for the person) or cuing to prompt the client to perform a task.
  - Be provided on an episodic or on a continuing basis.

- Includes assistance with ADLs and IADLs – see table on page 3
  - IADLs may not comprise the entirety of the service for a client, they must also have unmet need for and ***accept*** assistance with ADLs.

- May include tasks completed outside of the client's home as specified in the CARE plan to:
  - Support clients in community activities or to access other services in the community.
  - Assist a client with ADL needs in the workplace or as an adjunct to the provision of employment services.

Personal Care Service Providers

Clients may choose as the provider of their personal care:

- For In-Home,
  - an Individual Provider (IP) employed through the Consumer Directed Employer (CDE) contracted provider for Washington state, Consumer Direct of Washington (CDWA), or
  - a Home Care Agency provider.
- For Residential,
  - an adult family home (AFH), or
  - a licensed assisted living facility (ALF) which includes:
    - an Assisted Living (AL),
    - Enhanced Adult Residential Care (EARC), or
    - Adult Residential Care (ARC).

If the client chooses an IP,

- the IP is an employee of the CDE,
- the client will work with the CDE and the IP on assignment of the client's authorized in-home hours,
- the client will be the one to select, schedule, supervise, direct, and dismiss the IP.
  - If a client is unable to provide supervision, an alternate supervisor must be identified in the CARE plan.
  - The client is responsible for identifying back-up caregivers to cover for sick or vacationing caregivers.
  - If a client wants training on how to select, direct, or dismiss an in-home caregiver, they may request training materials at any time from their case manager or the CDE. See Caregiver Management Training for more information.

– See LTC Manual, Chapter 11 – Consumer Directed Employer for more information on CDE.

CDE contact numbers dedicated specifically to CM, Client, or IP:

For Case Managers *only*:	For Clients and IPs:	
Phone number: 1-866-932-6468	Phone number: 1-866-214-9899	
	Email: infocdwa@consumerdirectcare.com	

In-Home Providers

– Individual Providers (IPs):
  - Meet the qualifications listed in WAC 388-115-0510;
  - Are hired and employed by the CDE;
  - Must have:
    - successfully passed the appropriate criminal background check(s);
    - met all training and certification requirements; ***and***
  - Must be:
    - age 18 or older;
    - able to legally work in the United States; ***and***
  - Are regulated under WAC 388-71-0500 through 388-71-1006, and Revised Code of Washington (RCW) 74.39A.250.

Use Carina or the CDE to help clients locate IPs.

– Home Care Agency providers:
  - Must have a current Department of Health (DOH) license;
  - Must have a current Contract with DSHS or AAA; ***and***
  - Are regulated under Chapter 70.127 RCW, and Chapter 246-335 WAC.

In-home providers can only be paid once for the same hour/unit of personal care service, even when providing services in a multi-client household.

Residential Providers

– See LTC Manual, Chapter 8 – Residential Services
– Assisted Living (AL), Adult Residential Care (ARC), and Enhanced Adult Residential Care (EARC) must have a current:
  - ALF License under Chapter 18.20 RCW, and Chapter 388-78A WAC; ***and***
  - Contract with DSHS under Chapter 388-110 WAC.
– Adult Family Homes (AFH) must have a current:
  - AFH License under Chapter 70.128 RCW and Chapter 388-76 WAC;
  - Contract with DSHS; ***and a***
  - Specialty designation, if needed, based on the needs of the client.

Requesting funding from the Managed Care Organization (MCO) for Behavioral Health Wraparound Support (BHWS) or Community Behavioral Health Support (CBHS) service

Please see Chapter 22a – Apple Health Managed Care (MCO) and Apple Health Medicare Connect (DSNP) for Behavioral Health Wraparound Support (BHWS) or Community Behavioral Health Support (CBHS) service information and eligibility criteria.

In-Home Personal Care Services Outside Washington

Per WAC 388-106-0035, a client may receive personal care services from an Individual Provider (IP) employed through the CDE while temporarily traveling out of the state for **less than 30 days**.

All the following must be completed in order for out-of-state in-home personal care to be received and paid for:

1. Prior to the client leaving Washington, the case manager must:
    - Discuss with the client and/or client representative how the client's personal care needs will be met while the client is traveling out-of-state;
    - Obtain the temporary out-of-state address and phone contact;
    - Document in a SER note the conversation including the client's departure date and return date; and
    - Update the Client Details on the Contact Details screen in CARE to reflect the client's Washington address and phone contact **as well as** the temporary out-of-state address and phone contact(s);
2. Client's CARE plan must be in "current" status and services are authorized in the client's service plan prior to departure.
    - Out-of-state services are strictly for client's personal care and must not include provider's travel time or expenses.
    - The IP must be in good standing with the CDE and have met all required qualifications.
    - All other authorized services, except Wellness Education (if the client's CFC eligibility is through COPES), need to be closed while client is out-of-state.
3. Personal Care services must only be provided in the United States.
4. The client must also advise the CDE of the dates they will be out-of-state, and that the IP (employed through the CDE) will be with them. The IP should also notify the CDE.

Personal Care services are not allowed outside the United States.

If the client requests to receive personal care services out-of-state for **more than 30 days**, in addition to the above being completed, the following protocol must be followed:

5. The client must maintain Medicaid eligibility per Health Care Authority (HCA) WAC 182-503-0520 residency requirements;
6. The client must provide in writing to the case manager their intent to return to Washington once the purpose of their absence has been accomplished and provide adequate information of this intent. Written documentation from the client must be added to their case file (electronic case record for HCS/AAA or hard copy file for DDA);

Note: Steps 5 – 11 are in addition to the four (4) steps noted above.

7. If the client is eligible for CFC through COPES, they must receive Wellness Education (their ongoing monthly waiver service) while out-of-state which means the client needs to have their mail forwarded. Wellness Education is not delivered to a temporary address.
8. Advise the Public Benefits Specialist (PBS) via Barcode (ALTSA use form 14-443 and DDA use form 15-345) of the following:
    a. The dates the client will be out-of-state,
    b. The client's intention of returning to Washington and that a written document of such was received and placed in their file, and
    c. That the client will continue receiving personal care through CFC and if needed, the COPES ongoing monthly waiver service of Wellness Education.
9. Prior to the client leaving the state, an ETR must be reviewed and approved at the local, regional/AAA level.
    a. ETR Category and ETR Type will be "Other"
    b. Date Range: "Custom"
    c. Start date and End date boxes: will be the dates the client will be out of the state.
    d. Hours/Rate, Units, Quantity section: leave blank as the client will not be eligible for or able to use hours beyond their current CARE plan.
    e. WAC(s) referenced: add 388-106-0035 and 182-503-0520
    f. Request description section: indicate the ETR is for client to receive personal care out-of-state and to allow payment to the CDE (CDWA) for the IP that is also out-of-state beyond 30 days.
    g. Justification for request section: explain/notate the protocol steps listed above (in the less than 30-day section) that have been completed; and confirm that the written document from the client has been filed in the client's case record.
    h. ETR must go through your local office process for final review and approval.
10. During the time out of Washington, the client must not have been determined eligible for Medicaid or state funded health care coverage in another state (other than coverage in another state for incidental or emergency medical care); *and*
11. The client and/or their representative must contact the case manager:
    - *every* 30 days while the client is out of state to confirm that the CARE plan is meeting client's needs; *and*
    - each contact must be documented in a Monitor Plan SER note.
    - Set a CARE tickler to remind the case manager of the next required check-in.

Relief Care

Relief Care is available only to CFC clients receiving in-home care services. It is a service that allows the client to use alternate providers for personal care when their regular provider of personal care is not available or needs a break.

Relief Care is authorized separately from standard in-home personal care. On the provider's authorization, Relief Care is authorized using the service code T1019 – U2. See the Social Service Authorization Manual (SSAM) for more information.

- This service does not add any hours to the monthly hours generated by CARE. It is an alternate use of the CARE generated hours.
- Pre-planned use of relief care must be noted on the Service Summary by adding the paid relief care provider on the Supports screen under Care Planning in CARE – this will then print on the Service Summary.
- Use of Relief Care for un-planned absences, such as provider illness, does not need to be noted in the Service Summary, but must still be authorized using the correct Relief Care service code (T1019-U2) in ProviderOne (P1).
- Providers for Relief Care are IPs employed through the CDE and Home Care Agencies. For specific qualifications, see Personal Care Service Providers.
- If a relief care provider is in place:
  - Document a relief care provider on the Contact Details screen;
  - Add the relief care provider on the Providers screen; and
  - Assign tasks to the relief care provider on the Supports screen.

Nurse Delegation

Nurse Delegation (ND) services allows Registered Nurses (RNs) to delegate specific nursing tasks to qualified Long-Term Care Workers (LTCW) when:

a) The client's personal care is provided by a registered or certified nursing assistant, or a Certified Home Care Aide who has completed nurse delegation core training; *and*
b) The client's medical condition is considered stable and predictable by the delegating nurse; *and*
c) The specific nursing tasks are provided in compliance with WAC 246-840-930.

See LTC Manual, Chapter 13 – Nurse Delegation for information on the Training and Credentialing Requirements/Responsibilities for LTCW and further specifics related to ND.

NOTE:

- Paid Nurse Delegation allowed for CFC clients receiving care in-home, at a contracted Adult Family Home (AFH), or at a contracted Adult Residential Care (ARC) facility.
- Nurse Delegation is not allowed at Assisted Living (AL) facilities or Enhanced Adult Residential Care (EARC) facilities as these residential facilities are already contracted and paid to provide intermittent nursing services.

ND Service Parameters

- A Registered Nurse Delegator (RND) assesses a client for program suitability and teaches, evaluates competency, and supervises the performance of a LTCW.
- The qualified LTCW performs the delegated nursing task(s) for a client as instructed by the RND.
- These ND tasks may include:
  - Administration of medications;
  - Blood glucose monitoring;
  - Insulin injections;
  - Ostomy care;
  - Simple wound care;
  - Straight catheterization; *or*
  - Other tasks determined appropriate by the delegating nurse.
- Services do not duplicate personal care.

ND Exclusions

- ND tasks may not include:
  - Sterile procedures;
  - Administration of medications by injections, except insulin injections;
  - Maintenance of central intravenous lines; *or*
  - Acts that require nursing judgement.

ND Providers

- Home Health Agency
  - Licensed under Chapter 70.127 RCW.
  - Individual RNs employed by the agency must be licensed under Chapter 18.79 RCW.
- Registered Nurse
  - Licensed under RCW 18.79.040.

Personal Emergency Response System (PERS)

Personal Emergency Response System (PERS) is an electronic device (console) that enables clients to secure help in an emergency. The client wears an emergency response activator ("help" button), most clients choose a pendant or wrist bracelet "help" button. The console is programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals.

PERS Eligibility

Standard/basic PERS

PERS standard/basic unit using a landline or using wireless technology

- If the service is necessary to enable the client to secure help in the event of an emergency and if the client:
  - Lives alone in their own home; *or*
  - Is alone, in their home, for significant parts of the day and has no regular provider for extended periods of time; *or*
  - No one in the client's home, including the client, can secure help in an emergency.
- See WAC 388-106-0270 subsection 4.

PERS Add-On Services in addition to PERS standard/basic unit

1. PERS add-on service of fall detection if the client:
   - Is eligible for a standard/basic PERS unit; *and*
   - Has a recent documented history of falls.
   - See WAC 388-106-0273 subsection 1.

2. PERS add-on service of Global Positioning System (GPS) tracking device with locator capabilities if the client:
   - Has a recent documented history of short-term memory loss and a recent documented history of wandering with exit seeking behavior; *or*
   - Has a recent documented history of getting lost in familiar surroundings and being unaware of the need or unable to ask for assistance.
   - PERS standard/basic with GPS add-on service is the only PERS service that may be provided in a residential setting.
     - The PERS standard/basic unit and all installation fees are covered CFC services.
     - The GPS add-on service is paid for using the client's CFC SFY annual limit and is considered Assistive Technology.
     - Residential clients may not access a PERS standard/basic without GPS capabilities.
   - See WAC 388-106-0273 subsection 2.

   For PERS add-on service of GPS: If the client is **under the age of 12**, there must be information presented at the assessment that due to the client's disability, the support provided for memory or decision making is greater than is typical for a person of their age.

3. PERS add-on service of a medication reminder management system if the client:
   - Is eligible for a standard/basic PERS unit; *and*
   - Does not have a caregiver available to provide the medication management service; *and*
   - Is able to use the medication reminder system to independently take their medications.
   - See WAC 388-106-0273 subsection 3.

PERS Services

Standard/basic PERS

The standard/basic PERS unit is a covered service under CFC. It is not considered CFC Assistive Technology (AT) and its monthly fees are not considered when calculating how much of the client's CFC state fiscal year (SFY) annual limit is to be used.

- The standard/basic PERS unit includes the base device (console) that is connected through a landline or a cellular/wireless/mobile phone line and is programmed to signal a response center once the "help" button is activated by the client.
- Installation and maintenance of the standard/basic PERS unit is included in the PERS service under CFC and is not considered when calculating how much of the client's CFC SFY annual limit is to be used.

PERS Add-On Services

PERS add-on services to the standard/basic PERS unit are considered CFC AT and include:

- Fall detection units
- GPS units
- Medication Reminder Management systems

If a client needs/wants and qualifies for a PERS add-on service, the PERS add-on service is an add-on to a PERS standard/basic unit which the client must also want. PERS add-on services are NOT standalone options. There are other one-time purchase CFC AT options for a medication reminder management system if the client does not want, will not use, or does not qualify for a PERS standard/basic unit but needs/wants a medication reminder management system.

The monthly fee for a PERS add-on service is paid with the client's CFC SFY annual limit of $550.

- If the PERS add-on service(s) monthly fees for the state fiscal year (July 1st thru June 30th) exceed the CFC state fiscal year (SFY) annual limit of $550, an "Exceed CFC Annual Service Limit" ETR is needed.
- Only for PERS add-on services is the ETR reviewed/approved at the local level from the designated authority to cover the cost of the PERS add-on service for the full state fiscal year (July 1st thru June 30th).
- If there are only a few months left in the state fiscal year, the service may be authorized for the remainder of the fiscal year and an ETR would need to be requested, in late June or early July, for the following SFY if the total cost of the PERS add-on service amount for twelve months (that fiscal year) exceeds $550.00.

Any installation fee for a PERS add-on service is included in the PERS service under CFC and is not considered when calculating how much of the client's CFC SFY annual limit is to be used.

PERS Equipment

- Emergency response activator ("help" button)
  - must be able to be activated by breath, by touch, or some other means, and
  - must be usable by persons who are visually or hearing impaired or physically disabled.
- PERS console unit
  - must not interfere with normal telephone use and may include cordless equipment (cellular/wireless phone) that does not require a telephone landline.
  - must be capable of operating without external power during a power failure at the participant's home in accordance with UL or ETL requirements for home health care signaling equipment with stand-by capability.
- The PERS provider, per their contract, must install the PERS system within five (5) business days of the request for service.
- If/when a client is no longer eligible for PERS service,
  - immediately contact the PERS provider so that they can retrieve their equipment, and
  - terminate the authorized PERS service(s).

Lost or damaged PERS equipment:

Emergency response activator ("help" button)

- per their contract, replacement or repair is the responsibility of the PERS provider when required.

PERS console unit

- PERS provider must report any loss to the case manager within two weeks.
- PERS provider must make a good faith effort to recover or repair a lost or damaged console unit.
- Case manager will also attempt to recover the console unit.
- If the console unit cannot be recovered or repaired, documentation of the wholesale cost must be provided by the PERS provider with the request for reimbursement.
- Only **one** replacement console unit is covered under CFC in a client's lifetime.
  - To authorize the **once-in-a-lifetime** replacement PERS console, use service code S5160 PERS Installation to pay for the replacement device.
    - Add an authorization comment indicating the service line is for a replacement device and what the wholesale cost of the console is.
    - Documentation/receipt of the wholesale cost must be submitted to the client's electronic case record (ECR) behind the Social Services Packet Cover Sheet (DSHS 02-615).
- After termination of services
  - Reimbursement request from PERS provider must be submitted within 30 days of the termination notice.

- Reimbursement must be paid using the last date of service on the PERS authorization.

– After death of client
  - Reimbursement for equipment lost is *not* permitted.

PERS Providers

– PERS providers are contracted by the AAA.
  - Each local AAA maintains a list of eligible contracted PERS providers.
  - The list of eligible contracted PERS providers is used by the local HCS, AAA and DDA staff members for the client's county of residence.

– PERS contracts must list the standard/basic PERS rate and the PERS add-on service rates separately.
  - The PERS provider must bill for these add-on services separately from the standard/basic PERS unit.

– PERS providers must provide equipment (console and "help" button) approved by the Federal Communications Commission (FCC) and the equipment must meet the Underwriters Laboratories, Inc. (UL) or Electrical Testing Laboratories (ETL) safety standard for home health care signaling equipment. The UL or ETL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard.

Authorizing PERS Services

– Installation fee for the PERS standard/basic unit or add-on service
  - PERS installation fees are covered as a benefit under CFC and is not applied to the client's CFC SFY annual limit.
  - Use service code S5160
  - Add a comment on the authorization indicating what the installation is for (i.e., standard/basic unit or which PERS add-on service)
  - The authorized start date for PERS service(s) should align with when the equipment was installed.

– PERS monthly service fee
  - PERS standard/basic PERS unit is authorized on one service line
    - Use service code S5161
  - PERS add-on service(s) is authorized on a separate service line on the same authorization using the appropriate service code – see below

Service	P1 Code
PERS Installation Fee	S5160
PERS standard/basic unit	S5161
- Fall Detection Add-on to PERS (Assistive Tech)	S5161 – U1
- GPS Add-on to PERS (Assistive Tech)	S5161 – U2
- Medication System Add-on to PERS (Assistive Tech)	S5161 – U3

  - Only the monthly fee for the PERS add-on service is considered Assistive Technology and is applied to the client's CFC SFY annual limit.

- Once authorized in P1, the PERS add-on service fees will be automatically added to the Budget Calculator screen under Client Details in CARE to help track the expenditures purchased from the SFY annual limit. The case manager will add comments to the Budget Details indicating what type of PERS add-on service was authorized along with any other helpful details.
  - The monthly cost of the PERS add-on service is multiplied by the number of months it will be used and the total cost will be deducted from the client's CFC SFY annual limit.

    Example of authorization mid-SFY:
    The client received a PERS unit in *January 2024* and will have the unit indefinitely.
    - Standard/basic PERS unit and a GPS add-on service of $20 per month.
    - $20/month multiplied by the # of months left in the fiscal year (in this example, 6 months including January, the PERS unit start month) = $120 of the CFC SFY annual limit will be added to the Budget Calculator for the SFY July 1st, 2023 thru June 30th, 2024.

-- PERS authorizations do not automatically renew
- At the client's next face-to-face assessment, determine/confirm the client still meets eligibility for the PERS service(s) and still would like to receive the PERS service(s).
- Having confirmed the client's continued need/want and eligibility for the PERS service(s), after the assessment is moved to current, the authorization to the PERS provider can be extended for the new CARE plan year.

– PERS replacement console unit
- Only one replacement is covered under CFC in a client's lifetime.
- To authorize the **once-in-a-lifetime** replacement PERS console:
  - use service code S5160 PERS Installation to pay for the replacement console,
  - rate is the wholesale cost of the console,
    - See PERS Equipment section for more information about obtaining documentation of the wholesale cost of the console
  - add an authorization comment indicating the service line is for a replacement console.
- Documentation/receipt of the wholesale cost of the console must be submitted to the client's file to justify payment of the replacement console.
  - For ALTSA, submit to the client's electronic case record (ECR) behind the Social Services Packet Cover Sheet (DSHS 02-615).
  - For DDA, add to client's hard copy file.

Note: When a client moves from an in-home setting to a residential setting (e.g., AFH, ALF, or Supported Living) and does not meet the requirements for a PERS unit in a residential facility, the case manager must contact the PERS provider, ensure all the PERS equipment is returned to the provider, and terminate the PERS payment authorization. If the equipment is lost or damaged, the case manager will need to follow the procedures for "Lost or damaged PERS equipment" as outlined in this chapter, under PERS Equipment section.

PERS Exclusions and Limits

- Authorization of a PERS add-on service (fall detection, GPS, or medication reminder management system) without a PERS standard/basic unit.
  - NOTE: A PERS add-on service of medication reminder management system by itself, cannot be authorized when a client does not qualify for or does not need/want a PERS standard/basic unit as monthly ongoing/recurring fees for AT items are prohibited as noted in WAC 388-106-0274.
  - If the client only needs a medication reminder management system and NOT a PERS standard/basic unit, then make a one-time purchase of a medication reminder management system from an AT contracted provider.
  - There are many different medication reminder systems out there as one-time purchases that can meet a client's person-centered specific need.

    For example:
    - if they just need reminders to take insulin or have one pill to remember when the caregiver is gone, something like a Reminder Rosie or single pill bottle reminder cap/lid may work;
    - if their need is for a locked medi-set with reminders.
- Authorization of a PERS add-on service when a client is not eligible for and/or does not want or need a standard/basic unit.
- A PERS standard/basic unit that does not include a GPS add-on service may not be paid for through CFC in a residential setting.
- Services not covered under the PERS service contract.
- 24-hour nurse triage call center/nurse hotline services are not covered.
- Electronic device or system enhancements that monitor blood pressure, blood glucose levels, weight, etc. (e.g., Tele Health, Well Being monitor) are not covered.

CFC State Fiscal Year (SFY) Annual AT/SAT Limit

Each client enrolled in CFC has a CFC state fiscal year (SFY) annual limit of $550 to purchase and receive eligible Assistive Technology (AT) and Skills Acquisition Training (SAT) hours.

- This is a combined total of all purchases for AT (Goods and/or Services) and/or SAT hours.
- This limit applies only to the SAT hours not obtained using the client's eligible personal care hours.

The annual limit follows the state's fiscal year (July 1st through June 30th). This limit:

- Does not coincide with the client's CARE plan year.
- Does not reset when clients have another assessment (i.e., significant change) during the year.
- Is not pro-rated based on when services start (e.g., CFC clients starting services in April 2023 have $550, the same amount as clients having started CFC services in July 2022).
- Resets once per state fiscal year for each client on July 1st.
  - In June of each year, case managers will receive **one** tickler on their Tickler list stating "Budget Calculator will start a new budget line for the new state fiscal year beginning July 1", as a reminder that **all** their CFC clients will begin a new budget line for the next following state fiscal year.

Unused funds from a client's CFC SFY annual limit do not carry over or accumulate from year to year; they cannot be combined with funds from previous state fiscal years.

A documented need exceeds CFC SFY annual limit

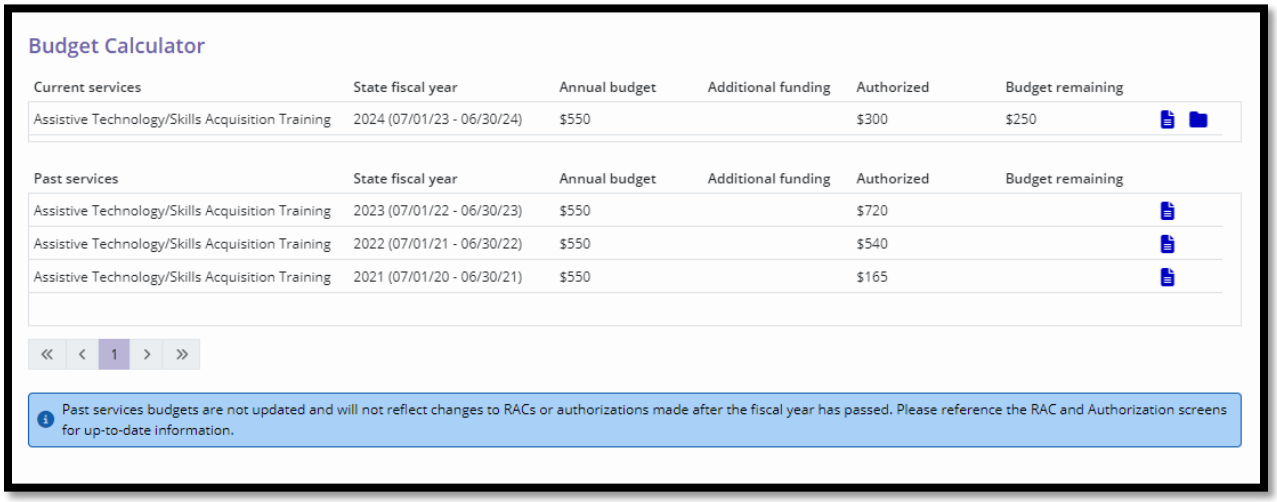
If the CFC client's need for an AT Good, AT Service, or SAT purchased hours, as documented on their individualized CARE plan, exceeds the CFC SFY annual limit (or remaining balance), the case manager may use the "Exceed CFC Annual Service Limit" ETR process to request the amount beyond the client's CFC SFY annual limit.

- ETR approval authority for "Exceed CFC Annual Service Limit" ETR request for an AT Good, AT Service, or SAT purchased hours:
  - For ALTSA, after the ETR goes through the initial review of your office, it will be sent to the CFC Program Manager at Headquarters (HQ) for final review and decision making.
  - For DDA, the ETR is sent for review and final decision making to the CFC Specialists in the regions, and then if needed, sent to DDA HQ.
- As the CFC annual limit is based on the fiscal year, ETRs expire on June 30th every year. If your ETR is for an ongoing service (i.e., PERS add-on service), a new "Exceed CFC Annual Service Limit" ETR will need to be submitted and approved before July 1st.

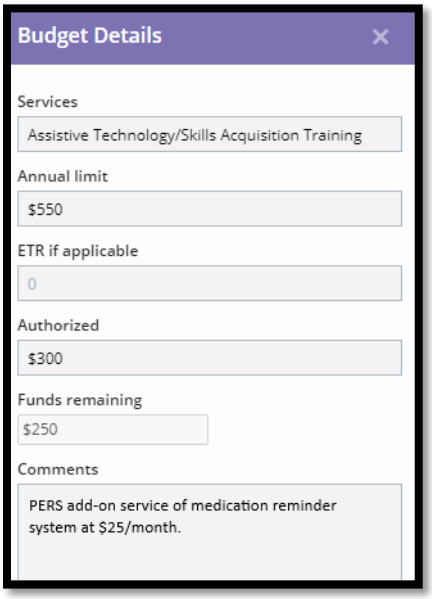
NOTE: For PERS add-on service fees that exceed a client's CFC SFY annual limit only, these "Exceed CFC Annual Service Limit" ETRs are **locally** reviewed and approved in your office.

Budget Calculator

The Budget Calculator is used to record AT Goods, AT Services, and SAT hours purchased/paid with the client's CFC SFY annual limit during that SFY. It also helps to monitor the amount that has been used for that SFY, what the client has purchased, and the budget remaining.



- Once AT Goods, AT Services, or SAT hours purchased are authorized in P1, the authorized amount will be automatically added to the SFY on the Budget Calculator.
- The case manager will add comments to the Budget Details indicating what AT Good, AT Service, or how many SAT hours were purchased along with any other helpful details.
  - Select the "Document" icon on the right side of the SFY line 
  - A Budget Details box will open where comments can be added



CFC SFY Annual Limit Exclusions and Limits

- Purchases must follow the guidelines provided for that benefit. See Assistive Technology (AT) and Skills Acquisition Training (SAT) benefit sections.
- Funding from the client's CFC SFY annual limit cannot be used to supplement the rate paid by Medicare or Medicaid for a purchase.
- If the AT Good or AT Service is covered by Medicare, Medicaid, or any other third-party payment source, a denial must be obtained for the item or service prior to payment from CFC or other social service program.
    - Exempted trust funds are not considered a third-party payment source and clients must not be required to use these funds prior to using state or federal funding.

Assistive Technology (AT) benefit

CFC Assistive Technology (AT) benefit includes AT Goods and AT Services.

AT Goods and AT Services must be:

1. In response to an assessed and documented need in the client's assessment and agreed to by the Client;
2. Authorized by the case manager to be implemented as part of and in accordance with a client's service plan;
3. Within the coverage and any specific parameters of the client's eligible program; and
4. A one-time AT Good or AT Service (not ongoing) that is not covered by Medicare, Apple Health, other insurances, or resources.

The cost of AT Goods and the fee for AT Services are both part of the client's CFC AT benefit and are applied to the client's CFC SFY annual limit of $550, which is based on the state fiscal year (July 1st to June 30th).

CFC AT Goods, including assistive equipment, are adaptive/assistive devices/items that increases a client's independence or substitutes for human assistance with an ADL, IADL, or health-related task. Exclusions and limitations of CFC AT Goods are listed below.

CFC AT Services may include:

- A written evaluation of what AT Good would best meet the client's need. The client's need must be determined and documented by the case manager in the service plan. The Contractor will evaluate what specific AT Good would best meet that need.
- Installation of a purchased AT Good (does not include any home modifications).
- Repair of an AT Good.
- Training (not ongoing) for the client and their caregivers on how to use and maintain the purchased AT Good that is:
    - Expected to achieve outcomes documented in the client's service plan;
    - Competent and relevant to the client's culture;

- Delivered in a manner and format that is individually tailored to the client's abilities, strengths, and learning styles; and
- Designed to be outcome based and measurable.

– A client's Medicaid Apple Health must be used first or exhausted for any covered evaluation or training available, for example those services provided by a Physical Therapist (PT), Occupational Therapist (OT), or Speech Therapist.

CFC AT Goods and AT Services are based on the assessed needs of the client. Before receiving AT Goods or AT Services:

– To help decide whether to authorize an AT Good and/or what AT Good would be most appropriate and cost-effective to meet the client's need, the client may need to obtain a recommendation from a professional.
  - The professional must:
    - have knowledge of the client's functional level, either through knowledge of the client or an assessment of the client, *and*
    - have knowledge that the client is functionally able to use the AT Good and would benefit from its use.
  - The professional could be:
    - the client's primary case manager who knows and has worked with the client; *or*
    - a treating healthcare professional familiar with the client who has examined the client and reviewed the client's medical/healthcare records.

– If the AT Good is something that may be covered by the client's medical benefits through Medicare, Medicaid (Apple Health), or a private insurance carrier, the client may also need a medical provider referral in order to have it covered by the client's medical benefits.

– The case manager will verify that the item is on the CFC Covered Items List and is within the $550 state fiscal year (SFY) annual limit. To determine whether an AT Good is a covered item:
  - Consult the "CFC AT Covered Item List"
    - If the item is on the list, it may be purchased from an AT contracted provider with subcode of AT Goods using CFC.
    - If the item is not on the list and it should be considered for addition to the list, contact your supervisor or Joint Relations Procurement (JRP) so that they may request consideration from the CFC Program Management team for ALTSA and DDA.
  - Confirm the AT Good meets CFC AT parameters:
    - Does it address the client's need; and
    - Is not on the Exclusions and Limits of CFC AT Goods list (described below).
  - To help determine if the requested item meets CFC AT Goods parameters, ask yourself:
    - What is the need that is being addressed?
    - Is this item adaptive or assistive? Such as a speech app for a non-verbal client to communicate their needs to their caregiver.
    - Will this item be:

    - helping the client be more independent with an ADL, IADL or health-related task? For example, use of a long-handled shoehorn so the client can put on their own shoes. **OR**
    - substituting for a caregiver needing to do the task? For example, a CPAP cleaning machine where the caregiver can do other tasks instead of cleaning the CPAP mask/gear.
- For DDA – The case resource manager may use the CFC AT Covered Item list for ideas of what is approvable, and if there is a question about what can be approved for a particular client's need staff with your supervisor or CFC Specialist.

Examples of CFC AT Goods

- Devices that automatically turn off appliances if there is no motion detected within a specific timeframe.
- Devices that enhance sound or allow a non-verbal client to achieve communication.
- Speech to text software; communication apps.
- PERS add-on services:
    - Fall detection
    - GPS
    - Medication management (reminder and/or dispenser) system.
        - Clients must be able to take their medications independently once reminded to take the medications and/or once the medications are dispensed.
- Devices that magnify or read and speak small print to enable the reader to read things such as medication labels and care instructions.
- Portable computing devices (tablet or laptop) – **base model level only** – that can increase an individual's independence or substitute for human assistance or allow a client to access tele-health appointments or remote services from a paid provider.

Exclusions and Limits of CFC AT Goods

- Any item that is covered under any other payment source, including but not limited to Medicare, Medicaid (Apple Health), and private insurance.
    - Medicare, Medicaid, or any other third-party payment source must deny payment for the item if the item is covered under one of these sources, prior to payment from CFC.
- Items provided without an assessed need or without an authorization by the case manager.
- Client choice of AT is limited to the most cost-effective option that meets the client's needs.
- Replacement of an AT item or similar item with the same function is limited to once every two years.
- Any items that are solely for recreational purposes.
- Subscriptions or items that require a monthly recurring cost such as connection fees, internet service or data plans, are not covered (with the exception of PERS add-on services).
- Portable computing device purchases are **base model level only**.

- Additions to basic model portable computing devices such as added memory or storage, mobile wireless capabilities (cellular), data, and accessories such as decorative cases/covers/coatings are not covered.
- Clients may use private funds to purchase additional memory or capabilities.

– Examples of items not covered under CFC AT:
  - Durable Medical Equipment (DME);
  - Specialized Medical Equipment (SME);
  - Specialized Equipment and Supplies (SES);
  - General use clothing or shoes that are not adaptive, such as slip-on shoes, and items which are considered medically necessary, including but not limited to compression socks/stockings and orthotics, that are covered by Medicaid Apple Health or another resource;
  - Environmental Modification;
  - Appliance locks that prevent access to food;
  - Hearing aids;
  - Prescription eyeglasses;
  - Reading glasses; or
  - Video surveillance or recording of client.

Exclusions and Limits of CFC AT Services

– Any service that is covered under any other payment source, including but not limited to Medicare, Medicaid (Apple Health), private insurance, waiver program, school, or other resources.
– Ongoing services.

Process to obtain AT Goods and AT Services

Documenting client's need for their CFC AT benefit

Medicaid will only pay for CFC AT Goods and AT Services when there is a documented need that the benefit service will address in a client's current CARE assessment.

– AT Goods,
  - For HCS/AAA, add the AT Good in the Equipment box on the most appropriate CARE screen. If necessary, complete an Interim assessment to add the client's need.

    Example: If the AT Good is to help a client be independent with putting on their shoes and needs/wants a long-handled shoehorn. Document the AT Good on the Dressing screen by selecting the "Assistive Technology" Type in the Equipment box with "needs/wants" as Status – this will pull the need to the Supports screen and can be assigned to the contracted AT provider. Add a comment on the Dressing screen specifying the AT Good is a long-handled shoehorn.

- For DDA, provide a description and explanation of the AT Good and how it will increase the individual's independence or substitute for human assistance with specific ADLs and/or IADLs or health-related tasks in the Person-Centered Service Plan (PCSP) comment box.

– AT Services (an evaluation, installation, repair, or training)
  - select "Programs: Other" on the Medical screen under the Treatments section.
  - In the comments section, add what AT Service is being requested.

Purchasing CFC AT

AT Goods can be purchased from an AT contracted provider with the AT Goods subcode, or if needed, a third-party purchaser such as a Community Choice Guide (CCG) for HCS/AAA clients or a Purchasing Goods and Services contracted provider for DDA clients. AT Services can be obtained by an AT contracted provider with the AT Services subcode.

AT contracted providers

– Find an AT contracted provider with the appropriate subcode/provider type on the CFC AT Providers list.
  - **Assistive Technology Goods** = Provider Type: Assistive Technology Provider with Taxonomy: 225CA0ATPL (*Assistive Technology Provider*)
  - **Assistive Technology Services** = Provider Type: Assistive Technology Practitioner with Taxonomy: 225CA2400X (*Assistive Technology Practitioner*)

– Not all items AT contracted providers sell are eligible AT Goods.

– Please consult with the AT contracted provider to determine if they sell the AT Good you are seeking – for example, an AT contracted provider who sells non-medical or medical devices such as a long-handled shoehorn or hand-held shower head does not sell tablets.

– Not all AT contracted providers are able to provide all AT Services (evaluation, installation, repair, or training). Please consult with them to determine what services they provide.

Not all AT contracted providers carry and sell all CFC AT Goods, such as tablets may not be sold by an AT contracted provider who sells non-medical or medical devices such as a long-handled shoehorn or hand-held shower head.

Third-party Purchaser – a Community Choice Guide (CCG) for HCS/AAA or a Purchasing Goods and Services contracted provider for DDA

– For HCS/AAA:
  - A contracted CCG may be used to purchase the AT Good *only*, meaning without the client, and just for the purchase transaction.
  - Under CFC AT, a CCG cannot provide other services aside from being the purchaser of the AT Good.
  - The local AAA office in your area will have a list of CCG providers that serve your client's county of residence
    - select a CCG who meets the qualifications and has chosen to be a purchaser as indicated by the Purchasing Subcode 1081SS [taxonomy: Non-medical

Equipment and Supplies (33NM00000L)] on their Community Choice Guiding contract.

- When using a CCG to purchase an AT Good, please note the CCG will be reimbursed for the actual amount spent on purchasing the CFC AT Good (SA075-U1 – CFC AT) plus the CCG's time issuing payment (SA266 – maximum of 4 units at $10/unit) will be applied to the client's CFC SFY annual limit of $550 and is subject to an approved "Exceed CFC Annual Service Limit" ETR if necessary.

– For DDA:
  - A contracted Purchasing Goods and Services (PG&S) provider may be used to purchase the AT Good and/or coordinate an AT Service.
  - The case resource manager (CRM) must review the Agency Contracts Database (ACD) to confirm the provider has a Purchasing Goods and Services contract in "signed" status.
  - The PG&S provider can be reimbursed $10 per unit (15 minute increments), for a range of 1 unit to 4 units, for time spent purchasing the item(s), or coordinating services, or issuing payment (SA266-U1 –maximum of 4 units at $10/unit); and reimbursed for the actual amount spent on purchasing the CFC AT Good (SA075-U1 – CFC AT).
  - A PG&S provider is the most cost-effective contracted provider to use.

Authorizing CFC AT Goods

– Connect with a contracted provider.
  - When making the request from an AT contracted provider with the AT Goods subcode, please inform the Contractor that the request is for AT Goods. As many of our AT contractors have multiple contracts, this will help them utilize their correct contract.

– Request a written itemized quote:
  - HCS/AAA – If using a CCG, the quote may not reflect their shopping without client fee, but this amount will need to be included in the total cost of the AT Good.
  - DDA – If using a Purchasing Goods and Services provider, the quote should contain:
    - The most appropriate and cost-effective AT Good; and
    - The presumed total cost prior to the items and services being provided.

– After obtaining the written itemized quote, the case manager will review it to ensure it is the most appropriate and cost-effective AT Good to meet the client's need as documented in the service plan.
  - The AT contracted provider cannot bill DSHS in excess of its "**usual and customary price"** per Federal regulations. Usual and customary means the price most commonly charged by the AT contracted provider for items sold to the general public.
  - If the quote received seems extraordinary or in excess of a usual and customary price, the case manager can request a quote from a different AT contracted provider or a contracted third-party purchaser.
    - If you do not know what a "usual and customary price" is of the item, do an internet search for the item to determine a usual cost range.

– The case manager will contact the client:
  - to advise them of the quote and obtain their consent to proceed with the ordering of the AT Good; and

- if the item is being shipped/delivered by the Contractor, verify the client's correct delivery address, including apartment numbers, etc. This is to help ensure the client receives the requested AT Good and to help prevent the item from being lost or stolen.

– If the quoted amount exceeds the client's CFC SFY annual limit of $550 or the balance the client has remaining, an "Exceed CFC Annual Service Limit" ETR will need to be created and approved before moving to the next step.
  - For ALTSA, after the ETR goes through the initial review of your office, it will be sent to the CFC Program Manager at Headquarters (HQ) for final review and decision making.
  - For DDA, the ETR is sent for review and final decision making to the CFC Specialists in the regions, and then, if needed, sent to DDA HQ.

– The case manager will notify the Contractor of the AT Good approval, and
  - If the AT Good is being delivered directly to the client by the Contractor, provide them with the client's correct delivery address; or
  - If allowed by your office/region, the AT Good can be shipped to the case manager who will deliver the AT Good to the client. Follow your office procedures/policy regarding receiving packages and delivery to client.

– Create the authorization to the contracted provider:
  - To pay for the CFC AT Good, use service code SA075-U1.
    – In the Comments section of the authorization, please note what the AT Good is.
  - If a third-party purchaser was used, add a service line for their purchasing time:
    – HCS/AAA:
      - Authorize service code SA266, maximum of 4 units at $10/unit for the purchasing transaction to a contracted CCG with a contract subcode of purchasing; and
      - select reason code "Purchase of Covered Assistive Technology"
    – DDA: authorize service code SA266-U1 to pay for the Purchasing Goods and Services provider's time spent making the purchase
  - Place authorization in "Reviewing" status.
  - Once it is confirmed the client received the AT Good and a receipt was received, update the authorization to "Approved" status.
  - Notify the contracted provider that the AT Good can be claimed via ProviderOne.

– Once authorized in P1, the total AT Good purchase amount (with the third-party purchaser fees if used) will be automatically added to the Budget Calculator. The case manager will add comments to the Budget Details indicating what AT Good was purchased along with any other helpful details, and

– To document and justify authorized payments made,
  - For HCS/AAA:
    – Submit a Social Services Packet Cover Sheet (DSHS 02-615) to DMS Hotmail with:
      - the receipt/invoice for the AT Good,
      - Activity Tracking Form (found in SCDS SA266) if CCG used, and

- any other supporting documents (i.e., written recommendation or denial letter if one was needed).

- For DDA:
  - File the following in the client's hard file:
    - the receipt/invoice for the AT Good, and
    - any other supporting documents (i.e., written recommendation or denial letter if one was needed).

Authorizing CFC AT Services

- Connect with an AT contracted provider with the subcode of AT Services and request the AT Service.
  - Please inform the Contractor that the request is for AT Services. As many of our AT contractors have multiple contracts, this will help them utilize their correct contract.
  - Please confirm the Contractor can perform the needed AT Service (i.e., maybe they only do evaluations and cannot do installation or repairs).
- After obtaining the written itemized quote for the most appropriate and cost-effective AT Service(s) to meet the client's need, the case manager will review the quote to ensure the scope of the request is appropriate for the AT Service based on the client's individualized assessed need.
- The case manager will contact the client to advise them of the quote and obtain their consent to proceed with the requested AT Service.
- If the quoted amount exceeds the client's CFC SFY annual limit of $550 or the balance the client has remaining, an "Exceed CFC Annual Service Limit" ETR will need to be created and approved before moving to the next step.
  - For ALTSA, after the ETR goes through the initial review of your office, it will be sent to the CFC Program Manager at Headquarters (HQ) for final review and decision making.
  - For DDA, the ETR is sent for review and final decision making to the CFC Specialists in the regions, and then, if needed, sent to DDA HQ.
- The case manager will notify the Contractor of the AT Service approval, inquire as to when the AT Service will be done, and remind them of any documents they may need to send you, i.e., written evaluation.
- Create the authorization to the contracted provider using the applicable service code:
  - SA636-U1 – Assistive Technology Services Evaluation
  - SA636-U2 – Assistive Technology Services Installation/Repair

    Note: For the AT Service of Repairs to an AT Good, the AT Contractor must have both subcodes (AT Goods and AT Services) in their contract because the fee for coordination and arrangement of the repair is authorized with SA636-U2, and the reimbursement for the repair is authorized with SA075-U1. Reimbursement can only occur after confirmation that the client received the repaired AT Good and the case manager receives the original receipt for repairs made.
  - SA636-U3 – Assistive Technology Services Training

- The rate is $60 per AT Service.

– Upon delivery of the AT Service, the Contractor must submit a final invoice/receipt and any applicable documents (i.e., written evaluation or training plan).
– After the final invoice/receipt is received, the case manager will contact the client to verify the AT Service(s) were received as authorized.
  - For AT evaluation, the AT Contractor will have also sent a written evaluation of what AT Good would best meet the client's need.
    – If this AT contracted provider has an AT Goods subcode and will be the provider of the AT Good, please obtain that written itemized quote as well.
    – If another contracted provider will be used, go through the process of obtaining the AT Good.
  - For AT training, the AT Contractor may have sent a written document of the training with expected and achieved outcomes.
– After receiving confirmation that the client received the AT Service, the case manager changes the authorization from "Reviewing" to "Approved" status.
– Once authorized in P1, the total AT Service amount will be automatically added to the Budget Calculator. The case manager will add comments to the Budget Details indicating what AT Service was purchased along with any other helpful details, and
– To document and justify authorized payments made,
  - For HCS/AAA:
    – Submit a Social Services Packet Cover Sheet (DSHS 02-615) to DMS Hotmail with:
      - the receipt/invoice for the AT Service, and:
      - for an AT evaluation, include the written evaluation of what AT Good would best meet the client's need;
      - for an AT installation, any supporting documents;
      - for an AT repair, include the original receipt for repairs made to the AT Good;
      - for AT training, any supporting documents regarding the training expectations and achieved outcomes.
  - For DDA:
    – File the following in the client's hard file:
      - the receipt/invoice for the AT Service, and:
      - for an AT evaluation, include the written evaluation of what AT Good would best meet the client's need;
      - for an AT installation, any supporting documents;
      - for an AT repair, include the original receipt for repairs made to the AT Good;
      - for AT training, any supporting documents regarding the training expectations and achieved outcomes.

Skills Acquisition Training (SAT)

Skills Acquisition Training (SAT) services include functional skills training to accomplish, maintain, or enhance ADLs, IADLs, or Health Related tasks. Health related tasks are specific tasks related to the needs of an individual that under state law licensed health professionals can delegate or assign to a qualified health care practitioner.

1. SAT is provided at the same time as client's other personal care (ADLs, IADLs, and/or health-related) tasks and must be provided directly to the client receiving CFC personal care services.
2. SAT is for the sole benefit of the client.
    - Formal and informal care providers may participate in the training in order to continue to support the client's goal outside of the training environment.
    - Use of this service should be determined and approved based on the client's direction.
3. Services may complement therapy or nursing goals when coordinated through the CARE plan.

SAT Qualified Providers:

- Individual Providers (IPs)
    - Must be an employee of the CDE; and
    - Must meet all other IP qualifications listed under Personal Care Services; and
    - May only provide ADLs that are in their scope of practice listed in WAC 246-980-140(5) and IADL tasks listed below.
- Home Care Agency providers
    - Must have a current Department of Health (DOH) license, as defined in Chapter 70.127 RCW and Chapter 246-335 WAC; and
    - A current contract with DSHS or AAA; and
    - May only provide ADL and IADL tasks listed below.

SAT provided by these providers is limited to training on ONLY the following tasks:

- Cooking and meal preparation
- Shopping
- Housekeeping tasks
- Laundry
- Limited Personal Hygiene tasks including only:
    - Application of deodorant
    - Application of make-up
    - Bathing (excludes any transfer activities)
    - Brushing teeth/denture care
    - Dressing
    - Menses care
    - Shaving with an electric razor
    - Washing hands and face
    - Washing, combing, styling hair

Documenting need for SAT in CARE:

1. On Medical screen, Treatment(s) section, select "Programs: Skills Acquisition Training"
    a. Add Comment indicating the tasks the client requests SAT to learn

for example, if a client wanted to learn how to shave, a suggested comment may be "client wants SAT to learn how to shave with an electric razor with non-dominant hand due to stroke affecting dominant side."

b. Select the provider and frequency

2. On the Supports screen, assign "Programs: Skills Acquisition Training" to the paid provider

For DDA clients, instructions for documenting a client's need may differ. CRM, please see your CFC Specialist for procedural instructions.

Authorizing SAT:

1. One-to-one even exchange of one personal care hour to one hour of SAT:
    - In-Home CFC clients may choose this option
    - authorized with service code T1019-U3;

or

2. Purchase SAT hours from a client's CFC SFY annual limit
    - In-Home and Residential clients may choose this option
    - authorized with service code T1019-U4.
        - The rate authorized and paid to the provider (the CDE for an IP or the Home Care Agency) will auto-populate in P1.
        - The authorized hourly rate is deducted from the client's CFC SFY annual limit.
        - Once authorized in P1, the total amount of purchased SAT hours authorized will be automatically added to the Budget Calculator.
        - The case manager will add comments to the Budget Details to add details of the SAT hours such as total number of hours, frequency of use, duration, what task is being learned, etc.
    - If the client's need, as documented on the individualized care plan, for SAT purchased hours exceeds the client's CFC SFY annual limit, the case manager may use the "Exceed CFC Annual Service Limit" ETR process.
        - For ALTSA, after the ETR goes through the initial review of your office, it will be sent to the CFC Program Manager at Headquarters (HQ) for final review and decision making.
        - For DDA, the ETR is sent for review and final decision making to the CFC Specialists in the regions, and then, if needed, sent to DDA HQ.

SAT Exclusions

- SAT does not include therapy such as Occupational Therapy, Physical Therapy, or Speech/Communication Therapy.
- SAT does not include nursing services or therapies that must be performed by a licensed Therapist or Registered Nurse.

Community Transition Services (CTS)

Community Transition Services (CTS) are one-time, set-up expenses necessary to help a client discharging from a qualified institutional setting: a skilled nursing facility (SNF), an institution for mental disease (IMD) or an intermediate care facility for individuals with intellectual disabilities (ICF/IID) to set up their own home in the community. When CTS are furnished to clients, the service is not considered complete, and cannot be authorized until the client discharges from the qualified institution AND is enrolled in the CFC program – determined functionally and financially CFC eligible.

CTS Definition

- Non-recurring set-up expenses for clients transitioning from a qualified institutional setting to a home and community-based setting.
- Are usually a one-time package of services, a grouping of items and services at the time of discharge getting the client into their community home.
- Are completed within 30 days of discharge from a qualified institutional setting.
- Allowable expenses are those necessary to enable a client to establish a basic household that do not constitute room and board and may include:
  - Security deposits required to obtain a lease on an apartment or home, including first month's rent;
  - Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, bed/bath linens, and basic items essential for living outside the institution;
  - Set-up fees or deposits for utilities, including telephone, electricity, heating, water, and garbage;
  - Services necessary for the client's health and safety such as pest eradication and one-time cleaning prior to occupancy;
  - Moving fees/expenses; and
  - Activities to assess need, arrange for, and procure needed resources.
- This service includes the training to the client and their caregivers, in the maintenance or upkeep of equipment purchased only under this service and does not duplicate training provided under other waiver services.
- Community Transition Services are furnished only to the extent that the:
  - Services are reasonable and necessary as determined through the CARE plan development process, and
  - Services are clearly identified in the CARE plan, and
  - The client is unable to meet such expense, and
  - Services cannot be obtained from other sources.
- CFC CTS funds may not exceed $2500 per discharge for items and services.
  - If reasonable and necessary services and items are determined as needed and exceed $2500, the Case Manager may use the ETR process to request the higher amount.

- The CFC "Community Transition Services" ETR would be sent to the CFC Program Manager at HQ for approval after field review.

Qualified Institutional Settings

- Skilled Nursing Facilities (SNF)
- Institution for Mental Disease (IMD)
  - most common are Eastern and Western state hospitals
  - Department of Health (DOH) licensed psychiatric hospitals with more than 16 beds
    - Select the Facility Type "Hospital Psychiatric License"; press "search"
    - A list will be created, select the License # of the facility to confirm their license is still valid (has not expired)
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

See LTC Manual, Chapter 10 – Nurse Facility Case Management and Relocation for more information on the use of CTS for clients discharging from a nursing facility.

CTS Providers

- Providers of CTS vary based on the needs of the client, for example, movers or pest eradicators.
- Providers of CTS are contracted with local AAA or DDA offices for the client's county of residence. These CTS providers hold a valid Community Transition and Sustainability Services (CTSS) contract and are paid directly via ProviderOne.
- Providers must meet any licensing or certification required by state statute or regulation to provide their services.
- Additionally, if the needed service is not one that is regulated, the State will ensure that such services are delivered as specified by the waiver beneficiary and detailed in the client's CARE plan.

NOTE: CTS service providers such as pest eradicators, janitorial services, and movers must be contracted with the Community Transition and Sustainability Services (CTSS) contract and paid directly via ProviderOne. No other purchasing option is available for these services (including using a purchaser – a CCG provider for HCS/AAA or a PG&S provider for DDA).

Documenting client's need for CTS

A requirement of the Centers for Medicare and Medicaid Services (CMS) is that a client's need for any service we pay for be documented in the CARE assessment, to reflect a client's need for CTS goods and/or services:

1. On Medical screen, Treatment(s) section, select "Programs: Other"

a. Add a comment indicating what CTS goods and/or services are needed, an example is: "moving services and essential goods for client to transition from ESH into their own apartment in the community."
b. Select the provider and frequency.

2. On the Supports screen, assign "Programs: Other" to the paid provider.

If a Community Choice Guide (CCG) is also being used to help with the process of transitioning to the community from a qualified institution, such as locating an apartment, to reflect this need for the CCG's service coordination, in addition to the separate CTS reflection (as noted above):

1. On Medical screen, Treatment(s) section, select "Programs: Community Integration"
   a. Add a comment such as "CCG will purchase CTS goods and services for client's transition from ESH to the community."
   b. Select the provider and frequency.
2. On the Supports screen, assign "Programs: Community Integration" to the contracted CCG provider.

For DDA clients, instructions for documenting a client's need may differ. CRM, please see your CFC Specialist for procedural instructions.

CTS Exclusions and Limits

- Community Transition Services (CTS) may not be used for items that an AFH, ARC, EARC or AL facility are required to provide per WAC 388-76-10685 (AFH settings) and WAC 388-78A-3011 (AL settings).
- Community Transition Services do not include:
  - Ongoing monthly rental expense;
  - Mortgage expense;
  - Room and board;
  - Regular utility charges;
  - Home modifications or adaptations; and/or
  - Household appliances or items that are intended for purely diversion/recreational purposes, such as a television, cable service, or DVD/DVR/VCR players.
- CTS funds do not pay for items or services that would otherwise be covered under other payment sources, including but not limited to Medicare, Medicaid, private insurance, and other resources.
- CTS funding are not available for clients discharging from an Evaluation & Treatment (E&T) center or a "step-down" facility.
- See WAC 388-106-0275 which reviews the limits to CFC CTS.

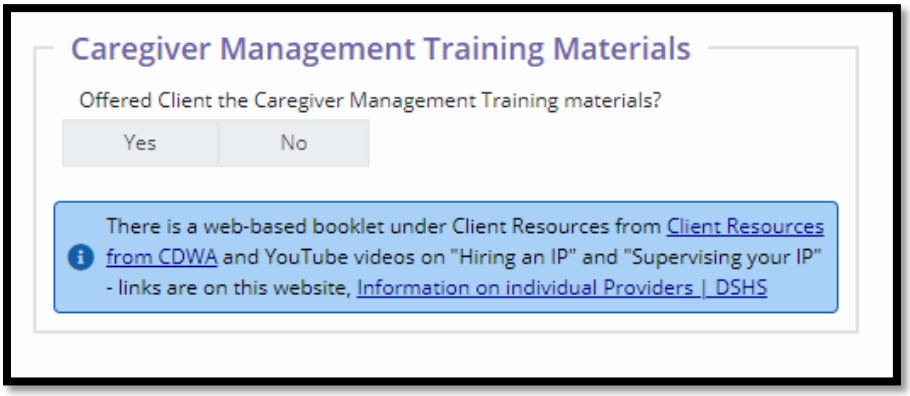
Caregiver Management Training

Caregiver Management Training is a service that the Centers for Medicare and Medicaid Services (CMS) requires when a state offers Community First Choice (CFC) as one of their Long-Term Services and Supports (LTSS). As Washington state has chosen to provide CFC as one of their Medicaid LTSS programs, Caregiver Management Training materials are available to any client and/or legal representative who would like to receive it. A client may request this Caregiving Management Training material at any time.

The Caregiver Management Training is designed as a self-study training to help clients understand how to select, manage, and dismiss a personal care provider. There is a web-based booklet and also two videos on YouTube.

Clients are offered the training by the case manager during service planning such as their assessment or when they are changing to an IP. A section in CARE Web has been created to easily document the Caregiver Management Training material was offered to the client and/or their legal representative. Having this information in CARE Web allows us to be able to pull a report and supply it to CMS when asked.

Indicate on the Profile screen under the Client Details section in CARE if the client and/or their legal representative was offered the Caregiver Management Training materials.



1. The web-based self-study training booklet, “Managing Employer Handbook”, which is downloadable from the CDWA website, Client Resources section. This booklet as well as the “Managing Employer Quick Start Guide” which has general information to help a client and their IP, can be found under the General Information section of the Client Resources page.

   There are also two online videos available on YouTube:
   - How to Hire the Right Individual Provider - YouTube
   - Supervising Your Individual Provider - YouTube

   Topics include:
   - Understanding the CARE plan;

- Creating job descriptions;
- Locating caregivers;
- Pre-screening, interviewing, and completing reference checks;
- Training, supervising, and communicating effectively with caregivers;
- Tracking authorized hours worked;
- Recognizing, discussing, and attempting to correct any caregiver performance deficiencies;
- Discharging unsatisfactory caregivers; and
- Developing a back-up plan for coverage of personal care services when the regular caregiver is not available or requires relief.

2. Through individualized training from a qualified Caregiver Management Training provider. Clients who have and manage multiple care providers will be offered the opportunity to receive individualized training on how to select, manage, and dismiss their caregivers.

Caregiver Management Training Providers

Community Choice Guides (CCG)

- CCGs can be used by HCS/AAA clients.
- The CCG must contract with DSHS through an AAA before being paid to provide services and must meet any licensing or certification required by State statutes or regulations. Prior to contracting, the AAA must verify that the CCG:
  - Has a valid current photo identification and Social Security card; *and*
  - Has cleared the initial and ongoing background checks as required by state law and remain free of disqualifying crimes and/or negative actions; *and*
  - Is age 18 or older.
- The CCG must also demonstrate by relevant successful experience, training, license, or credential that they have the skills and abilities to provide Caregiver Management Training services that are:
  - Expected to achieve outcomes identified by the client; *and*
  - Competent and relevant to the client's culture; *and*
  - Delivered in a manner and format that is individually tailored to the client's abilities, strengths, and learning styles.

Peer Support Specialist

- Peer Support Specialist must contract with the Department before being paid to provide peer support services for caregiver management training.
- Prior to contracting, the Department must verify that the Peer Support Specialist:
  - Has a valid current photo identification and Social Security card; *and*
  - Has cleared the initial and ongoing background checks as required by state law and remain free of disqualifying crimes and/or negative actions; *and*

- Is age 18 or older.

– The Peer Support Specialist must also demonstrate by relevant successful experience, training, license, or credential that they have the skills and abilities to provide Caregiver Management Training services that are:
  - Expected to achieve outcomes identified by the client; *and*
  - Competent and relevant to the client's culture; *and*
  - Delivered in a manner and format that is individually tailored to the client's abilities, strengths, and learning styles.

SERVICE NEEDS BEYOND CFC ONLY

Home Delivered Meals (HDM)
If a CFC-only client is receiving home delivered meals (HDM), regardless of payment funding source, a 0.5 hour (30 minutes) deduction from the client's eligible in-home care hours will be made for each meal up to a 15 hour maximum deduction.

HDM is a service paid under the COPES Waiver and a CFC client is functionally eligible to enroll in COPES (see next section for more information). Please see LTC Chapter 7d – COPES for more information about HDM. To received HDM, a client must meet all the criteria below:

- Is homebound and lives in their own private residence;
  - Homebound means that leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, intermittent absences for non-medical reasons, such as a trip to the barber or to attend religious services.
- Is unable to prepare the meal;
- Doesn't have a caregiver (paid or unpaid) available to prepare the meal; and
- Receiving the meal is more cost-effective than having a paid caregiver.

CFC clients that need other services beyond those available under CFC,

- For HCS/AAA clients, may also receive services through the COPES waiver if they meet criteria for the COPES service.
- For DDA clients,
  - may also receive services through CFC and either the Basic Plus, Core, Children's Intensive In-Home Behavioral Support (CIIBS), or Individual and Family Service (IFS) waivers.
  - must receive prior approval from DDA Headquarters to enroll on a waiver program.

MOVING BETWEEN CFC AND CFC+COPES

1. If a CFC client has needs beyond the amount, duration, and scope of the CFC program, consider enrolling the client into the COPES waiver and choosing the program option CFC+COPES on the Care Plan screen in CARE.

Clients who are financially eligible for CFC can ONLY be authorized under CFC+COPES if:

- Documentation in CARE indicates why the client's needs are beyond the amount, duration, or scope of CFC; and
- The Public Benefits Specialist (PBS) has verified eligibility for COPES waiver services. You must work with your PBS even if the client is on Supplemental Security Income (SSI).

To be eligible for waiver or institutional services, a recipient must not have:

1. Transferred an asset for less than fair market value;
2. Ownership of a home that has equity greater than the current Home Equity Limit found on the Washington Apple Health Income & Resources Standards chart (April 2023 changes);
3. Ownership of an annuity that does not meet the requirements in Chapter 182-516 WAC.

2. When authorizing HCBS waiver services (COPES) for SSI recipients, inform the SSI recipient of the requirement to submit an "*Eligibility Review for Long-Term Services and Supports"* form, DSHS 14-416. This form will need to be submitted to the PBS for processing.

   a) The CFC+COPES option may be used when the client requires frequent COPES services.
   - If the client is enrolled in CFC+COPES, they are enrolled in **both** the CFC state plan *and* the COPES waiver.
   - The client will not need to switch between programs to access the services as they are already eligible for these two programs.
   - When a client is enrolled in CFC+COPES, they **must access at least one ongoing COPES service every month** (such as Wellness Education or Home Delivered Meals) in order to continue to be eligible for the COPES waiver. See LTC Manual, Chapter 7d – COPES for more information.

   b) If the client is only enrolled in CFC and wishes to access a waiver service on a short-term basis (for example: the client is eligible for and needs a piece of SME),
   - The client may enroll in CFC+COPES temporarily to access the waiver service.
   - Once the service has been completed, the client then disenrolls from the COPES waiver and returns to only the CFC program.
   - No change needed on the Care Plan screen in CARE – client's program selection will remain "CFC" only.

   If the client's need for a COPES waiver service is **short-term** ask the client to complete and sign DSHS 14-416 at the time of assessment (when the COPES service need is requested by the client and documented in CARE). This will ensure that the PBS is notified of the change before the short-term use of COPES waiver service ends.

3. Use the Financial/Social Services Communication form (DSHS 14-443) in Barcode to notify the PBS of an SSI recipient applying for waiver services.
   a) The client must be financially approved and converted to CFC+COPES before a COPES waiver service can be authorized and paid.

b) Complete an Acknowledgement of Services (DSHS 14-225) form if this was not done at the time of the assessment to meet both CFC and COPES waiver enrollment requirements.
c) Verify financial eligibility has been completed and there is a communication in Barcode from the PBS showing that the client is financially eligible for waiver program services.

4. Authorize COPES Services:
   a) If this will be an **ongoing** COPES service (e.g., Home Delivered Meals or Adult Day Care):
      i) Enter the RAC for COPES into CARE;
      ii) Select the CFC+COPES dropdown selection on the Care Plan screen in CARE;
      iii) The authorization Start Date will be the first day the COPES service begins, and the End Date will be the CARE plan end date; *and*
      iv) Notify PBS on Barcode form DSHS 14-443 of the COPES program addition for the CARE plan period. Advise the PBS of the start date for the COPES waiver service(s).

Examples of ongoing monthly COPES services:
- Wellness Education (WE)
- Adult Day Services
  - Adult Day Health (ADH)
  - Adult Day Care (ADC)
- Home Delivered Meals (HDM)
- Skilled Nursing Services

   b) If this will be a **short-term** waiver service use (e.g., environmental modification service of a wheelchair ramp):
      i) Enter the RAC for COPES into CARE;
      ii) The authorization Start Date must be the 1st day of the month for the month that the needed short-term service will be paid;
      iii) Notify PBS on Barcode form DSHS 14-443 of the COPES program addition – advise that this is short-term for 30 days; *and*
      iv) Once the service is paid,
         (1) Close all COPES service lines/authorizations; *and*
         (2) Terminate the COPES RAC effective the last day of the month; *and*
         (3) Notify PBS on Barcode form DSHS 14-443 of the COPES termination date.

Note: If the client is also on Medicare and has high prescription co-payments, you may go through the process above (client completes and signs DSHS 14-416 and DSHS 14-225 with CFC and COPES selected and you notify the PBS) and authorize CFC+COPES for the entire CARE plan period with client receiving at least one ongoing monthly waiver service (i.e. Wellness Education).

SWITCHING BETWEEN PROGRAMS

Functional eligibility for MPC clients wishing to enroll in CFC **or** CFC+COPES:

- MPC eligible clients were determined not to meet institutional level of care criteria and do not qualify functionally for CFC services.
  - They can no longer do a "one month flip" to COPES waiver when their needs are beyond the amount, duration, and scope of MPC services. This is because MPC clients do not meet institutional level of care (NFLOC for ALTSA and ICF/IID for DDA).
- If they are re-assessed in CARE and found to meet institutional level of care criteria, they *must* change programs from MPC to CFC as they are no longer functionally eligible for MPC.
- Require a functional eligibility determination in CARE before enrolling in CFC.
- The institutional level of care criteria applies to both CFC and to COPES.

COPES Financial Eligibility

- Financial criteria for the COPES waiver is different than for the CFC program.
- A PBS must approve eligibility before enrolling any client into COPES, which may require a financial eligibility review.
- Contact PBS through Barcode form 14-443 as soon as you are aware the client wishes to enroll in COPES.

MPC to CFC	A functional eligibility determination in CARE that determines NFLOC is required.
MPC to CFC+COPES	• A functional eligibility determination in CARE that determines NFLOC is required. • Financial eligibility review and determination through financial.
MAGI on ABP MPC to CFC+COPES	MAGI-based ABP MPC (N-track) clients are not part of the Aged, Blind, Disabled population that is required to be eligible for waiver services, therefore the client: • must complete a Social Security Disability Determination (or the Non-Grant Medical Assistance (NGMA) process – see Appendix IV in LTC Manual Chapter 7h – Appendices for information on NGMA) before being considered for COPES or any other waiver service. • must also apply for SSI related medical using HCA form 18-005. Information about the form and the process to fill out the application can be found here. Clients who have completed the above-mentioned disability determination process, will then need to have a functional and financial determination as noted in the "MPC to CFC+COPES" row above.
CFC to CFC+COPES	CFC clients enrolled in COPES are required to continue to receive a service from COPES *every month* in order to maintain waiver eligibility. Clients who need a one-time service from COPES, such as SME, may only remain on the waiver if they receive a monthly, ongoing COPES waiver service.

	Examples of COPES services that may occur monthly include: - Wellness Education - Home Delivered Meals - Adult Day Services - Skilled Nursing services

ACKNOWLEDGEMENT OF SERVICES FORM

By federal rules, clients who are functionally and financially eligible for CFC or both CFC and a waiver program can choose to receive their care in an institution or in the community. The Acknowledgment of Services form (DSHS 14-225) is the documentation that the program choices have been explained to the client and the client has acknowledged their choice of CFC state plan services and/or waiver services over nursing home or institutional care. For DDA, this acknowledgement of services form is entitled Voluntary Participation form (DSHS 10-424).

- This Acknowledgement of Services form is mandatory as it provides documentation that the federal requirement has been met.
  - CFC services and waiver services cannot be authorized without the client's dated signature on this form.

- If the CFC and/or waiver client enters the nursing facility, services are terminated on that date.
  - A new Acknowledgment of Services form is required if the client wants to return to the community on CFC and/or on waiver services. The DSHS 14-225 is documentation of the client's choice to receive services outside of the nursing facility.
  - A new DSHS 14-225 is not required if the nursing facility stay is short-term, less than 30 days (i.e. client is attending post-surgery rehabilitation and will be returning to place of residence.).

- Two copies are required – one copy is given to the client and a correctly completed dated/signed copy is placed in the client's file:
  - For HCS/AAA, send completed DSHS 14-225 to DMS Hotmail to be included in the client's electronic case record.
  - For DDA, file completed DSHS 10-424 in the client's hard file.

RESOURCES

Related Washington Administrative Codes (WAC)

WAC 388-106-0270	Services available under CFC
WAC 388-106-0271	Limits to Skills Acquisition Training

WAC 388-106-0272	Qualified providers for Skills Acquisition Training
WAC 388-106-0273	PERS add-on services
WAC 388-106-0274	Limits to Assistive Technology
WAC 388-106-0275	Limits to Community Transition Services
WAC 388-115-0510	Qualifications of an individual provider (IP)

Forms

DSHS 02-615	Social Services Packet Cover Sheet
DSHS 10-424	Voluntary Participation (DDA)
DSHS 13-712	Behavioral Health Wraparound Support (BHWS) Request for MCO Funding
DSHS 14-225	Acknowledgement of Services
DSHS 14-416	Eligibility Review for Long Term Services and Supports
DSHS 14-443	Financial/Social Services Communication (use form in Barcode)
HCA 18-005	Health Care Authority Washington Apple Health Application for Aged, Blind, Disabled / Long-Term Care Coverage

Exception to Rule (ETR) Reference Grid for CFC Services

Here is a link to an ETR reference grid for CFC services.

Acronyms

AAA	Area Agency on Aging
ABP	Alternative Benefit Plan
ACD	Agency Contracts Database
ALTSA	Aging and Long-Term Support Administration
ADL	Activities of Daily Living
AFH	Adult Family Home
ALF	Assisted Living Facility
ALTSA	Aging and Long-Term Support Administration
ARC	Adult Residential Care
AT	Assistive Technology
BHPC	Behavioral Health Personal Care
BHWS	Behavioral Health Wraparound Support
CARE	Comprehensive Assessment and Reporting Evaluation
CBHS	Community Behavioral Health Support
CCG	Community Choice Guide
CDE	Consumer Directed Employer
CDWA	Consumer Direct Care Network of Washington
CFC	Community First Choice
CIIBS	Children's Intensive In-Home Behavioral Support
CM	Case Manager, also refers to DDA Case Resource Manager
CMS	Centers for Medicare and Medicaid Services

CN	Categorically Needy
COPES	Community Options Program Entry System
CRM	Case Resource Manager with DDA
CTS	Community Transition Services
CTSS	Community Transition and Sustainability Services
DDA	Developmental Disabilities Administration
DME	Durable Medical Equipment
DMS	Document Management Services
DOH	Department of Health
DSHS	Department of Social and Health Services
EARC	Enhanced Adult Residential Care
ECR	Electronic Case Record
ETL	Electrical Testing Laboratories
ETR	Exception to Rule
FCC	Federal Communications Commission
GPS	Global Positioning System
HCA	Health Care Authority
HCBS	Home and Community-Based Services
HCS	Home and Community Services
HIU	Hub Imaging Unit
HQ	Headquarters
IADL	Instrumental Activities of Daily Living
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
IFS	Individual and Family Service
IMD	Institute for Mental Disease
IP	Individual Provider
JRP	Joint Relations Procurement
LTC	Long-Term Care
LTCW	Long-Term Care Worker
LTSS	Long-Term Services and Supports
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
MPC	Medicaid Personal Care
ND	Nurse Delegation
NFLOC	Nursing Facility Level of Care
NGMA	Non-Grant Medical Assistance
P1	ProviderOne
PBS	Public Benefits Specialist – HCS financial worker
PCSP	Person-Centered Service Plan
PERS	Personal Emergency Response System
PG&S	Purchasing Goods and Services – a DDA contracted provider
RAC	Recipient Aid Category
RCW	Revised Code of Washington
RND	Registered Nurse Delegator

SAT	Skills Acquisition Training
SCDS	Service Code Data Sheet
SER	Service Episode Record
SES	Specialized Equipment and Supplies
SFY	State Fiscal Year
SME	Specialized Medical Equipment
SNF	Skilled Nursing Facility
SSAM	Social Service Authorization Manual
SSI	Supplemental Security Income
UL	Underwriters Laboratories, Inc.
WAC	Washington Administrative Code

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
08/2024	Victoria Nuesca	• revised MCO-funded behavioral health section, formerly known as BHPC, to align with the services of BHWS and CBHS • moved the CBHS / BHWS section into the Personal Care section to align with the MPC chapter	
04/2024	Victoria Nuesca	• Added information about home delivered meals reduction in in-home hours • Revised eligibility section for better flow • Added clarification for CFC Services introduction section • Aligned words with CARE Web terms/screens • Fixed formatting, links, and acronyms	H24-018
08/2023	Victoria Nuesca and Sue Halle	• Added clarification to sections on Personal Care, Nurse Delegation, and the CFC state fiscal year annual limit • Added procedure tasks/assistance to Skills Acquisition Training (SAT) and Community Transition Services (CTS) • Updated info to reflect the Budget Calculator	H23-071
05/2023	Victoria Nuesca	• Update DDA CFC Program Manager contact info • Corrected links • Added authorization information for a client's once-in-a-lifetime PERS console replacement • Skills Acquisition Training (SAT) – amount	H23-039

		deducted when SAT hours are purchased from CFC SFY annual limit will be the authorized provider rate	
11/2022	Victoria Nuesca and Pon Manivanh	• Fixed grammatical errors • Removed reference to rescinded Chapter 11 – Individual Providers • Added clarification to the following: ▪ Out-of-State Personal Care ▪ Personal Emergency Response System (PERS) add-on service of Global Positioning System (GPS) ▪ Caregiver Management Training material	H22-064
08/2022	Victoria Nuesca and Pon Manivanh	• Updated info to correctly reflect the changes that are now in place due to the Consumer Directed Employer (CDE). • Clarified policy language for better understanding and consistency. • Added Community Transition Services (CTS) provider information to align with other program chapters. • Updated the CFC Assistive Technology (AT) Covered Item list. • Added an Exception to Rule (ETR) Reference Grid for CFC Services • Corrected links.	H22-042
03/2022	Victoria Nuesca and Pon Manivanh	• Updated info to reflect that Individual Providers are now employees of the Consumer Directed Employer (CDE) and made the appropriate changes, i.e., removing the Home Care Referral Registry which will now be a function of the CDE. • Aligned the "In-Home Personal Care Services Outside Washington" section with the policy for Medicaid Personal Care (MPC). • Clarified the Assistive Technology (AT) Benefit section to provide more descriptive information and instruction. • Reorganized process steps for further clarity and simplicity. • Corrected links.	H22-020
12/2021	Victoria Nuesca and Pon Manivanh	Clarified policy related to PERS, AT and CTS. Added the service codes for AT Services. Added the new CTS limit for items and services per discharge.	H22-005

		Made minor grammatical word changes. Updated links.	
05/2021	Victoria Nuesca with Pon Manivanh	Fixed formatting; changed order of sections. Clarified policy related to AT, SAT, and CTS; added some clarifications for DDA staff.	H21-050
11/2020	Victoria Nuesca	Updated section related to BHPC Wraparound Support services funded by MCO	H20-104
03/2019	Victoria Nuesca	Placed chapter into the new template. Fixed hyperlinks and form numbers. Clarified policy for CFC services.	H19-015
10/2017	Jacqueine Cobbs	Changes based on the CFC State Plan Amendment	H17-078
03/2017	Jacqueine Cobbs	Information related to RSN funding of personal care services was updated and moved into new section, 7h – Appendices	H17-021
12/2015	Tracey Rollins	Review the chapter for clarification of policy and procedure as it relates to CFC	H16-002

Medicaid Personal Care

Chapter 7c describes the Medicaid Personal Care (MPC) program which provides assistance with personal care services that enable individuals to remain in, or return to, their own communities through the provision of coordinated, comprehensive and economical home & community-based services (HCBS). Rules governing MPC can be found in Washington Administrative Code (WAC) 388-106-0200 through 0235 – see Resources for full list of WACs.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Victoria Nuesca ALTSA Community First Choice (CFC) Program Manager
360.725.2393 victoria.nuesca@dshs.wa.gov

Sue Halle DDA Community First Choice (CFC) Program Manager
425.512.7764 suzan.halle@dshs.wa.gov

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BACKGROUND

Medicaid Personal Care (MPC) is a Medicaid State Plan program. It is available to those clients who do not meet institutional level of care otherwise known as Nursing Facility Level of Care (NFLOC) in Aging and Long-Term Support Administration (ALTSA) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) in Developmental Disabilities Administration (DDA). MPC provides an opportunity for individuals to receive assistance with personal care tasks so they can remain in their own home or move into a community-based setting.

Just like Community First Choice (CFC), MPC pays for personal care which is assistance with the following Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and health-related tasks (for example, nurse delegation). Assistance for IADLs is available only when the client also needs assistance with ADLs.

ADLs and IADLs as listed in Washington Administrative Code (WAC) 388-106-0010 include:

ADLs	• Bathing • Body Care • Dressing • Eating • Personal hygiene • Toilet use	• Medication management • Transfer • Bed mobility • Locomotion outside room • Locomotion in room & immediate living environment • Walk in room & immediate living environment
IADLs	• Meal preparation • Ordinary housework • Essential shopping	• Wood supply *(when sole source of heat)* • Travel to medical services • Telephone use

ELIGIBILITY

To be eligible for the MPC program, and before services can be authorized, the client must meet **ALL** of the following eligibility criteria:

Age

If services are authorized by Home and Community Services (HCS)/Area Agency on Aging (AAA), clients must be 18 years of age or older;

If services are authorized by DDA:

- Clients who meet DDA's determination of a developmental disability may be any age
- Children with functional disabilities who do not meet DDA's determination of a developmental disability may be served by DDA until age 18. DDA will refer adults age 18 and over who are not DDA eligible to HCS.

Functional eligibility

Individual must meet functional eligibility as determined by Comprehensive Assessment Reporting Evaluation (CARE).

- The individual has an unmet or partially met need as defined in WAC 388-106-0210; and
- Does not meet institutional level of care as outlined in WAC 388-106-0355(1).

Financial eligibility

To be financially eligible for MPC, an individual must be eligible for non-institutional categorically needy (CN) or alternative benefit plan (ABP) medical. See Chapter 7a of the Long-Term Care (LTC) manual for more information regarding financial eligibility for LTC programs.

MPC SERVICES

The services available through MPC are limited to personal care services, nurse delegation (in certain settings), nursing services, and caregiver management training.

Use the following service codes to authorize MPC services:

- In-home personal care T1019-U6
- Adult Family Home (AFH) personal care T1020-U1
- Adult Residential Care (ARC) personal care T1020-U2
- Nurse Delegation (Residential Settings only) H2014-U5

Personal Care Services

The definition of personal care services can be found in WAC 388-106-0010 and is as follows:

> *Physical or verbal assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) due to functional limitations. Assistance is evaluated with the use of assistive devices.*

Personal care services include assistance:

- Provided to enable clients to accomplish tasks that they would normally do for themselves if they did not have a disability;
  - This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the client to perform a task.
  - Personal care services may be provided on an episodic or on a continuing basis.
- To complete ADLs;
- To complete IADLs if not comprising the entirety of the service for an individual and the client also has an unmet need and accepts assistance with ADLs;
- For tasks completed outside of the client's home as specified in the CARE plan.
  - Personal care may be furnished to support clients in community activities or to access other services in the community.

In-home providers can only be paid once for the same hour/unit of personal care service, even when providing services in a multi-client household.

- Personal care may be furnished in order to assist a person to function in the workplace or as an adjunct to the provision of employment services.

Requesting funding from the Managed Care Organization (MCO) for Behavioral Health Wraparound Support (BHWS) or Community Behavioral Health Support (CBHS) service

Please see Chapter 22a – Apple Health Managed Care (MCO) and Apple Health Medicare Connect (DSNP) for Behavioral Health Wraparound Support (BHWS) or Community Behavioral Health Support (CBHS) service information and eligibility criteria.

In-Home Personal Care Services Outside Washington

Per WAC 388-106-0035, a client may receive personal care services from an Individual Provider (IP) employed through the Consumer Directed Employer (CDE) while temporarily traveling out of the state for **less than 30 days**.

All the following must be completed in order for out-of-state in-home personal care to be received and paid for:

1. Prior to the client leaving Washington, the case manager must:
   - Discuss with the client and/or client representative how the client's personal care needs will be met while the client is traveling out-of-state;
   - Obtain the temporary out-of-state address and phone contact;
   - Document in a SER note the conversation including the client's departure date and return date; and
   - Update the Client Details on the Contact Details screen in CARE to reflect the client's Washington address and phone contact **as well as** the temporary out-of-state address and phone contact(s);
2. Client's CARE plan must be in "current" status and services are authorized in the client's service plan prior to departure;
   - Out-of-state services are strictly for client's personal care and must not include provider's travel time or expenses;
   - The IP must be in good standing with the CDE and have met all required qualifications;
   - Other services such as nurse delegation need to be closed while client is out-of-state.
3. Personal Care services must only be provided in the United States.
4. The client must also advise the CDE of the dates they will be out-of-state, and that the IP (employed through the CDE) will be with them. The IP should also advise the CDE.

Personal Care services are not allowed outside the United States.

If the client requests to receive personal care services out-of-state for **more than 30 days**, in addition to the above being completed, the following protocol must be followed:

5. The client must maintain Medicaid eligibility per Health Care Authority (HCA) WAC 182-503-0520;

Note: Steps 5 – 11 are in addition to the four (4) steps noted above.

6. The client must provide in writing to the case manager their intent to return to Washington once the purpose of their absence has been accomplished and provide adequate information of this intent. Written documentation from the client must be added to their case file (electronic case record for HCS/AAA or hard copy file for DDA);
7. Advise the Public Benefits Specialist (PBS) via Barcode (ALTSA use DSHS form 14-443 and DDA use form 15-345) of the following:
    - The dates the client will be out-of-state,
    - The client's intention of returning to Washington and that a written document of such was received and placed in their file, and
    - That the client will continue receiving personal care through MPC.
8. Prior to the client leaving the state, an Exception to Rule (ETR) must be reviewed and approved at the local, regional/AAA level.
    - ETR Category and ETR Type will be "Other"
    - Date Range: "Custom"
    - Start date and End date boxes: will be the dates the client will be out of the state.
    - Hours/Rate, Units, and Quantity boxes: leave blank as the client will not be eligible for or able to use hours beyond their current CARE plan.
    - WAC(s) referenced: add 388-106-0035 and 182-503-0520
    - Request description section: indicate the ETR is for client to receive personal care out-of-state and to allow payment to the CDE (CDWA) for the IP that is also out-of-state beyond 30 days out-of-state.
    - Justification for request section: explain/notate the protocol steps listed above (in the less than 30-day section) that have been completed; and confirm that the written document from the client has been filed in the client's case record.
    - ETR must go through your local office process for final review and approval.
9. During the time out of Washington, the client must not have been determined eligible for Medicaid or state funded health care coverage in another state (other than coverage in another state for incidental or emergency medical care); *and*
10. The client and/or their representative must contact the case manager:
    - Every 30 days while the client is out of state to confirm that the CARE plan is meeting client's needs; *and*
    - Each contact must be documented in a Monitor Plan SER note.
    - Set a CARE tickler to remind the case manager of the next required check-in.

Nurse Delegation

Nurse Delegation means nursing tasks, such as administration of medication, blood glucose monitoring, insulin injections, ostomy care, simple wound care, or straight catheterization, which may be delegated under the direction of a licensed, registered nurse if the provider meets the requirements of a nursing assistant certified and/or registered in the State of Washington.

The following tasks CANNOT be delegated:

- Injections other than insulin,
- Central lines,

- Sterile procedures, and
- Tasks that require nursing judgments.

In the MPC program, nurse delegation is only available in Adult Family Homes (AFH) and some Adult Residential Care (ARC) facilities. In-home personal care providers are compensated for these services within their regular hourly rate.

For more information related to nurse delegation see LTC Manual Chapter 13 - Nurse Delegation.

Nursing Services

Nursing Services offer clients, providers, and case managers with health-related assessment and consultation in order to enhance the development and implementation of the client's plan of care.

The goal of nursing services is to help promote the client's maximum possible level of independence and contribute nursing expertise by performing the following activities:

- Comprehensive Assessment Reporting Evaluation (CARE) review;
- Nursing assessment/reassessment;
- Instruction to care providers and clients;
- Care and health resource coordination;
- Referral to other health care providers; and/or
- Evaluation of health-related care needs affecting service planning and delivery.

A Nursing Services provider is not a direct care provider of intermittent or emergency nursing care, skills, or services requiring physician orders and supervision. Skilled treatment is provided by Nursing Services only in an emergency. For example, the provisions of CPR or First Aid until emergency responders arrive to provide care.

This service does not typically require an authorization in ProviderOne since HCS and AAA nursing staff are most commonly used for this service. For more information about Nursing Services, including referral process and resources, see LTC Manual Chapter 24 - Nursing Services.

Nursing Service provider qualifications:

- Registered Nurse licensed under Chapter 18.79 Revised Code of Washington (RCW) and Chapter 246-840 WAC
- Contracted with the AAA, employed by the AAA, or employed by HCS

Caregiver Management Training

Caregiver Management Training is designed as a self-study training to help clients understand how to select, manage, and dismiss their personal care provider. There is a web-based booklet and also two videos on YouTube. Training should be provided to any client that requests this information.

The web-based self-study training booklet, "Managing Employer Handbook", which is downloadable from the CDWA website, Client Resources section. This booklet as well as the "Managing Employer Quick Start Guide" which has general information to help a client and their IP, can be found under the General Information section of the Client Resources page.

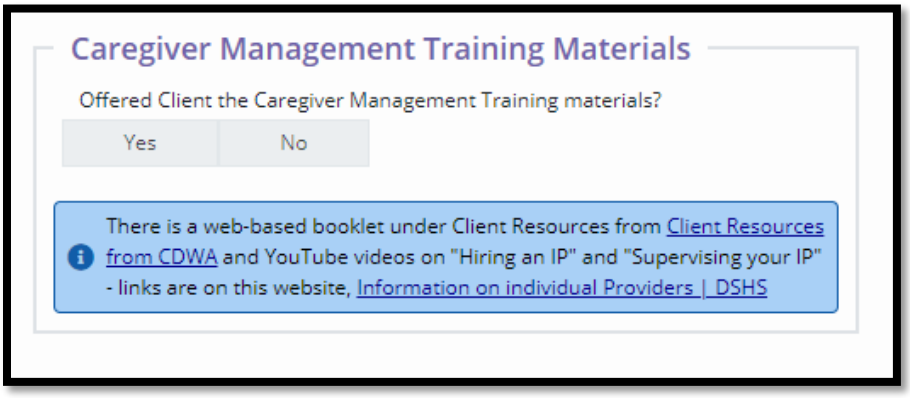
There are also two online videos available on YouTube:

- How to Hire the Right Individual Provider - YouTube
- Supervising Your Individual Provider - YouTube

Training topics include:

- Understanding the CARE plan;
- Creating job descriptions;
- Locating caregivers;
- Pre-screening, interviewing, and completing reference checks;
- Training, supervising, and communicating effectively with caregivers;
- Tracking authorized hours worked;
- Recognizing, discussing, and attempting to correct any caregiver performance deficiencies;
- Discharging unsatisfactory caregivers; and
- Developing a back-up plan for coverage of services when the regular caregiver is not available or requires relief.

Clients may be offered the training by the Case Manager during service planning such as their assessment or when they are changing to an Individual Provider (IP). Indicate on the Profile screen under the Client Details section in CARE if the client and/or their legal representative was offered and/or if they requested the Caregiver Management Training materials.



SETTINGS & PROVIDER QUALIFICATIONS

Clients enrolled in MPC have the right to choose to receive services using a qualified provider in one of the following settings:

Client's Home

Where the client resides (own home, relative's home, etc.). Client's "own home" is defined in WAC 388-106-0010.

Individual Provider (IP)

Clients may choose an Individual Provider (IP) as their provider. If the client chooses an IP,

- The IP is an employee of the Consumer Directed Employer (CDE) contracted vendor for Washington state, Consumer Direct Washington (CDWA),
- The client will work with the CDE and the IP on assignment of the client's authorized in-home hours,
- The client will be the one to select, schedule, supervise, direct, and dismiss the IP.
    - If a client is unable to provide supervision, an alternate supervisor must be identified in the CARE plan.
    - The client is responsible for identifying back-up caregivers to cover for sick or vacationing caregivers.
    - If a client wants training on how to select, direct, or dismiss an in-home caregiver, they may request training materials at any time from their case manager or the CDE. See Caregiver Management Training for more information.

Qualifications:

- Meet the qualifications listed in WAC 388-115-0510;
- Are hired and employed by the CDE (see LTC Manual, Chapter 11 – Consumer Directed Employer for more information on CDE);
- Must have:
    - Successfully passed the appropriate criminal background check(s);
    - Met all training and certification requirements; ***and***
- Must be:
    - Age 18 or older;
    - Able to legally work in the United States; ***and***
- Are regulated under Chapter 388-71 WAC (specifically 388-71-0500 through 388-71-1006), and RCW 74.39A.250.

CDE contact numbers dedicated specifically to CM, Client, or IP:

For Case Managers *only*:
- 1-866-932-6468

For Clients and IPs:
- 1-866-214-9899
- infocdwa@consumerdirectcare.com

Home Care Agency:

Qualifications:

- Must have a current Department of Health (DOH) license;
- Must have a current Contract with DSHS or AAA; ***and***
- Are regulated under Chapter 70.127 RCW, and Chapter 246-335 WAC.

Adult Family Home (AFH)

Qualifications:

- AFH License under Chapter 70.128 RCW and Chapter 388-76 WAC;
- Contract with DSHS; ***and a***
- Specialty designation, if needed, based on the needs of the client.

Licensed Assisted Living Facility (ALF)

Qualifications:

- ALF License under Chapter 18.20 RCW and Chapter 388-78A WAC;
- Contract with DSHS under Chapter 388-110 WAC; ***and***
- Current DSHS contract for Adult Residential Care (ARC) services.

Community Settings

Personal care tasks specified on the CARE plan may be provided outside the client's residence:

- To support clients in community activities or to access other services in the community.
- To assist a person to function in the workplace or as an adjunct to the provision of employment services.

> Payment for services cannot occur while the client is in an institutional setting (such as hospital, nursing facility, residential habilitation center, or jail). Authorizations for services must be adjusted or terminated during this time.

SERVICE NEEDS BEYOND MPC

Home Delivered Meals (HDM)
If an MPC client is receiving home delivered meals (HDM), regardless of payment funding source, a 0.5 hour (30 minutes) deduction from the client's eligible in-home care hours will be made for each meal up to a 15 hour maximum deduction.

HDM is a service paid under the COPES waiver. Please see LTC Chapter 7d – COPES for more information about HDM. To received HDM, a client must meet all the criteria below:

- Is homebound and lives in their own private residence;

  - Homebound means that leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, intermittent absences for non-medical reasons, such as a trip to the barber or to attend religious services.
- Is unable to prepare the meal;
- Doesn't have a caregiver (paid or unpaid) available to prepare the meal; and
- Receiving the meal is more cost-effective than having a paid caregiver.

See below to determine if the MPC client would be eligible for CFC+COPES and choose to have HDM through COPES if they meet the criteria.

Moving from MPC to CFC or CFC+COPES

If an MPC client's needs exceed what MPC can provide, and the MPC client wishes to enroll in CFC **or** CFC+COPES:

- MPC eligible clients were determined not to meet institutional level of care criteria and do not qualify functionally for CFC services.
- If they are re-assessed in CARE and are found to meet institutional level of care criteria, they *must* change programs from MPC to CFC as they are no longer functionally eligible for MPC.
- The institutional level of care criteria applies to both CFC and to COPES.

See LTC manual chapter 7b – CFC and chapter 7d – COPES for additional information.

MPC to CFC	A functional eligibility determination in CARE that determines NFLOC is required.
MPC to CFC+COPES	• A functional eligibility determination in CARE that determines NFLOC is required. • Financial eligibility review and determination through financial.
MAGI on ABP MPC to CFC+COPES	MAGI-based ABP MPC (N-track) clients are not part of the Aged, Blind, Disabled population that is required to be eligible for waiver services, therefore the client: • must complete a Social Security Disability Determination (or the Non-Grant Medical Assistance (NGMA) process – see Appendix IV in LTC Manual Chapter 7h – Appendices for information on NGMA) before being considered for COPES or any other waiver service. • must also apply for SSI related medical using Health Care Authority (HCA) form 18-005. Information about the form and the process to fill out the application can be found here. Clients who have completed the above-mentioned disability determination process, will then need to have a functional and financial determination as noted in the "MPC to CFC+COPES" row above.

RESOURCES

Related WACs and RCWs

WAC 388-106-0200	MPC Services
WAC 388-106-0210	MPC Eligibility
WAC 388-106-0215	MPC Eligibility Date
WAC 388-106-0220	MPC Remaining Eligible
WAC 388-106-0225	MPC Paying for Services
WAC 388-106-0230	MPC Employment
WAC 388-106-0235	MPC Waiting Lists
WAC 388-71	Home and Community Services and Programs
WAC 388-76	Adult Family Home Minimum Licensing Requirements
WAC 388-106	Long-Term Care Services
WAC 388-110	Contracted Residential Care Services
WAC 246-335	In-Home Services Agencies
WAC 246-840	Practical and Registered Nursing
RCW 18.20	Assisted Living Facilities
RCW 70.127	In-Home Services Agencies
RCW 70.128	Adult Family Homes

Acronyms

AAA	Area Agency on Aging
ABP	Alternative Benefit Plan
ADL	Activities of Daily Living
AFH	Adult Family Home
ALF	Assisted Living Facility
ALTSA	Aging and Long-Term Support Administration
ARC	Adult Residential Care
BHWS	Behavioral Health Wraparound Support
CARE	Comprehensive Assessment and Reporting Evaluation
CBHS	Community Behavioral Health Support services
CDE	Consumer Directed Employer
CDWA	Consumer Direct Care Network of Washington
CFC	Community First Choice
CM	Case Manager
CN	Categorically Needy
COPES	Community Options Program Entry System
CRM	Case Resource Manager with DDA
DDA	Developmental Disability Administration
DOH	Department of Health
DSHS	Department of Social and Health Services

ECR	Electronic Case Record
ETR	Exception to the Rule
HCA	Health Care Authority
HCBS	Home and Community-Based Services
HCS	Home and Community Services
IADL	Instrumental Activities of Daily Living
ICF/IID	Intermediate Care Facilities for Individuals with Intellectual Disabilities
IP	Individual Provider
LTC	Long-Term Care
LTSS	Long-Term Services and Supports
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
MPC	Medicaid Personal Care
ND	Nurse Delegation
NFLOC	Nursing Facility Level of Care
NGMA	Non-Grant Medical Assistance
P1	ProviderOne
PBS	Public Benefits Specialist – HCS Financial Worker
PCSP	Person-Centered Service Plan
RAC	Recipient Aid Category
RCW	Revised Code of Washington
RND	Registered Nurse Delegator
SCDS	Service Code Data Sheet
SER	Service Episode Records
SSAM	Social Service Authorization Manual
WAC	Washington Administrative Code

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
4/2025	Annie Moua	• Update template • Update MPC contact	
08/2024	Annie Moua	• Removal of BHPC • Added BHWS and CBHS reference in Chapter 22a	H24-044
04/2024	Annie Moua	• Aligned Out-of-State Personal Care and Caregiver Management Training sections with updated information • Added information about home delivered meals reduction in in-home hours • Fixed formatting, links, and Acronyms	H24-018
10/2023	Annie Moua	• Corrected eligibility for services authorized by DDA	H23-071
06/2023	Annie Moua	• Updated contacts	H23-039

03/2022	Grace Brower	• Updated contacts and links, updated info to reflect that Individual Providers are now employees of the Consumer Directed Employer (CDE) and made the appropriate changes, clarified information regarding In-Home Personal Care Services Outside Washington, added acronyms	H22-020
10/2020	Beth Adams	• Moved to new template, re-arranged content	

Community Options Program Entry System (COPES)

Chapter 7d defines the Community Options Program Entry System (COPES) waiver and the services available to enrolled clients. This waiver provides services to over 51,000 clients who live in their own homes, adult family homes or assisted living facilities. The purpose of the waiver is to develop and implement supports and services to successfully enable individuals to live in their chosen community setting.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Annie Moua — Medicaid Unit Manager
509.590.3909 anne.moua@dshs.wa.gov

Julie Cope — RCL/NFCM Unit Manager
360.725.2529 julie.cope@dshs.wa.gov

Susan Worthington — Nursing Services Program Manager
360.485.2291 susan.worthington@dshs.wa.gov

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WHAT IS COPES?

COPES is one of the 1915(c) Medicaid waivers operated by ALTSA. This waiver provides the opportunity for individuals who, in the absence of the home and community-based services and supports provided under COPES, would otherwise require the level of care furnished in a nursing facility. The COPES waiver was first established in 1982 and is one of the oldest waivers in the nation!

Services in the COPES waiver act as a wraparound to services available to the Community First Choice (CFC) State Plan program. Since July 1, 2015, it would be highly unusual for a person to be enrolled in COPES and not also be enrolled in CFC because personal care is no longer available in COPES. Rules governing the COPES waiver can be found in WAC 388-106-0300 through 0335.

WHO IS ELIGIBLE FOR COPES?

To be eligible for the COPES program, and before services can be authorized, the client must meet **ALL** the following eligibility criteria:

- Age:
  - Age 18 or older & blind or has a disability as outlined in WAC 182-512-0050; or is
  - Age 65 or older
- Functional Eligibility:
  - CARE algorithm determines that the individual meets nursing facility level of care as outlined in WAC 388-106-0355(1), WAC 182-515-1506; or
  - Will likely need the level of care within 30 days unless waiver services are provided; and
  - Client chooses community services under the waiver instead of nursing facility services.
- Financial Eligibility:
  - Meet the Supplemental Security Income (SSI) disability criteria; and
  - Be eligible for institutional categorically needy (CN) medical coverage group.
  - See Chapter7a of the LTC manual for more information regarding financial eligibility for LTC programs.
- Individual must have needs that exceed what is available in CFC.

Use ACES On-line to verify financial eligibility at initial, annual, or significant change assessments.

Clients who are functionally and financially eligible for the COPES waiver program can choose to receive their care in an institution or in the community. The Acknowledgment of Services form (DSHS 14-225) is the documentation that the program choices have been explained to the client and the client has acknowledged their choice of waiver services or nursing facility care. This form is a federal requirement and waiver services cannot be authorized without the client's signature on it. Have the client sign the form, submit the original to DMS and provide the client with a copy of the form for their records.

If a waiver client enters a nursing facility for less than 30 days, waiver services cannot be provided during the time the client is in the nursing facility. The end date for all waiver service authorizations must be changed to match the admission date into the nursing facility. However, enrollment on the waiver is not terminated and eligibility does not have to be re-determined when returning to the community. A new DSHS 14-225 is not required if the stay is short term (less than 30 days).

If a waiver client enters a nursing facility for 30 days or longer, waiver services are terminated, and the client is dis-enrolled from the waiver. The client must have their eligibility reestablished if they reenter the community on waiver services. A new DSHS 14-225 is required when the client returns to the community after a stay of 30 days or more in the nursing facility.

When a MAGI-based client on CFC is enrolling in the COPES waiver or a MAGI-based client is leaving MPC and enrolling in the COPES waiver, the start date for the waiver needs to be the 1st day of the following month. Start dates should not be mid-month.

WHERE CAN INDIVIDUALS RECEIVE COPES SERVICES?

COPES services can be received by clients living in a private residence or a licensed residential setting. See the chart below for a summary of services and location.

Waiver Services by Setting

Service	In-Home COPES	Residential COPES
Adult Day Care	◆	
Adult Day Health	◆	◆
Client Support Training/Wellness Education	◆	◆
Community Choice Guide	◆	◆
Community Supports: Goods and Services	◆	Available to assist with transitioning to an in-home setting
Environmental Modifications	◆	
Home Delivered Meals	◆	
Nursing Services	◆	◆
Skilled Nursing	◆	◆
Specialized Medical Equipment & Supplies	◆	◆
Transportation	◆	◆

SERVICES AVAILABLE THROUGH COPES WITH PROVIDER QUALIFICATIONS

Clients may receive any combination of waiver services if they meet the secondary eligibility criteria for each of these services. Waiver services cannot be duplicative of each other.

Federal rule requires that waiver services not replace other services that can be accessed under Medicaid, Medicare, health insurance, Long Term Care (LTC) insurance, and other community or informal resources available to them.

- If a client has other insurances or resources, case managers must document the denial of benefits before the client can access waiver services. This documentation must be in the client's file.
- Waiver services may not be used when the vendor refuses the reimbursement or considers the payment inadequate from the other resources.
- Waiver services may not supplement the reimbursement rate from other resources.
- ETRs are not allowed for the above circumstances.

Providers of waiver services must meet certain qualifications and be contracted through the local AAA prior to services being authorized. Each local AAA maintains a list of contracted, eligible providers for HCS and AAA.

Note: All services must be indicated in a client's plan of care and assigned to a paid provider prior to authorization. Clients must have also approved their plan of care.

The services available through the COPES waiver are described below (defined in WAC 388-106-0300 and 388-106-0305).

Adult Day Care (ADC)

ADC is a supervised daytime, in-person or remotely through telephonic or other technology media, program providing core services for adults with medical or disabling conditions that do not require the intervention or services of a registered nurse or licensed rehabilitative therapist acting under the supervision of the client's physician or Advanced Registered Nurse Practitioner (ARNP). For more detailed information regarding how to make referrals, authorize and monitor this service, including details about the remote/hybrid program, see LTC Manual Chapter 12 Adult Day Services.

Adjusting CARE generated hours for ADC:
For clients receiving adult day care services, there is no manual reduction of personal care hours generated by CARE. For all clients receiving ADC, **the assessor must include the ADC provider as informal support when coding status for each ADL and IADL task** that is provided by the ADC provider.

Add Adult Day Care program in CARE as a *Treatment* in the *Medical screen*, as required.

Adult Day Care Service Codes:

- S5102 UA **Adult Day Care intake –** authorize for intakes, both in-person and remote
  - Authorization for client intake is a onetime approval per attendance cycle
  - If the client discharges from services and at a later date is reauthorized, the authorization may be forced by the HQ Program Manager.
- S5100 **Adult Day Care in-person services** – when the client is attending ADC for less than 4 hours in a day
  - 1 unit = 15 minutes
- S5100 U1 **Adult Day Care remote services –** when the client is attending ADC remotely
  - 1 unit = 15 minutes
  - The provider will be able to claim a minimum of one (1) hour, or four (4) units, per visit.
- S5102 HQ **Adult Day Care day services –** when the client is attending for 4 or more hours in a day
  - 1 unit = 15 minutes

Provider Qualifications:

- Meet the requirements of WAC 388-71-0702 through 388-71-0776; and
- Have a current contract with the Department.

Adult Day Health (ADH)

ADH is a supervised daytime program, in-person or remotely through telephonic or other technology media, providing skilled nursing and rehabilitative therapy services in addition to the core services of Adult Day Care. Adult Day Health services are appropriate for adults with medical or disabling conditions that require the intervention or services of a registered nurse or licensed rehabilitative therapist acting under the supervision of the client's physician or ARNP. For more detailed information regarding how to make referrals, authorize and monitor this service, including the details about the remote/hybrid program, see LTC Manual Chapter 12 Adult Day Services.

Adjusting CARE generated hours for ADH

For clients receiving adult day health services, there is no reduction of personal care hours generated by CARE. For all clients receiving ADH, ***the assessor must include the ADH provider as informal support when coding status for each ADL and IADL task*** that is provided by the ADH provider.

Adult Day Health Service Codes:

- S5102 CG **Adult Day Health intake –** authorize for intakes, both in-person and remote
  - Authorization for client intake is a onetime approval per attendance cycle.
  - If the client discharges from services and at a later date is reauthorized, the authorization may be forced by the HQ Program Manager.
- S5102 TG **Adult Day Health in-person day services –** when the client attends ADH four (4) hours or more per day
- S5100 U2 **Adult Day Health remote services –** when the client is attending ADH remotely
  - 1 unit = 15 minutes
  - The provider will be able to claim a minimum of one (1) hour or four (4) units, per visit.

Adult Day Health Provider Qualifications:

- Meet the requirements of WAC 388-71-0702 through 388-71-0839, and
- Have a current contract with the Department.

Client Support Training/Wellness Education (WE)

The Client Support Training/Wellness Education (WE) service is identified in the client's CARE assessment and if needed, specific training needs can be identified in a professional evaluation. This service is provided in accordance with a therapeutic goal outlined in the plan of care and includes but is not limited to:

- Adjustment to a serious impairment,
- Maintenance or restoration of physical functioning,
- Self-management of chronic disease,
- Acquisition of skills to address minor depression,
- Development of skills to work with care providers including behavior management, and
- Self-management of health and well-being through use of actionable education materials

Note: In a residential setting, the training must be in addition to and not a replacement of the services required by the department's contract with the residential facility.

Please note regarding Client Training Support services offered by an occupational therapist or physical therapist: These services must exceed the scope of services offered through the Medicaid State Plan (Apple Health). Per WAC 182-501-0060, occupational and physical therapy are services offered through home health and outpatient rehabilitation services, and these services, available as a benefit from the client's medical plan, should be exhausted first. For example, a client may need a home safety evaluation for fall prevention. This is a service offered through the State Plan and this benefit should be used before authorizing client training for a home safety evaluation.

Prior to authorizing Client Training by these provider types, the client should coordinate with their healthcare provider and request a prescription for services through the Apple Health benefit and be referred to a Medicaid contracted home health agency. If the service is denied or the client has exhausted their State Plan benefit, document this in the Service Episode Record (SER) prior to authorizing Client Training by an occupational or physical therapist. The OT or PT contracted to provide Client Training must also have a prescription from the healthcare professional to provide this service to ensure it is not a duplication of existing services offered through the State Plan.

The Client Training Contract (1073XP) is used for Client Support Training services provided by medical and non-medical providers as well as providers like Chronic Disease Self-Management (CDSM) and PEARLS workshops.

Provider qualifications are based on provider type:

- Chronic Disease Self-Management Training – Individual:
  - Certification in an evidence-based, chronic disease, self-management training program such as the Stanford University Chronic Disease Self-Management Program (CDSMP).

- Chronic Disease Self-Management Training – Agency:
  - Each employee/trainer must have certification in an evidence-based, chronic disease, self-management training program such as the Stanford University Chronic Disease Self-Management Program (CDSMP).
- Community Mental Health Agency:
  - Licensed under WAC 182-538
- Home Health Agency:
  - Licensed under Chapter 70.127 RCW and Chapter 246-335 WAC
  - Have core provider agreement with Health Care Authority
- Home Care Agency:
  - Licensed under Chapter 70.127 RCW and Chapter 246-335 WAC
- Certified Dietician/Nutritionist:
  - Certified under Chapter 18.138 RCW as dietician/nutritionist
  - Have core provider agreement with Health Care Authority
- Independent Living Provider meeting one of the following qualifications:
  - Bachelor's degree in social work or psychology with two years of experience in the coordination or provision of Independent Living Services (ILS); or
  - Two years of experience in the coordination or provision of ILS in a social service setting under qualified supervision; or
  - Has had a personal disability for four years and experience providing independent living skills training.
- Physical Therapist
  - PT license under Chapter 18.74 RCW
  - Have core provider agreement with Health Care Authority
  - Have site visit as required by federal regulations
- Registered Nurse
  - RN license under Chapter 18.79 RWC and Chapter 246-840 WAC
  - Have core provider agreement with Health Care Authority
- Licensed Practical Nurse
  - LPN license under Chapter 18.79 RWC and Chapter 246-840 WAC
  - Have core provider agreement with Health Care Authority
- Community College
  - Community-based, non-profit organizations in Washington State which provide services by, and for, people with disabilities. Centers for Independent Living receive funding through the Federal Department of Education/Rehabilitation Services Administration and are contracted in the state of Washington through the Department's Division of Vocational Rehabilitation.
- Pharmacist
  - Licensed per Chapter 18.64 RCW and Chapter 246.863 WAC
  - Have core provider agreement with Health Care Authority
- Human Service Professional
  - Bachelor's degree or higher in Psychology, Social Work or a related field with a minimum of two years of experience providing services to aging or disabled populations.
- Occupational Therapist

  - OT license under Chapter 18.59 RCW
  - Have core provider agreement with Health Care Authority
- Centers for Independent Living (CIL)
  - Community based non-profit organizations in Washington State which provide services by and for people with disabilities. CILs receive funding through the Federal Dept. of Education/Rehabilitation Services Administration and are contracted in the State of Washington through the Department's Division of Vocational Rehabilitation.
- Board-Certified Music Therapist

Client Support Training Examples:
Music Therapy:
Music therapy is the use of musical interventions to promote the accomplishment of individualized goals within a therapeutic relationship. Services may include music improvisation, receptive music listening, song writing, lyric discussion, music and imagery, music performance, or other expressive musical forms.

Contracted providers are required to conduct an intake and review documentation regarding the waiver participant to determine the most effective course of music therapy intervention, develop and implement a plan, provide progress reports to the case manager every 90 days, at a minimum, and participate in and/or consult with the client's case managers as needed.

Chronic Disease Self-Management:
The Chronic Disease Self-Management Program (CDSM) is a workshop for adults with at least one chronic health condition, which may include arthritis. It focuses on disease management skills including decision making, problem-solving, and action planning. This interactive program aims to increase confidence, physical and psychological well-being, knowledge of ways to manage chronic conditions, and motivation to manage challenges associated with chronic diseases. Key activities may include interactive educational activities like discussions, brainstorming, practice of action-planning and feedback, behavior modeling, problem-solving techniques, and decision making; as well as symptom management activities like exercise, relaxation, communication, healthy eating, medication management, and managing fatigue.

PEARLS (Program to Encourage Active, Rewarding Lives):
PEARLS is a treatment program designed to reduce symptoms of depression and improve quality of life among older adults and among all-age adults with epilepsy. The goals of the sessions include solving problems and becoming socially and physically active.

STAR-C:
STAR-C is an evidence-based behavioral intervention where the caregivers of clients with dementia are taught to monitor concerns, to identify environmental triggers for behavioral challenges, and to develop effective methods to alter the environment to decrease disruption to a client. Caregivers are also taught to identify pleasurable activities for the client as a means of decreasing depression.

Client Support Training Service Codes (for Client Training: Behavior Support, see next section**):**

- **H2014 UC** (Medical) and **H2014 UD** (Non-Medical) - The provider's credentials is the determinate for which code to use. For example, if a nurse is teaching a client how to use their diabetic medications, then using code H2014 UC would be appropriate.
- **T2025 U1** for Chronic Disease Self-Management workshops
- **T2025 U2** for PEARLS workshops
- **T2025 U6** for Star-C

NOTE: There is a limit of 80 units (20 hours) in a six-month period for client support training services. This service can be authorized again after the initial six-month period has ended.

Client Training-Behavior Support:
This waiver service provides *training* to the client and caregivers in an in-home, adult family home, or assisted living facility setting through the development of a client-centered behavior support plan. The goal of this plan is to develop positive interactions and outcomes which help facilitate a successful care plan.

Please note: Client Training-Behavior Support should not be authorized in place of a client's Medicaid health insurance benefits. If a client may benefit from additional behavioral health services offered through a client's insurance (also referred to as a client's Apple Health benefit), a referral should be made to the local mental health agency. Behavioral health services provided through insurance include but are not limited to individual therapy, family therapy, group therapy, medication management, crisis services, and the Program for Assertive Community Treatment (PACT).

> For services related to the Residential Support Waiver (Expanded Community Services or Specialized Behavior Support), please refer to Chapter 7f.

Provider responsibilities once the service is authorized:

- The behavior support provider will begin with an assessment of the client's behavior to determine the causes, triggers, and purposes behind the challenging behavior.
- The behavior support provider will **develop a behavior support plan** within 30 days of the client's assessment and provide this to the case manager. The behavior support plan will address things such as:
  - Factors that are associated with an individual's documented or identified behaviors.
  - Written strategy of behaviorally specific interventions designed to address those behaviors and promote optimal functioning with recommendations for improving the client's overall quality of life, teaching methods and environmental changes designed to decrease the behaviors that may be impacting the client remaining or transitioning to a community setting.
  - Direct interventions with the client to decrease the behavior that compromises their ability to remain in the community. This could include demonstrating and practicing new interventions and skills with formal and informal supports and significant others to support the individual in their community setting.

- Case consultation regarding escalating situations.
- Make recommendations for treatment and assisting with making referrals for community behavioral health services.

Examples of Client Training-Behavior Support:

Client #1 Example: Lisa has a traumatic brain injury and aphasia. She experiences anxiety daily and becomes easily irritable and agitated and has difficulty expressing herself. Lisa becomes frustrated when she is not understood by others and at times yells at the caregiver. Lisa and her Case Manager have a meeting, and Lisa agrees to receive Client Training-Behavior Support.

The behavior support provider begins working with Lisa to develop new techniques when communicating with caregivers. The provider also works with Lisa's caregivers to develop successful interventions when Lisa becomes agitated and angry, as well as strategies to help prevent the behavior from occurring. A behavior support plan is developed.

In addition to Client Training-Behavior Support services, a referral is made to the local mental health agency for individual therapy. Lisa begins seeing a counselor and attending weekly therapy sessions to address her anxiety.

Client #2 Example: John has quadriplegia and depression and experiences crying/tearfulness daily, is easily irritable and agitated, and uses foul language with caregivers. As a result, John is having difficulty maintaining caregivers, jeopardizing his ability to remain in the community. During his annual assessment, John agrees to receive Client Training-Behavior Support services. In addition, a referral is made to the local mental health agency to address John's depression through individual therapy.

The behavior support provider begins working with John to develop communication skills and identify triggers when communicating with caregivers. In addition, the provider works with John's caregivers on successful interventions, as well as strategies to minimize the severity or duration of the behavior. A behavior support plan is developed.

Client #3 Example: Erin experiences delusional thoughts and is living at an adult family home (AFH). Erin is already receiving direct counseling services from her local mental health agency. Erin is often resistive to care and has been combative in the past with caregivers. The Case Manager received a phone call from the AFH explaining that providing care to Erin was increasingly difficult and recently she had begun cussing at caregivers and others living in the home.

The Case Manager visits Erin at the AFH, and she agrees to accept services through Client Training-Behavior Support. The behavior support provider begins working with Erin and staff at the AFH to identify the causes, triggers, and purpose behind the behaviors. A behavior support plan is developed.

CARE Assessment Documentation for Client Training-Behavior Support:

- On the Treatments screen in CARE: Select Client Training/Waiver under the Rehab Restorative Training header.
- On the Pre-Transition and Sustainability screen found below the Client Details section in CARE, select the Sustainability Goals tab. From the drop down, select the goal description, and describe the goal of behavior support in the comments. This section helps the provider understand the specific reasons for the development of a behavior support plan.
- On the Care Plan Supports screen, assign Client Training to the behavior support provider.
- Send the chosen behavior support provider a copy of the Assessment Details, Service Plan, and Sustainability Goals.

The Behavior Support Services Contract (1044XP) is used for Client Training-Behavior Support and the qualifications include:

- Master's Degree in Psychology, Education, Social Work, or related discipline, or a Doctoral Degree in Psychology, Education, or related field.

Client Training-Behavior Support Service Code:

- **H2019** Behavior Support – Individual

Note: there is a limit of 80 units (20 hours)/month in a three-month (92 day) period for client support training services. This service can be authorized again after the initial three-month (92 day) period has ended with a local ETR.

Wellness Education (WE) is a customized, monthly newsletter service available to clients enrolled in COPES to help manage health related issues, achieve goals on their service plan, and address topics of community living. Data from a client's assessment is used to target articles specific to the client.
It is important that the client's address is correct on the Client Contact screen. NSAs receive a copy of the client's WE, so it is also important that the NSAs address is accurate on the Collateral Contact screen. See "Helpful Tips" in the Appendix to ensure delivery of this service.

WE is available in 27 languages, based on the client's preferred written language in CARE. Some clients indicate Braille in CARE but prefer to have WE read to them. If a client with visual impairment wants WE in Braille, please contact the WE Program Manager to have the client added to the list for Braille transcription.

Wellness Education is offered in the following languages:

Albanian	English	Large Print	Somali
Arabic	Farsi/Persian/Dar	Moldavian/Romanian	Tagalog
Amharic	Hindi	Punjabi	Thai
Armenian	Ilocano	Russian	Tigrinya
Braille	Japanese	Samoan	Ukrainian
Cambodian/Khmer	Korean	Serbo-Croatian	Urdu
Chinese	Lao	Spanish	Vietnamese

If WE is not currently being provided in a client's preferred written language and English is not meeting the client's needs, please contact the WE Program Manager.

Wellness Education Service Code:

- **SA080**
- This service may be authorized for 1 unit per month.

> **Note:** the start date for this service can be between the 1st and the 20th of each month. If the start date will be after 7:00pm on the 20th, the start date should be the first of the following month.

Community Choice Guide (CCG)

Community Choice Guide (CCG) services can be authorized to clients enrolled in COPES to establish or stabilize a person currently in a community living arrangement including a licensed residential setting, such as an adult family home or assisted living facility, or in a private residence. Individuals are eligible for CCG services when the person's community living situation is unstable and the person is at risk of institutionalization. Examples include if a client is experiencing:

- Frequent institutional contacts (ER visits, SNF stays, hospital admits, etc.).
- Frequent turnover of caregivers resulting in an inability to maintain consistency of care.
- Threat of imminent eviction or loss of current community setting.

CCG services in COPES assist the eligible COPES client to live in the community setting of their choice by:

- Identifying needs and locating necessary resources to establish and achieve successful integration into the participant's community setting of choice.
- Coordinating, educating, and linking the client to resources which will establish or stabilize their community setting, including arrangements with pharmacies, primary care physicians, financial institutions, utility companies, housing providers, social networks, local transportation options, household budgeting, and other needs identified in care plan.
- Providing and establishing networks of relevant participant partners: nursing or institutional facility staff, case managers, community providers (including AFH providers), medical personnel, legal representatives, paid caregivers, family members, housing agencies and landlords, informal supports and other involved parties.
- Ensuring all necessary paperwork and documentation is identified and completed to obtain and maintain entitlements and other services necessary for community integration.
- Assisting with the development of a plan for, and when necessary, providing, emergency assistance to sustain a safe and healthy community setting.
- Assisting the participant in arranging for transportation to effectively connect the participant with the community. An example would be a one-time purchase and reimbursement of a bus pass.
- Locating and arranging appropriate, accessible housing, including working with ALTSA Housing Resources, local housing authorities and other community resource providers and landlords, when applicable and authorized (see Chapter 5b for more information).

- If client needs more intensive, long-term support with housing than a CCG can assist with locating, please see Chapter 30d for information on Foundational Community Supports-Supportive Housing.

- Assisting in finding a qualified caregiver (see **Note** below).

Below are specific tasks a CCG can be authorized to assist the case manager with that are not a duplication of services. This information will be included in a new chapter of the LTC Manual in the future.

Note: CCGs do not have access to Carina but can assist clients with other tasks related to locating a potential IP and guiding the potential IP to CDWA for hiring, when authorized by the case manager. The case manager should follow the steps detailed in MB H21-083.

1. The CM will send the Assessment Details and Service Summary to CDWA through the standard file transfer process (through CARE) or via email to InfoCDWA@consumerdirectcare.com.
2. The CCG should be listed as a Collateral Contact if a CCG will be authorized to assist in locating an IP and the CCG copied on the email.
3. Authorized CCG tasks that could expedite posting of an ad when directed by a CM and the hiring of an IP, could include:
   a. *When directed by the CM*, email CDWA at InfoCDWA@consumerdirectcare.com.
      - **Note:** CCG should always copy the authorizing case manager when communicating with CDWA.
      - CDWA applies email filters based on the subject and key words to direct the email internally to CDWA's Client/IP Referral Support Team, so emails must use the exact subject lines below to communicate.
   b. Subject lines for specialized needs:
      - For client's new to Medicaid Services use the subject line: "*CDWA new client / new to Medicaid services*".
      - For clients who are discharging from an acute care setting or skilled nursing facility, has left a facility AMA, has APS involvement, or nursing/ wound involvement, use subject line: "*CDWA urgent hire required*".
   c. If the IP is already a CDWA employee, the CCG can include the IP name, phone number, email, and mailing address in the email, if known.
   d. If the IP is a brand-new IP, the CCG can include the IP name, phone number, email, and mailing address in the email (if known). Refer the IP to the "Careers" tab on the CDWA website to begin the hiring process.
   e. The CCG can be authorized to assist the Client/AR with interviewing and hiring the IP, if authorized by the CM, including emailing the CDWA Client/IP Support Team of the client's IP choice, copying the CM.

Tasks outside of CCG scope of work:

- Activities that require specific training or licensure/certification (e.g. pest eradication, moving services)

- Anything that has to do with a client's personal finances (e.g. cashing personal check, loaning money to client, using client's money as down payment, etc.)
- Becoming a co-signer (e.g. rental applications, loans, etc.)
- Driving a client or representative's owned vehicle (even with insurance required to provide transportation).
- Enter a client's home without the client's/representative's expressed/written permission.
- Perform tasks or skill building which fall under the Client Training scope of work.

Community Choice Guide – Issuing a Payment/Shopping: Client Not Present (SA266)
Based on a client's eligibility:

- Shopping for necessary household goods/items or paying for rental deposits (to include first month rent), utility hookup fees, or rent/emergency rental assistance service when no client is present. This shopping/paying code will rarely be authorized without the accompanying SA263 CCG Services code.
    - This service assists clients transitioning out of institutions or when needed to stabilize a client's community living.
- This service code is to compensate the provider for the time spent shopping/paying when no client is present.
    - The provider is also reimbursed for the authorized purchases after it is verified the client received the goods or service. Authorization for the item/service is under a separate service code and case managers will process the reimbursement(s) for these one-time goods and services supports to the CCG as timely as possible. This reimbursement should not exceed 30 days after the CCG has provided an invoice/receipt as proof of the purchase.
- If the client is present or the CCG performs other services to complete the payment/shopping, SA263 Community Choice Guide should be authorized. For example, if a CCG purchases the items without the client present (SA266) and then helps the client set up the purchased items at the client's home (SA263).

Community Choice Guide Service Codes:

- **SA263** CCG (includes the most recent Activity Tracking Form)

NOTE: Service providers, such as pest eradicators janitorial services, and packing/moving services must be performed by a contracted provider who hold the Community Transition and Sustainability Services (CTSS) contract and paid directly via ProviderOne. Authorizing a CCG to perform the CTSS scope of work is prohibited. HCS may consider using the HQ managed purchasing card when there is CTSS contracted provider capacity concerns. Further instructions on HCS use of the HQ purchasing card can be found in Chapter 10: Nursing Facility Case Management and Relocation.

- **SA266** shopping/paying-client is not present (includes the most recent Activity Tracking Form, almost always authorized with SA263 units)

Clients residing in King County:
Agency CCGs may have negotiated a different rate when performing authorized tasks for clients who are residents of King County (SA263; see SCDS for more information). When authorizing services, confirm

the correct contracted CCG rate has been selected for a client who resides in King County. When the rate for an Agency CCG provider is county specific and a move has occurred that impacts rate (into or out of King County, for example), the service line should be modified prior to transferring the file following all instructions in the Social Service Authorization Manual (SSAM).

Community Choice Guide Provider Qualifications:

- Bachelor's degree in social work or psychology with two years' experience in the coordination of Independent Living Services (ILS). Examples of ILS include working as a supported employment or supported living staff, peer trainer or mentor, volunteer or staff of an Independent Living Center, or similar where you teach and support individuals to maintain or learn skills to increase independence.
- Two years' experience in the coordination of ILS in a social service setting under qualified supervision.
- Four years personal experience with a disability.

See *Which Program to Use: CCG and Shopping/Paying and Transition Resource Guide* in the Appendix for a reference guide.

Steps to Authorize Community Choice Guide (CCG) Services:

1. Contact a contracted CCG provider to discuss the case. The provider will determine capacity to assist the client with the goals and tasks. CCG Providers can decline referrals without providing a reason.
2. Add the CCG business name to the Contact Details screen under Client Details.
3. Add "Community Integration" and "Community Transition Services" and/or "Community Transition Goods and Items" in the Treatment section of the Medical Screen in CAREWeb.
    a. Enter a brief comment for each treatment. Examples include:

        Community Integration: CCG to assist with transitioning a client to the community **OR** CCG to assist with stabilizing client in the community.

        Community Transition Services/Community Transition Goods and Items: CCG to assist with purchasing goods or services as authorized.

4. Add the CCG Provider to the Providers screen within the CARE Planning section of assessment.
5. Assign Community Integration to the CCG on the Support Screen.
6. Complete the Sustainability Goals outlining the goals and tasks the CCG is assigned to assist the client with.
7. Send documents to CCG Provider:
    a. Sustainability Goals
    b. Signed DSHS Consent form
    c. Assessment Details (if available)
    d. Service Summary (if available)
        i. CCG Providers are not required to sign the Service Summary

*Ensure appropriate RAC is entered: RCL, CFC, CFC-Ancillary, COPES, CTSS, or WA Roads.

See *Which Program to Use: CCG and Shopping/Paying and Transition Resource Guide* in the Appendix for a reference guide.

8. Authorize SA263 and/or SA266.
9. Create an approval Planned Action Notice (PAN) for all services the client is authorized to receive as outlined in CARE (with the exception of any services provided through WA Roads).

Community Supports: Goods and Services

Community Supports: Goods and Services are non-recurring set-up expenses for individuals that are not eligible for Community Transition Services provided under the 1915(k) Community First Choice program and who are transitioning from a provider operated living arrangement to an in-home setting.

Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

- Security deposits that are required to obtain a lease on an apartment or home;
- Essential household furnishings, including furniture, window coverings, food preparation items, and bed/bath linens;
- Set-up fees or deposits for utility or service access, including telephone, electricity, heating, and water;
- Services necessary for the individual's health and safety such as pest eradication and non-recurring cleaning prior to occupancy;
- Moving expenses;
- Necessary home accessibility adaptations; and,
- Activities to assess need, arrange for and procure needed/resources.
- Assisting the participant in arranging for transportation to effectively connect the participant with the community. Examples include a one-time purchase and reimbursement of a bus pass.

These services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources.

NOTE: Service providers, such as pest eradicators janitorial services, and movers must be contracted with the Community Transition and Sustainability Services (CTSS) contract and paid directly via ProviderOne. Authorizing a CCG to perform the CTSS scope of work is prohibited. HCS may consider using the HQ managed purchasing card when there is CTSS contracted provider capacity concerns. Further instructions on HCS use of the HQ purchasing card can be found in Chapter 10: Nursing Facility Case Management and Relocation.

These services do not include monthly rental or mortgage expenses, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes.

Community Supports service codes to authorize:

- SA296 Community Transition and Sustainability Services: Items (Matched Funds)
- SA297 Community Transition and Sustainability: Services (Matched Funds)

A case manager may authorize the CCG to purchase items, to pay for rental set up fees and/or pay for utility deposits and will process the reimbursement(s) for these Community Supports to the CCG as timely as possible. This reimbursement should not exceed 30 days after the CCG has provided an invoice/receipt as proof of the purchase.

See *Which Program to Use: CCG and Shopping/Paying and Transition Resource Guide* in the Appendix for reference guide.

NOTE: Community Transition Services – Items (SA296) does not permit payment of tips. With online orders/pickups, some companies have added an automatic tip to the overall total of the transaction. This cannot be reimbursed using Community Transition Services-Items. If the automatic tip cannot be removed from the transaction total, shopping at these companies should be avoided altogether.

Paying a money order/cashier's check fee as part of a move-in cost (payment of first month's rent/deposit) is allowable.

Environmental Modifications

Environmental modifications are those minor physical modifications to the private residence of the client (owned or rented) that are:

- Justified by the client's service plan,
- Necessary to ensure the health, welfare and safety of the client or enable the client to function with greater independence in the home, and
- Is the most cost-effective option to meet the client's identified need.

All authorized modifications must meet ADA specifications, including the slope of a ramp. Modifications may include:

- The installation of ramps and grab-bars,
- Widening of doorway(s),
- Modification of existing bathroom facilities,
- The installation of specialized electric and plumbing systems that are to accommodate the medical equipment and supplies that are necessary for the health and welfare of the client,
- Lift systems not covered by insurance (such as EWC-type lifts).

Excluded are:

- Modifications or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the client.

- Repairs or general maintenance needed prior to a modification being completed (or determined during the modification), including testing and removal or abatement of asbestos or mold or repairs required due to water or pest damage. Repair and general maintenance of a dwelling are the responsibility of the owner.
- Tile showers, walls, or floors as there are typically other, less costly options. If a contractor can demonstrate that a basic tile is the most cost-effective option, tile may be considered.
- Modifications that add to the total square footage of the home except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- Modifications to licensed settings such as adult family homes or assisted living facilities.
- Modifications to more than one entrance/exit

Prior to pursuing an environmental modification, explore cost-effective alternatives that might meet the client's needs. Examples of considerations include:

- **Equipment:**
  - Is there specialized medical or non-medical equipment that can assist the client to address the barrier? Some examples: transfer bench, grab bars, toilet rails.
  - If a patient lift (such as a Hoyer) cannot be used, would a stationary lift system assist with transfers?
  - Is an inflatable bathtub or portable shower an option? If the client moves frequently or the home is not in a condition to complete an environmental modification, this may be an alternative.
  - Are there assistive devices that may help a client safely navigate stairs such as a stair cane? Or is there a room on the main floor that could be used as a bedroom?
  - How much does a doorway need to be widened? Can replacing existing door hinges with extended, swing-away hinges provide the additional width required?
- **Training:**
  - If the client already has equipment, is training needed to maximize effectiveness by client/caregiver?
- **Insurance covered benefits:**
  - If a patient lift (such as a Hoyer) is not working for the client, has the client's healthcare provider been contacted to see about possible solutions?
    - Could the client benefit from physical therapy or occupational therapy?
    - Should an OT evaluation be done to determine whether equipment can meet the need or if a modification is the most cost-effective alternative?
    - Is the client eligible for a different type of lift paid for by insurance?

Additional considerations when determining viable alternatives and the possibility of an environmental modification:

- How long has the client lived at their residence?
- Do they own or rent?
- Are they planning on staying at this residence?
- Are repairs or general maintenance needed prior to using waiver funds for the modification? Does the client/landlord have the resources necessary to complete them?

- What condition is the home in?
  - General repairs or necessary maintenance discovered during a modification cannot be paid for using waiver funds. An example would be mold or asbestos discovered during a modification. Repairs and maintenance are considered "general utility" and are the responsibility of the homeowner.
- Will the home accommodate the changes structurally?
- Does the client already have an accessible entrance/exit from the home?
  - Social services may not be used if there is a safe, accessible entrance/exit or for more than one entrance/exit.

Additional Information:

- For modifications that will require an Exception to Rule (ETR) request to exceed rate maximum limits, cost-effective alternatives explored to address the barrier must be documented in the ETR (this should include specific alternatives such as Specialized Medical Equipment, not simply that the client's wants to remain in the community setting).
- For high-cost modifications, consider staffing the unique client situation with a supervisor to ensure all alternatives have been explored.
- A stair lift requires an elevator installation permit. The installation permit can only be purchased by a licensed elevator contractor. Prior to considering a stair lift, explore all available options which may include converting a room or part of a room on the main floor into a bedroom, if there are adequate bathroom facilities on the main floor.

When a client is in a nursing facility:

- Modifications may be authorized up to 180 days in advance of the community transition of a resident of a nursing facility.
- Environmental modifications started while the client is institutionalized are not considered complete and may not be billed until the date the client leaves the institution and is enrolled in the waiver.
- If the project is started for a client residing in a nursing facility and the client does not transition due to changing their mind, a significant change in condition, or dies before completion, the authorization must be switched to state-only funds (SOAP RAC).
- If an in-home client dies or admits into a nursing facility or acute care hospital, and the client is not expected to return in a timely way, the authorization for environmental modification must be switched to the SOAP RAC.

When a client is renting their home:

- Under fair housing laws, landlords must *provide* reasonable accommodations, which could include things like providing a lease in large print, reading aloud the lease for someone who is blind, and providing a doorbell signaler for someone who is deaf. Reasonable accommodations are adjustments in rules, procedures, or services.
- Under fair housing laws, landlords must *allow* reasonable modifications, but they are not necessarily obligated to pay for the modifications. Reasonable modifications are a change in a dwelling that is needed to live safely. Some landlords may be willing to complete and pay for reasonable modifications, so that resource should always be explored first.

- Examples of "reasonable modifications" include widening doorways, installing grab bars in the bathroom, and adding ramps to make a primary entrance accessible.
- The landlord is responsible for general maintenance and repairs that may be required prior to the start or completion of the modification (such as mold or asbestos removal).
- Approval for a modification must be given in writing from the landlord/homeowner prior to an authorization being created. Use DSHS form 27-147, Housing Modification Property Release Agreement to obtain written approval. This form is a legally binding form and cannot be altered in any way.
- If a landlord refuses to sign the form, a client may consider seeking legal advocacy.

NOTE: Use DSHS form 27-147A for RCL's Environmental Adaptations In-Home: General Utility or Repairs Allowance (service code S5165 U3). See Chapter 29: Roads to Community Living for more information about Environmental Adaptations In-Home General Utility or Repair Allowance.

Authorization of Environmental Modification

1. Best practice: obtain at least two bids for environmental modification, when possible, to allow client's choice of provider and to ensure paying a competitive rate.
2. Create the authorization in "Reviewing" status based on the approved bid.
3. Prior to authorizing payment, obtain a final invoice to verify actual costs and completion of the environmental modification. Confirm: 1) the project was completed as bid and authorized; and 2) document in an SER that the client is satisfied with the completed project.
4. If criteria described in #2 (above) is confirmed, change the authorization to "Approved" status and change the end date to the date the modification was completed. Payment will automatically be made to the provider.
5. Submit the final invoice with a completed Social Service Packet Cover Sheet to DMS.

Environmental Modification Service Code:

- **S5165 UA**
- Limit without ETR $700.00 per occurrence.
- Limit of $4000 without ETR for construction of ramps.

Provider Qualifications:

- Meet the standards of Chapter 18.27 RCW Registration of Contractors, and
- Have a current contract with the Department.
- If a stair lift is being authorized, the contracted environmental modification provider must hold an elevator license.

Volunteer Provider Qualifications:

- Sign Confidentiality Statement,
- Have knowledge of building codes as applicable to the task,
- Have costs less than $500 per Chapter 18.27.090(9) RCW (Note: volunteers are reimbursed for costs of supplies and materials but are not reimbursed for labor), and
- Have a current contract with the Department.

See Specialized Equipment and Supplies section for information regarding portable ramps less than eight (8) feet in size. Ramps larger than eight (8) feet must be installed by a vendor with an Environmental Modification contract.

Home Delivered Meals (HDM)

HDM provide nutritionally balanced meals delivered to the client's home. Home delivered meals offer additional face-to-face contact to monitor the client's well-being and safety or a mail delivery option is available when the in-person delivery is not feasible.

To qualify for home delivered meals the client must meet all of the following criteria:

- Is homebound and lives in his/her own private residence;
  - Homebound means that leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, intermittent absences for non-medical reasons, such as a trip to the barber or to attend religious services.
- Is unable to prepare the meal;
- Doesn't have a caregiver (paid or unpaid) available to prepare the meal; and
- Receiving the meal is more cost-effective than having a paid caregiver.

NOTE: Clients currently receiving home delivered meals only from an Older Americans Act (OAA) HDM program should be transitioned to CFC + COPES at their next regularly scheduled assessment to access the in-home COPES waiver HDM service.
For a CFC only client, an NGMA may need to be completed, see Chapter 7h: Appendices.

These meals must not replace nor be a substitute for a full day's nutritional regimen but must provide at least one-third (1/3) of the current recommended dietary allowance as established by the Food and Nutrition Board of the National Academy of Sciences, National Research Council.

A unit of service equals one meal. No more than one meal per day will be reimbursed under the waiver. This is not subject to an Exception to Rule.

When a client's needs cannot be met by a Title III provider due to geographic inaccessibility, special dietary needs, the time of day or week the meal is needed, or existing Title III provider waiting lists, a meal may be provided by:

- Restaurants,
- Cafeterias, or
- Caterers who comply with Washington State Department of Health and local board of health regulations for food service establishments.

Deductions from CARE generated hours for Home Delivered Meals:

- A deduction of 0.5 hour (30 minutes) must be taken at the end of the assessment for each home delivered meal regardless of the funding source. Through COPES funding, only one meal per day

may be authorized. If 31 days are authorized, a maximum of 15 hours should be deducted from the CARE hours.
    - If a client is on CFC or MPC, and not eligible for COPES, and is receiving home delivered meals, a deduction of 0.5 hour (30 minutes) must still be taken at the end of the assessment for each home delivered meal. See Chapter 7b and 7c.
- If the client chooses to receive additional home delivered meals through another non-ALTSA paid funding source, then a 0.5 hour (30 minutes) deduction will be made for each additional meal beyond the 15-hour COPES maximum deduction.

Clients must not be referred to the OAA HDM program unless the client:
- Is an in-home waiver client age 60 years or older,
- Still has an unmet need in meal preparation for other meals, and
- Choses to get the need met with an additional HDM rather than having the in-home provider prepare the meal.

Home Delivered Meals Service Code:
- **S5170**
- There is a limit of one meal per day through COPES funding.
- An ETR for more than one meal per day is not available.

Provider Qualifications:
- Provider must have a staffing pattern that includes a Nutrition Program Director, Registered Dietician, or Individual with Comparable Expertise (ICE) certified under RCW 18.138;
- Deliver meals in a manner that provides a face-to-face contact with the client to monitor general well-being and safety;
- Comply with the state Senior Nutrition Program Standards for home delivered meals;
- Meet Food Service Vendor rules – home delivered nutrition program standards and Chapter 246-215 WAC (food service); and
- Have a contract with DSHS or AAA.

Note: The service is considered completed when the meals are delivered to the client. If a client enters the hospital after the service has been completed the service line can be end dated with the date the client enters the hospital with no reduction of units and no overpayment referral for the provider.

Nursing Services

Nursing Services is not a specific waiver service but is available to COPES waiver clients. Nursing Services offer clients (e.g., COPES, CFC, MPC and DDA Waiver Personal Care), providers, and case managers with health-related assessment and consultation to enhance the development and implementation of the client's plan of care.

A nursing services provider is not a direct care provider of intermittent or emergency nursing care, skills or services requiring physician orders and supervision.

The goal of nursing services is to help promote the client's maximum possible level of independence and contribute nursing expertise by performing the following activities:

- Comprehensive Assessment Reporting Evaluation (CARE) review, which includes Skin Observation Protocol (SOP) and the other triggered referrals;
- Nursing assessment/reassessment;
- Instruction to care providers and clients;
- Care and health resource coordination;
- Referral to other health care providers; and/or
- Evaluation of health-related care needs affecting service planning and delivery.

Skilled *treatment* is provided by Nursing Services only in an emergency. For example, the provisions of CPR or first aid until emergency responders arrive to provide care.

This service does not typically require an authorization in ProviderOne since HCS and AAA nursing staff are most commonly used for this service. For more information about Nursing Services, including referral process and resources, see LTC Manual Chapter 24 Nursing Services.

Provider Qualifications:

- Registered nurse (RN) licensed under Chapter 18.79 RCW and Chapter 246-840 WAC, and
- Contracted with the AAA, employed by the AAA, or employed by HCS.

Skilled Nursing

Skilled Nursing services must be included in the client's service plan and the skilled tasks must be within the scope of the State's Nurse Practice Act.

Skilled Nursing services under the waiver differ and are beyond the amount, duration or scope of Medicaid-reimbursed home health services as provided under WAC 182-551-2100 in the State Plan:

- Under the State Plan, skilled nursing is intended for short-term, intermittent treatment of acute conditions or exacerbation of a chronic condition.
- Under the waiver, skilled nursing is used for treatment of chronic, stable, long-term conditions that cannot be delegated, self-directed or provided under State Plan skilled nursing.

Skilled Nursing visit authorizations:

- For all Skilled Nursing visits (with the exception of Skin Observation Protocols (SOP) visits) the case manager will authorize the visits using 1 unit = 15 minutes.
- The case manager can authorize up to 100 units per month.
- The Skilled Nurse can bill for visit time, documentation, and travel time.
- Each Skilled Nurse will need to keep a "Time Sheet Log" and have it available upon request of the Area Agency on Aging (AAA) or the HCS Nursing Services Program Manager for the purpose of auditing and billing questions.

Skilled Nursing Service Codes:

- **T1002** for Skilled Nursing RN visits
- **T1003** for Skilled Nursing LPN visits
- **T1001-U1** for Nurse Consultation SOP Skilled Nurse visits
- No exceptions to the rule (ETR) are needed
- For the most current Skilled Nursing rate, check the rate sheet online here.

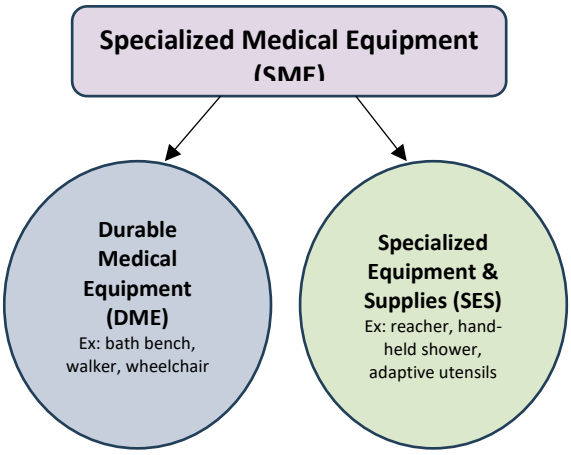
> **Note:** COPES client support training cannot be used to authorize training a nurse to complete skilled nursing tasks.

Provider Qualifications:

- Registered Nurse licensed under Chapter 18.79 RCW and Chapter 246-840 WAC, or
- Licensed Practical nurse licensed under Chapter 18.79 RCW and Chapter 246-840 WAC, working under the supervision of a Registered Nurse per State law, or
- Home Health Agency licensed under Chapter 70.127 RCW, and
- Have a Waiver Skilled Nursing Services contract with the AAA.

Specialized Medical Equipment and Supplies (SME)

SME, as defined in the waiver, includes items that may also be known as durable medical equipment (DME) and specialized equipment and supplies (SES). All items must meet applicable standards of manufacture, design, and installation. Once purchased, the item becomes the client's property. This service also includes maintenance and upkeep of items covered under the service and training for the client/caregivers in the operation and maintenance of the item. Training may not duplicate training provided in other waiver services.



DME, as defined under WAC 182-543, include items which are necessary for:

- Life support;
- To increase the client's ability to perform ADLs;
- To perceive, control, or communicate with the environment in which he/she lives; or
- Are directly remedially beneficial to the client; and
- Do not replace, any medical equipment and/or supplies otherwise provided under Medicare and/or Medicaid.

Lift Chairs:

- See the SCDS for SA419 for instructions and policy specific to authorizing purchase of lift chairs.
- An ALTSA HQ ETR must be approved prior to creating the authorization for a lift chair when the client needs cannot be met within the rate range for the furniture portion of the chair:
    - After processing the ETR locally in CARE, email the quote and medical recommendation to DME ETR Committee
    - After reviewing locally, the ETR is sent Pending HQ Approval to "DME ETR Committee" in CARE.
    - If approved, case manager creates the authorization in CARE and request to have the rate forced by the DME ETR Committee staff.

Bathroom Equipment:
The Apple Health Medicaid benefit covers DME bathroom equipment. Per the Health Care Authority's (HCA's) Washington Apple Health (Medicaid) Medical Equipment and Supplies Billing Guide covered durable medical "bathroom safety equipment is considered medically necessary when, based on the client's medical condition, the client is at risk of falls or other injuries while performing activities of daily living (ADLs) necessary to maintain or improved their health, such as bathing and toileting."

Because Medicaid LTSS is the payor of last resort, if a case worker receives a request from a client for DME bathroom equipment or is aware of the client's need for DME bathroom equipment, the case worker will direct the client or the client's designated representative to the client's healthcare provider who will write a prescription for the DME bathroom equipment and will send the prescription to the client's chosen DME provider/supplier. DME bathroom equipment should be covered through the client's Apple Health medical benefit.

The DME provider/supplier will know the HCA billing process and what documentation is needed to process the DME bathroom equipment request. Here is the step-by-step guide for prior authorization that DME providers/suppliers have been given, but can be shared with them.

Bathroom equipment should never hold up a hospital or nursing facility discharge, the discharge planner and the DSHS/AAA case worker should connect and coordinate regarding equipment needs. If there is an urgent need or any issues, the case worker can reach out to the HCA DME inbox (DME@hca.wa.gov) with the client's name and their ProviderOne ID for assistance.

When Apple Health/HCA Denies the DME Bathroom Equipment Request (which should not be often)

If the client's Medicaid Apple Health medical benefit does not cover the needed/requested DME bathroom equipment and an HCA denial is received, which should be rare, the client should submit an appeal of the denial to HCA through an HCA administrative hearing.

If through the HCA administrative hearing process, the client does not get the DME bathroom item approved, the case worker may submit a Specialized Medical Equipment & Supplies ETR request to headquarters (HQ) for review. For DDA, the request is a Prior Approval.

To inquire about the status of a DME bathroom equipment request, denial or appeal, the case worker can email the HCA DME inbox (DME@hca.wa.gov). In the email, provide the client's name, the client's ProviderOne ID number, and your inquiry.

If a Specialized Medical Equipment & Supplies ETR is required, case workers will complete the following:

1. **Assessment:** the need for the DME bathroom equipment must be documented as "Needs, wants" on the Bathing or Bladder/Bowel Activity of Daily Living (ADL) screen in CARE.
2. **ETR created in CARE**:
    - ETR Category: select "waiver services" for COPES clients
    - ETR Type: "Specialized Medical Equipment and Supplies"
    - Request description section: use the following template language:
        - Request is to purchase a [enter DME bathroom item] that has been denied by HCA. Client's request did not meet HCA's criteria for coverage of this bathroom equipment.
    - Justification for request section: add information to support the purchase and the reason the item was denied by HCA.
    - Alternatives explored section: n/a
    - Assign the DME ETR to ALTSA HCS DME ETR Committee
3. Email the following **supporting documents** to dmeetr@dshs.wa.gov:
    - The DME provider/supplier quote with justification that the rate is 80% of the Manufacturer's Suggested Retail Price (MSRP) or 125% of the provider's invoice cost.
    - The healthcare professional's prescription/recommendation (signed by the healthcare professional with their printed name and credentials).
    - The denial documentation from HCA.
4. After the DME ETR is reviewed by the HQ DME ETR Committee and an approval is received, the case worker creates a social service payment authorization for the approved equipment using the DME blanket code SA875, following all instructions, with the authorization in "Reviewing" status.
5. Upon confirmation that the client has received the equipment, and the case manager has received an invoice from the DME provider/supplier, the case manager will update the authorization status to "Approved" and the DME provider/supplier will be able to claim.
6. Submit to the client's electronic case record (ECR) a Social Services Packet Cover Sheet (DSHS 02-615) with the DME provider/supplier's invoice, their cost justification documented, the healthcare professional's prescription, and the denial from HCA.

Most commonly requested items in the SA875 blanket code include but are not limited to:

- Bath stools
- Bathtub wall rail (grab bars)
- Bedside commode chair
- Raised toilet seat
- Shower chair (not rolling)
- Shower/commode chair (not rolling)
- Standard and heavy-duty bath chairs
- Transfer bench for tub or toilet (not rolling

See *Bathroom ETR Reference Tools* for more information.

Coverage of Other Durable Medical Equipment by Apple Health
WAC 182-543-7200 allows for the Limitation Extension of services in cases when a provider can verify that it is medically necessary to provide more units of service (quantity, frequency, or duration) than are allowed in the State Plan. Case workers should assist clients in requesting the DME vendor to pursue an approval of limited extension from Apple Health (FFS or MCO) prior to authorizing additional units of service through the waiver. Examples include when a client needs more incontinence supplies than allowed in a month or a walker needs to be replaced sooner than allowed.

Some DME requires a **Prior Authorization** (PA) to be covered by Apple Health. WAC 182-543-7100 details the prior authorization process that a vendor must follow for coverage. It is the responsibility of the DME vendor to be aware of the criteria and process necessary to pursue PA or LE per the published DME Billing Guide. Case workers can assist clients with the process, as necessary.

DME vendors must accept the Medicare and/or Medicaid DME rate as payment in full. The vendor cannot accept additional funds from the client, personal assistants, family, other Medicaid services (e.g., waivers) or any other organizations for services/items covered. However, the vendor can refuse to serve the client for any reason, including due to the rate. If a vendor refuses to serve a client, the case manager/social worker may use the ProviderOne Find a Provider search tool to assist the client to find a different vendor or look on the client's managed care organization's website.

Medicare and Apple Health publish their reimbursement rates for DME. Published reimbursement rates cannot be exceeded, including through a social service authorization or an ETR in CARE.

Waiver funds can only be used to pay for medical equipment and supplies that have been denied by, or are not covered by, Medicare and/or Medicaid. If the item is denied, documentation of the denial should be included in the client's electronic record (if not available to review in ProviderOne).

- Authorize DME services in "Reviewing" status using cost included in quote.
- Once it has been confirmed that the DME has been received by the client, update the authorization to the actual cost as reflected in the invoice.
- Change the status of the authorization to "Approved", allowing the provider to claim.
- The case worker should submit a Social Services Packet Cover Sheet to DMS with the invoice from the vendor and medical recommendation paperwork attached.

Durable Medical Equipment Service Codes:

- SA875-SA887
- If you are unsure what DME code should be used, ask the vendor what Health Care Procedure Code System (HCPCS) item code they will use to bill for the equipment in the ProviderOne billing system. Durable Medical Equipment codes (referred to as Group codes on the list) are "blanket" codes that cover multiple HCPCS codes. You can then search the HCPCS code (titled Proc/Svc code) in the link above to identify the corresponding DME code.

There is a limit of $700 per occurrence without a local ETR (this ETR is not in regard to the rate of an item, it is solely to exceed the maximum service limit).

HQ DME ETRs are required for the following situations:

- An item is covered by insurance, but the client does not meet the medical criteria for the item to be paid for by insurance (example: client needs a heavy-duty hospital bed to live successfully in a community setting but does not meet the weight criteria for coverage by medical insurance).
- The item is never covered by insurance, but it may be necessary for a client to live successfully in the community [example: fully electric bed is needed (not just for convenience), but insurance only covers a semi-electric bed].

Specialized Equipment and Supplies (SES)
SES are non-medical equipment and supplies such as items that are never covered by Health Care Authority. Examples include waterproof mattress covers, handheld showers, reachers, urinals, adaptive utensils/plates/cups and portable ramps that don't involve any structural modifications to the client's home. To provide SES, a provider must hold the statewide SES contract, which is executed by ALTSA HQ.

SES are items that are:

- Necessary to increase the client's ability to perform activities of daily living; or
- Necessary for the client to perceive, control, or communicate with the environment in which the client lives; and
- Of direct remedial benefit to the client; and
- In addition to any medical equipment and supplies provided under the Medicaid State Plan, Medicare, or other insurance.

Notes:

- **Ramps:** When a portable, mini, or threshold ramp will meet the client's needs, a vendor with a Specialized Equipment and Supplies (SES) contract can provide the item when there is a single step with a maximum 7.75" rise:
  - The ramp must meet ADA specifications regarding slope.
  - The ramp cannot exceed 8 feet in length and cannot require installation other than to secure to the residence with a few screws.
  - The CM authorizes service code SA421.
  - Reminder: for ramps necessary to cross more than one step, the vendor must have an environmental modification contract, and it is to be authorized as an environmental modification. This includes a ramp made of wood, a modular aluminum system (also

referred to as a semi-permanent ramp), or any other material. See the Environmental Modification section for more information.

- **Portable vehicle ramps:**
  - Not available through COPES due to concerns about the length of the ramp required to meet ADA slope requirements as well as potential risk of injury to the client and potential risk of damage to the wheelchair and vehicle if not set up and used correctly.
  - If a client has a bulky, motorized wheelchair, a lightweight manual chair may be available through Apple Health (AH). See AH's Medical Equipment and Supplies Billing Guide for additional information.
- **Grab bars:**
  - All grab bars should be authorized using SA421 regardless of placement in the home (bathroom, hall, near doors/stairs, etc.).
  - All policies regarding SES apply.
  - A bathtub rail is considered a grab bar. **NOTE:** Toilet rails are NOT considered a grab bar and continue to be subject to the bathroom equipment ETR process because they may be covered by Apple Health.
  - Reminder: ensure that the most cost-effective item that will meet the client's needs is selected. At times, there can be a drastic difference in rate a grab bar depending on the selection of the finish (for example: nickel vs. white).
  - Current policy regarding installation is still valid:
    - Grab bars are to be included in a bid from a contracted environmental modification provider if installation is required. A separate authorization for the grab bar is not necessary if it is provided by the e-mod contractor.
    - If the only "modification" occurring is the installation of the grab bar(s), please make sure there are no other installation options available before authorizing an environmental modification. Consider: apartment maintenance staff (if applicable), family member, ADA compliant suction cup version (if appropriate), etc.
  - For CFC-only clients:
    - A client who needs a grab bar may be COPES eligible and a NGMA should be pursued. The client may benefit from other waiver services in addition to the grab bar.
  - If a client is not COPES eligible, other CFC benefits may be considered, including AT. If a client has used their annual AT budget, an ETR should be submitted to the ALTSA CFC Program Manager.
- **Incontinence Wipes (SA421/U2 modifier):** Incontinence wipes are not approved as a complete replacement for toilet paper and cannot be requested to aid in menses care or for caregiver convenience.
  - Incontinence wipes are considered non-medical supplies that do not require Medicaid denial.
  - Incontinence wipes authorized for a client are the client's property and should not be stored or used communally in residential settings like adult family homes or assisted living facilities.
  - Before a case worker creates an authorization for incontinence wipes, the case worker must ensure the client's assessment:
    - Describes the client's support needs surrounding toileting and hygiene.
    - Identifies frequency and special considerations of toileting needs.

        - Explains how incontinence wipes will increase independence with proper hygiene or prevent reoccurrence of a documented health condition.
    - If a client requires a specialized kind of wipe (e.g., organic, all-natural, water-based, plant-based), the client must have an allergy or chronic skin condition documented in CARE and verified in a recent medical record.
        - The allergy must be to an ingredient in a standard wipe.
        - The chronic skin condition must be exacerbated by an ingredient in a standard wipe.
    - SA421/U2 is a monthly recurring payment type. The authorization is created based on the quote for a monthly supply (plus sales tax and shipping costs).
    - Authorizations for monthly recurring payments are not subject to being created in Reviewing status. The provider will be able to claim monthly with no action required from the case worker on the authorization.
    - To help determine appropriate monthly amount of wipes: a study by the NIH concluded that residents of nursing homes could be adequately cared for using 3-4 wipes per toileting session.

Specialized Equipment and Supplies:

- **SA421**
    - Limit of $700 per occurrence without ETR.
    - Limit of $4000 only for portable ramps per occurrence without ETR (see note above).
    - Authorize in "Reviewing" status.
        - Make a note of the item being authorized, sales tax and shipping costs per quote, in the comments section of the authorization.
    - Authorize SES services in "Reviewing" status using costs included in quote.
    - Once it has been confirmed that the SES has been received by the client, update the authorization to the actual cost as reflected in the final invoice.
    - Change the status of the authorization to "Approved", allowing the provider to claim.
    - The case worker should submit a Social Services Packet Cover Sheet to DMS with the invoice from the vendor.
    - If the client did not receive the item and the vendor claimed, the vendor is at risk for an overpayment, as detailed in the provider's contract.
- **SA421/U2** Modifier (incontinence wipes)
    - Create authorization for up to a six-month period.
    - A provider with a fully executed Specialized Equipment and Supplies contract must be authorized for incontinence wipes. Because SES contracts are statewide and these will be shipped, any vendor with the SES can provide wipes (not limited to local providers).
    - Create based on a quote for a one-month's supply, including sales tax and shipping costs.
        - Sales tax and shipping costs should be documented in the Comments section of the authorization.
    - Need for incontinence wipes should be re-evaluated regularly and the authorization ended if client no longer has a documented need, or the need is being met in another way.
    - SA421/U2 is a monthly recurring payment type, so the authorization is not subject to being placed in Reviewing status.

- Per current SES policy, the case worker must verify that the client received incontinence wipes as authorized each month.
- The case worker should submit a Social Services Packet Cover Sheet to DMS with the invoice from the vendor.
- If the client did not receive the item and the vendor claimed, the vendor is at risk for an overpayment, as detailed in the provider's contract.

Items that are not covered/allowed using COPES SME funding include, but are not limited to:

- Hearing aids
- Visual aids, including eyeglasses
- Computer software and accessories
- Nutritional supplements (prescribed or not)
- Heating pads and cold packs
- Foot massagers
- Thickeners
- TENS units
- Exercise equipment
- Dentures
- Furniture that is of general utility (e.g., tables, lamps, etc.)
- Household items that are of general utility (e.g., shampoo/soaps, air conditioners, shower capes, sharps containers, toileting stool aka "poop stool", etc.)
- Vehicle modifications including portable vehicle ramps, scooter/wheelchair racks, etc.
- Items HCA considers experimental (e.g., PureWick female catheter system, "stand-up" walkers, stair climbers, seat elevators, etc.)
- Home telemetry devices (home heart monitors for use with a smart device)

Provider Qualifications:

- DME vendors must have a Core Provider Agreement (CPA) with the Health Care Authority (HCA) as a Medicaid vendor and be Medicare certified.
- Specialized Equipment and Supplies (SES) vendors:
  - Must have a current SES contract.
  - May also have a CPA as a DME vendor, but it is not required.
  - Have provider taxonomy 33NM00000L.
  - SES contracts are statewide contracts (vendors not limited to a specific service area).

Transportation

Transportation is a service offered to enable clients enrolled in the waiver to gain access to waiver and other community services, activities and resources, as specified in the service plan. 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 **must not replace them**.

Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge should be utilized.

To authorize transportation services, the case manager must ensure the service:

- Provides access to community services and resources to meet the client's therapeutic goal; and
- Is not diverting in nature (such as traveling to recreational activities); and
- Is in addition to, and does not replace, the Medicaid-brokered transportation 42 CFR §440.170(a) or transportation services available in the community; and
- Does not replace the transportation services required by the DSHS contract for clients living in licensed residential facilities.

This service does not replace Individual Provider (IP), or home care agency provided transportation to medical appointments and essential shopping as assessed and assigned in CARE.

In the CARE assessment "Supports" screen connect "Other Treatment" non-medical transportation as a **paid** task to **paid** transportation service provider.

To authorize transportation services:

1. Receive a bid from the contracted vendor(s). This bid should include milage and any additional rates.
2. Authorize the transportation service with service code **T2003** **for one (1) unit per trip** for the period of time that the client will receive the service.
    a. There should be a matching invoice per trip that is submitted to the case manager after the service is provided.
3. After the service is provided, the contracted vendor will then claim the unit in ProviderOne and the payment will be issued.

Transportation Service Code:

- **T2003** **Transportation Expense Reimbursement** to authorize non-medical transportation rates and milage.

Provider Qualifications:

- Have Waiver Transportation Services contract with the AAA
- Meet the same standards as those applied to vendors who provide access to State Plan medical services
- May include:
    - Agencies
    - Sole Proprietors
    - Volunteers
    - Taxis
    - Public transit

RESOURCES

Related WACs and RCWs

WAC 182-501-0060	Health care coverage—Program benefit packages—Scope of service categories.
WAC 182-512-0050	SSI-related medical—General information.
WAC 182-515-1506	Home and community based (HCB) waiver services authorized by home and community services
WAC 182-543-7100	Prior authorization
WAC 388-71-0701 through 0839	Adult Day Services
WAC 388-106	Long-term Care Services
WAC 388-106-0300 through 0335	Community Options Program Entry System (COPES)

Acronyms

AAA	Area Agency on Aging
ADA	Americans with Disabilities Act
ADC	Adult Day Care
ADH	Adult Day Health
ADL	Activity of Daily Living
AFH	Adult Family Home
ALTSA	Aging and Long-Term Support Administration
ARNP	Advanced Registered Nurse Professional
CARE	Comprehensive Assessment Reporting Evaluation
CCG	Community Choice Guide
CDSMP	Chronic Disease Self-Management Program
CFC	Community First Choice
CIL	Centers for Independent Living
CM	Case Manager
CN	Categorically Needy
COPES	Community Options Program Entry System
DDA	Developmental Disabilities Administration
DME	Durable Medical Equipment
DMS	Document Management Services
DSHS	Department of Social and Health Services
ETR	Exception to Rule
FFS	Fee For Service
HCA	Health Care Authority
HDM	Home Delivered Meals
HQ	Headquarters
IADL	Instrumental Activity of Daily Living
ILS	Independent Living Services

LPN	Licensed Registered Nurse
LTC	Long Term Care
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
MPC	Medicaid Personal Care
OAA	Older Americans Act
OT	Occupational Therapist
PA	Prior Authorization
PACT	Program for Assertive Community Treatment
PT	Physical Therapist
RN	Registered Nurse
SER	Service Episode Record
SES	Specialized Equipment and Supplies
SLA	Service level agreement
SME	Specialized Medical Equipment
SOP	Skin Observation Protocol
SSAM	Social Service Authorization Manual
SSI	Supplemental Security Income
WAC	Washington Administration Code

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
4/2025	Annie Moua	• Update chapter template • Minor formatting and grammar updates • Update to DME bathroom equipment process to follow process outlined in MB H24-067 • Updated CCG guides and added a clarifying note	TBD

7/2024	Annie Moua	• Update Adult Day Services to include information about the remote/hybrid service delivery option
		• Update CCG services to align with the RCL Chapter and include:
		  ○ Additional information regarding tasks outside of CCG scope of work
		  ○ Details under the SA266 service code to clarify its use.
		  ○ Steps to authorize CCG Services
			H24-044

5/2024	Annie Moua	• Include Spanish in list of translation options for Wellness Education	H24-018

		• Clarification on personal care hour deduction for clients not eligible for COPES but receiving HDM through another funding source. • Added descriptions examples of client support trainings • Added reference to DSHS form 27-147A, RCL's Environmental Adaptations In-Home General Utility or Repair Allowance Property Release Agreement.	
1/1/2024	Annie Moua	• Update Adult Day Care to include the ADC provider as informal support when coding status for each ADL and IADL task that is provided by the ADC provider • Update Transportation service codes and authorization process • Clarification added in CCG and Community Supports: Goods and Services	H23-090
10/1/2023	Annie Moua	• Corrected eligibility for services authorized by DDA.	H23-071
6/1/2023	Debbie Blackner	• Added contact information for Medicaid Waiver Program Manager • Clarification regarding storage of incontinence supplies in AFH, ALF • Clarification regarding CCGs and 1) housing search, 2) driving a client's car, and 3) going into a client's home without the client or representative present. • Details that SME is the property of the client once purchased. • In Appendix: removed some attachments and inserted link	
12/30/2022	Debbie Blackner	• Clarifications and corrections regarding Client Training • Information on which tasks a CCG can complete when a client needs assistance hiring an IP. • Updates to the Environmental Modification section. • Removed the local review/approval requirement for bathroom equipment ETRs.	H22-064
9/13/2022	Grace Brower	• Update Consumer Directed Employer of WA relating to Community Choice Guide services	H22-042

		• Home Delivered Meals service note	
6/9/2022	Debbie Blackner	• Updated the Nursing Service Program Manager information • Clarified transportation options under Community Supports: Goods and Services • Added a section regarding incontinence wipes authorized using SA421/U2. • Provided clarifications regarding Environmental Modifications • Added a section on SA421/U2 for authorizations of incontinence wipes.	H22-028
4/12/2022	Grace Brower	• Updated Transportation service codes	H22-020
8/4/2021	Debbie Blackner	• Added information regarding Wellness Education. • Clarified contracting requirements for pest eradication, janitorial services and movers. • Added updated information regarding vehicle ramps, rolling shower equipment, and grab bars. • Added examples of items HCA considers experimental • Added additional reference tools to the Appendix.	H21-080
1/3/2020	Debbie Blackner	• Added information regarding CCG rate revision	H19-051
10/1/2019	Debbie Blackner	• Reworded the DME definition to align with current WAC	
10/1/2019	Debbie Blackner	• Provided process to request an increase to the rate on the furniture portion of a lift chair	NA

APPENDIX

Wellness Education: Helpful Tips for Addresses

Purchasing Desk Aid – DME SES AT CTSS

Which Program to Use: CCG and Shopping/Paying

Transition Resources Guide

DME Links:

- HCA Equipment and Supplies Billing Guide
- Detailed DME Trainings, including environmental modifications, bathroom equipment ETR process and reference tools

New Freedom Budget-Based Participant Directed Services (Limited availability based upon county of residence)

The purpose of this chapter is to educate staff about the New Freedom waiver and the benefits it offers to participants as well as to provide instruction on how the program works.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:
Darrelyn Nuesca New Freedom Program Manager
360.725.2446 darreyln.nuesca1@dshs.wa.gov

If you have questions or need clarification about ACES$, please contact:
ACES$ Financial Management Services
goodservice@mycil.org

TABLE OF CONTENTS

BACKGROUND

What is Participant Directed Services?

Participant Directed Services is a philosophy and orientation to home and community-based services that gives participants the authority to make choices about services and supports that work best for them, regardless of the nature or extent of their disability.

Participant direction empowers participants and their families by expanding their degree of choice and control over the long-term services and supports they need to live at home. This is done in Collaboration with the Area Agency on Aging (AAA) Care Consultant. Participants can share authority with or delegate authority to family members or others close to them. Designation of a representative enables adults with cognitive impairments or those who would rather not be fully responsible to be involved in participant direction.

Participant direction represents a major paradigm shift in the delivery of publicly funded home and community-based services. In the traditional service delivery model, decision-making and managerial authority is vested in professionals who may either be state employees/contractors or service providers. Participant direction transfers much (though not all) of this authority and responsibility to participants and their families (when chosen or required to represent them).

What is New Freedom (NF)?

New Freedom is a voluntary budget-based program that provides participants who are eligible for Home and Community Based Services (HCBS) through the 1915c Medicaid Waiver Program. It offers participants a choice in how they receive services in their home. NF offers Participants the opportunity for increased responsibility, choice and control over their services and supports.

The goal of NF is to provide the opportunity for qualified participants to choose from a wide array of approved services to meet their needs within a set monthly budget. NF Participants can choose the amount and type of services **(within the definitions in this chapter and the state and federal regulations)** that meet their needs as long as they have sufficient funds within their individual monthly service budget. NF provides flexibility to adjust services and allows participants to exercise more decision-making authority and to take primary responsibility for obtaining services.

Participants who choose NF receive an individual monthly service budget that they can use to purchase items and services that meet their care needs that enable them to live as independently as possible in the community. The program provides participants the ability to save for and purchase services, equipment or supplies that decrease their need for Medicaid services and/or increase safety in their home environment.

Participants in New Freedom have the choice to decide:

- What qualified services, goods and supports they need within their approved service budget.
- When and how those services and supports are to be delivered.
- Who will provide those services and supports.
- Who will provide personal care assistance (individual provider/homecare agency).

New Freedom Roles

New Freedom participants work with a Care Consultant and a Financial Management Service vendor (ACES$) to design and implement their individual participant spending plan. Each play an important role in working with participants to develop an individualized monthly service budget that details approved authorizations and guides the participant's purchasing of services/supports to meet their needs.

Role	Summary of Responsibilities
Participant or Authorized Representative	Participant or Authorized Representative will work with their Care Consultant to make choices about approved services and supports that work best for them within their approved New Freedom budget. They will work with ACES$ Financial Management Services to obtain those approved services and supports. This may entail monitoring their own services including the budget and informing the Care Consultant of any changes.
Care Consultant	Assists the participant in development and management of their New Freedom budget. The Care Consultant is available to advise participants in how to gain access to needed services, assisting in the development of the New Freedom Spending Plan, coaching the participant on how to monitor their services included in the budget, and updating the service plan as necessary. The Care Consultant reviews and approves all purchases and adds them to the New Freedom Spending Plan. In addition, the Care Consultant provides ongoing functional eligibility determinations for participants enrolled in the program.
ACES$ Financial Management Services (FMS) provider	Handles all financial transactions for New Freedom participants outside of monthly personal care. All New Freedom expenses incurred, except personal care, by participants are billed through ACES$ Financial Management Services (FMS). The only supports/services that will be allowed under New Freedom have been approved by the Care Consultant under the guidance of this chapter and the appropriate state and federal regulations. .
New Freedom Program Manager	Manages the New Freedom program including all policy. • Responsible for updating program related documents. • Continuing education and training. Darrelyn Nuesca: darrelyn.nuesca1@dshs.wa.gov

WHAT ARE THE ELIGIBILITY REQUIREMENTS FOR NEW FREEDOM?

To determine functional eligibility, a personal care assessment, also known as your Comprehensive Assessment Reporting & Evaluation (CARE) assessment, must be completed. The financial and functional eligibility requirements for New Freedom are the same as the other Medicaid waiver programs, such as the COPES waiver. New Freedom is also available if a Community First Choice (CFC) client meets the waiver eligibility criteria, has a need that cannot be met by CFC and wants to enroll in New Freedom. New Freedom is currently an option available only to participants who live in participating counties and choose to receive in-home services.

Participants who receive services through the New Freedom Waiver meet each of the following criteria (WAC 388-106-1410):

Participants are eligible for New Freedom Consumer Directed Services (NFCDS)-funded services if they reside in their own home and meet **all** the following criteria. The participant's needs will be assessed using CARE and determine that:

(1) They are in NFCDS HCBS waiver specified target groups of:

(a) Eighteen or older and blind or have a disability; or

(b) Sixty-five or older; and

(C) They reside in a county where New Freedom is offered (King, Pierce, Ferry, Pend Oreille, Spokane, Stevens, or Whitman County).

(2) They meet financial eligibility requirements described in WAC 182-513-1315. This means the participant's finances will be assessed, if their income and resources fall within the limits, and determine the amount they may be required to contribute, if any, toward the cost of their care as described in WAC 182-515-1505; and

(3) They:

(a) Are not eligible for Medicaid Personal Care services (MPC); or

(b) Are eligible for MPC services, but it is determined that the amount, duration, or scope of their needs is beyond what MPC can provide; and

(4) Their CARE assessment shows they need the level of care provided in a nursing facility as defined in WAC 388-106-0355; and

(5) They live in their own home or will be living in their own home by the time NFCDS start.

A participant must also be willing and able to self-direct their services or select an Authorized Representative.

WHAT SERVICES ARE COVERED UNDER NEW FREEDOM?

Federal rule requires that waiver services not replace other services that can be accessed under state plan, Medicaid, Medicare, health insurance, Long Term Care (LTC) insurance, and other community or informal resources available to them.

- If a participant has other insurances or resources, case managers must document the denial of benefits before the participant can access waiver services. This documentation must be in the participant's file.
- Waiver services may not be used when the vendor refuses the reimbursement (from the FMS) or considers the payment inadequate from the other resources.
- Waiver services may not supplement the reimbursement rate from other resources.
- Exceptions To Rule are not allowed for the above circumstances.

All purchases under New Freedom must be pre-approved by the Care Consultant and meet the following criteria:

1. Be allowable under WAC 388 106 1400: What services may I receive under New Freedom consumer directed services (NFCDS)?
    a. Be for the sole benefit of the participant.
    b. Be of reasonable cost and meet a therapeutic need identified in the participant's CARE assessment.
    c. Meet the participants identified needs and outcomes from the CARE assessment and address the health, safety, and welfare of the participant related to their medical diagnosis, Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and health-related tasks (for example, nurse delegation and PERS units).
    d. Be documented on the participant's New Freedom Spending Plan;
2. The Care Consultant and/or Financial Management Service may require a physician or other licensed professional, such as an Occupational or Physical Therapist to recommend a specific purchase in writing. This recommendation is required to ensure the service, support, or item will increase, maintain, or delay decline of functional abilities, and to ensure the purchase supports the participants health and welfare.
3. Medicare or Medicaid state plan benefits or other insurance must be used prior to using NF funds if the goods or services are covered under these programs.
4. A participant may use their individual budget to purchase services, supports, or items that fall into the following service categories (as defined in the WAC 388-106-1400):
    a. Personal Assistance Services
    b. Treatment and Health Maintenance
    c. Individual Directed Goods, Services and Supports
    d. Environmental or Vehicle Modifications
    e. Training and Educational Supports
5. A participant may receive comprehensive adult dental services as defined in WAC 388-106-0300(15)
6. Trained Service Animals as identified by the American Disability Act (ADA) website below.
    a. Dogs that are trained to perform a task directly related to a person's disability.
    b. https://www.ada.gov/topics/service-animals/
    c. See additional information in Trained Service Animal section in Appendix A for complete description.

WHAT SERVICES ARE NOT COVERED UNDER NEW FREEDOM?

All purchases under New Freedom must be pre-approved by the Care Consultant and must not be excluded under WAC 388-106-1405 and 1915c waiver. Services and supports that cannot be purchased with New Freedom budgets include:

- Those items identified in WAC 388 106 1405: "What services are not covered under New Freedom Consumer Directed Services (NFCDS)?"
- Any goods, services, or supports that are considered of general utility.
    - General utility is defined as an item that is not of direct medical or remedial benefit to the participant. An item that would be a purchase made by any person whether they have a disability or not. Examples include lamps, air conditioners, rugs, beds, non-specialized clothing etc.
    - The service/good/support is not specific to the individuals' needs based on their disabilities or health conditions as identified in the CARE assessment.
- Services/supports covered by the Medicaid State Plan, Medicare, or other programs or services.
- Any fees related to health or long-term care incurred by you, including co-pays, waiver cost of care (participation), or insurance. This includes costs that other insurances will not pay.
    - If Medicaid funds (Apple Health) are used, then the participant cannot also use New Freedom funds (which are also Medicaid funds) to pay any remaining balance as it would be double dipping into the Medicaid pool of funds.
        - Example: Costs that exceed the participant's medical/dental benefit allowance for using Medicaid funds.
    - If only Medicare funds are used, then NF funds may be allowable.
- Home modifications or improvements that only add any square footage to the home.
- Home modifications or improvements that are of general utility and are not of direct medical or remedial benefit to the participant.
- Repairs or general maintenance needed prior to a modification being completed (or determined during the modification), including testing and removal or abatement of asbestos or mold or repairs required due to water or pest damage. Repair and general maintenance of a dwelling are the responsibility of the owner.
- Vacation or travel expenses other than the direct cost of provision of personal care services.
    - A participant may not use New Freedom funds to pay travel expenses for their provider.
- Rent/room and board.
- Tobacco or alcohol products.
- Lottery tickets.
- Entertainment items (TV, cable or DVD players), and other electronics, that are nonadaptive in nature.
- Vehicle purchases/maintenance/upgrades that do not include modification related to disability.
- Tickets and related costs to attend sporting or other recreational events.
- Standard household supplies, furnishings, equipment and maintenance, and major household appliances.
- Pets, comfort, or therapy animals and their related costs (including purchase of the pet, comfort or therapy animal, their food or veterinary services).
- Non-routine veterinary services for a Trained Service Animal (Veterinary care over the cost of $500 per occurrence.)
- Postage outside of shipping costs related to prior approved service plan items.

- Experimental or investigational services, procedures, treatments, devices, medications, or application of associated services, except when the individual factors of an individual participant's condition justify a determination of medical necessity under WAC 182-500-0070.
    - This also applies to Trained Service Animals. Experimental or investigational services, procedures, treatments, devices, medications, or application of associated services are not covered.
- Exercise equipment greater than $500 per item.
- Monthly service fees for utilities, including ongoing utilities.
- Warranties (for equipment, furnishings, or installations).
- Computers and electronics, that do not meet therapeutic need or are not adaptive in nature.
- Cosmetic services and treatments.
- Basic groceries, clothing, and footwear.
- Any item previously purchased through Medicaid funding that is within the health care authority replacement period.

Authorized Representative

The New Freedom waiver supports participants to use an Authorized Representative to assist them (or manage on the participant's behalf) in managing and directing their budgets. Both the participant and the representative must sign the New Freedom Authorized Representative Form giving the responsibility to the person of their choice. An Authorized Representative is authorized to complete and sign all forms. An Authorized Representative will work with the Care Consultant to use the New Freedom Spending Plan (NFSP) monthly budget to purchase goods, services, and other items to meet the participant's personal care needs as identified in their CARE assessment.

Authorized Representatives can ensure that participants' preferences are known and respected and can manage tasks that they would carry out if they were able. These individuals are surrogate decision makers for those who choose or may need some or total assistance to direct their services and supports. In New Freedom (per WAC 388-106-1435) an Authorized Representative cannot also be a paid provider under the participant's NFSP.

An Authorized Representative Must:

- Act in the participant's best interest
- Respect the participant's preferences
- Maintain regular contact with the participant
- Be willing and able to meet and uphold all program requirements on behalf of the participant
    - Including working and collaborating with the participant's Care Consultant
- Be at least 18 years old

An Authorized Representative CANNOT:

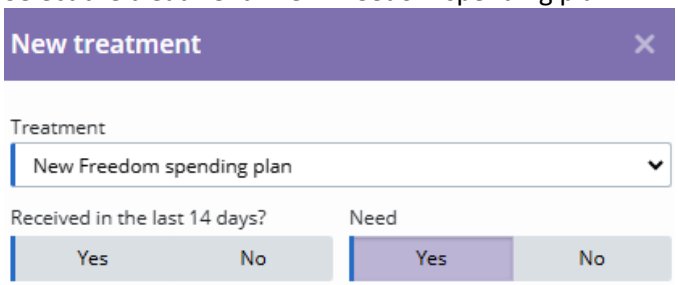
- Be paid for this service
- Be a paid provider for the participant

The Participant or Authorized Representative may end this agreement at any time.

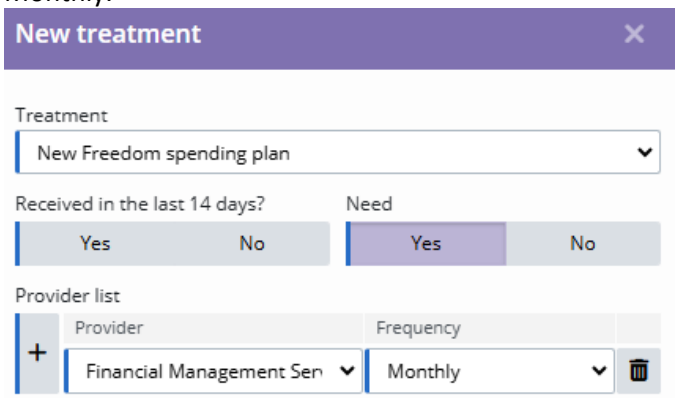
HOW DO PARTICIPANTS ENROLL IN NEW FREEDOM?

Choosing New Freedom in CARE:

1. Complete the CARE assessment to determine functional eligibility.
2. Obtain a financial eligibility determination;
3. Offer New Freedom as an option when the client is determined financially and functionally eligible.
    a. The financial and functional eligibility requirements for New Freedom are the same as the other Medicaid waiver programs, such as the COPES waiver. New Freedom is also available if a Community First Choice (CFC) client meets the waiver eligibility criteria, has a need that cannot be met by CFC and wants to enroll in New Freedom.
    b. New Freedom is currently an option available only to participants who live in participating counties and choose to receive in-home services.
        i. As of 01/01/2025, participants must reside in a county where New Freedom is offered (King, Pierce, Ferry, Pend Oreille, Spokane, Stevens, or Whitman County).
4. If the client chooses New Freedom, start by adding New Freedom as a Treatment
    a. On the "Medical" screen, add a New Treatment.
    b. Select the treatment "New Freedom spending plan".

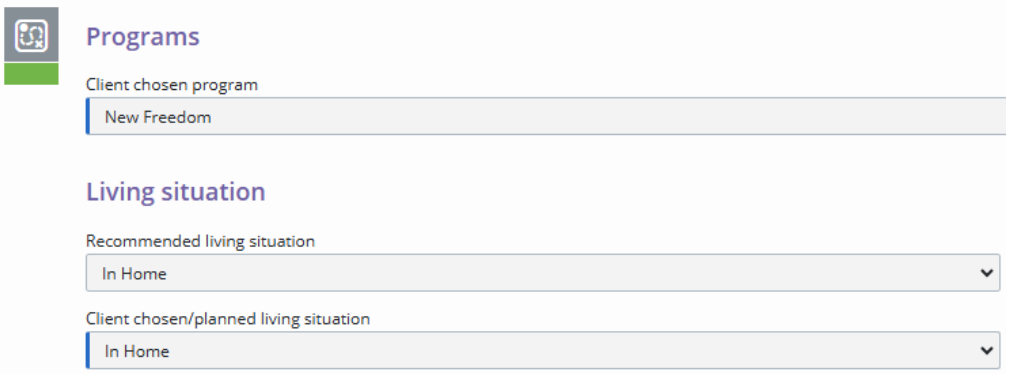


    c. Select No for "Received in the last 14 days?" and Yes for "Need".
    d. In the Provider List drop down, add "Financial Management Service" with a frequency of Monthly.

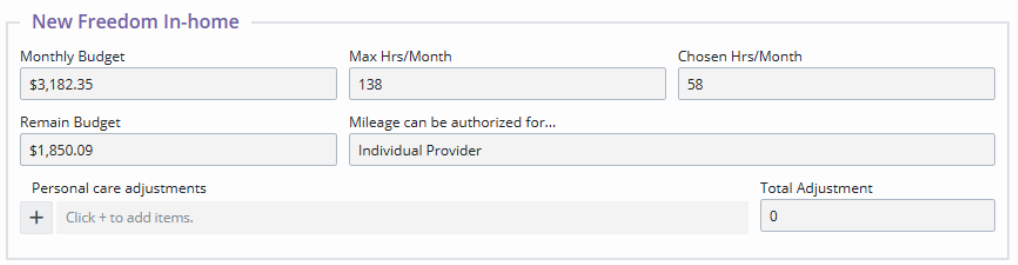


    e. Select "Add Treatment"

5. Once the Treatment screen is completed, add New Freedom to the "Care Plan" screen:
    a. On the "Care Plan" screen in CARE, select New Freedom on the 'Client chosen program' screen.



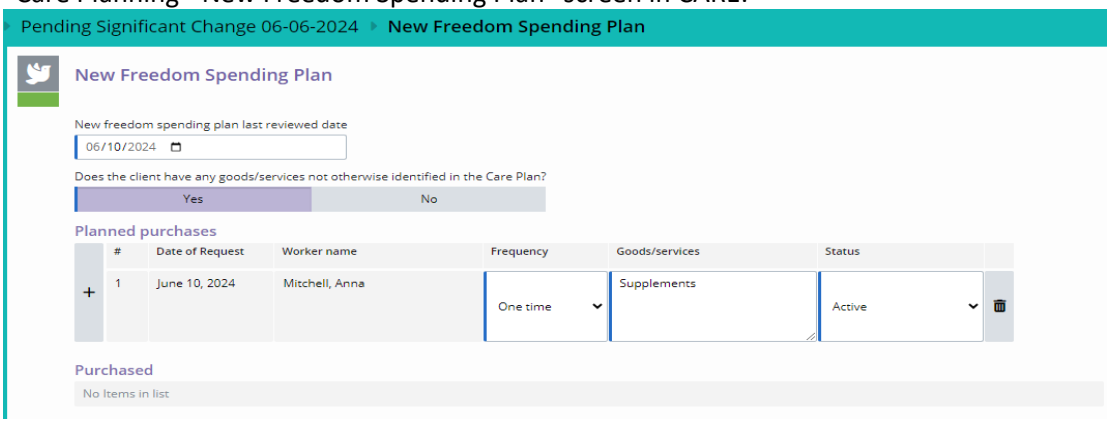
    b. Once the CARE classification has been determined, the 'Monthly Budget' will populate in the New Freedom In-Home section of the Care Plan.



    c. Enter in the number of hours the client has chosen to use for personal care and the "Remaining Budget" amount for goods and services will self-populate;
        i. Per WAC 388-106-1458, participants must choose the number of hours they wish to use for the month before the beginning of that month. After the month starts, the only way to change hours in the current month is through a significant change assessment or an Exception to Rule.
        ii. If a participant elects to use a certain number of hours, and does not use all those hours, they will not be able to convert those hours back to their budget funds.
    d. The amount in the 'Remaining Budget' will transfer to the Financial Management Services provider once the Care Plan is brought to current.
6. "Care Planning – Supports" screen in CARE:
    a. Once you have entered New Freedom as the 'Client chosen program', add the PAID caregiver and any UNPAID informal supports to the "Supports" screen and assign tasks as appropriate.
        i. Add "ACES$ Financial Management Services – New Freedom" agency (ACES$ 208768001. DO NOT USE THE 02 LOCATION CODE FOR NEW FREEDOM) on the Supports screen.
        ii. If you add PERS, Environmental Modifications, or Specialized Medical Equipment, assign them to "ACES$ Financial Management Services - New Freedom".

CREATING THE NEW FREEDOM SPENDING PLAN (NFSP) IN CARE

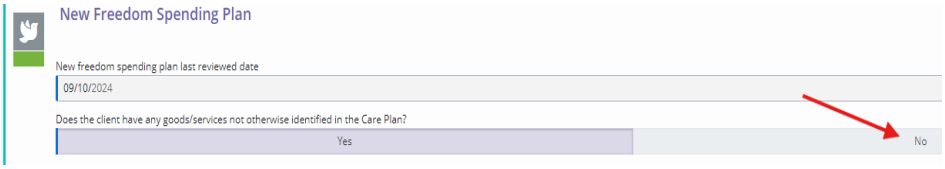
1. After you have entered New Freedom as the 'Client chosen program', the New Freedom Spending Plan section will be created.
    a. This must be completed for every Initial/Annual/Significant Change assessment.
2. "Care Planning - New Freedom Spending Plan" screen in CARE:



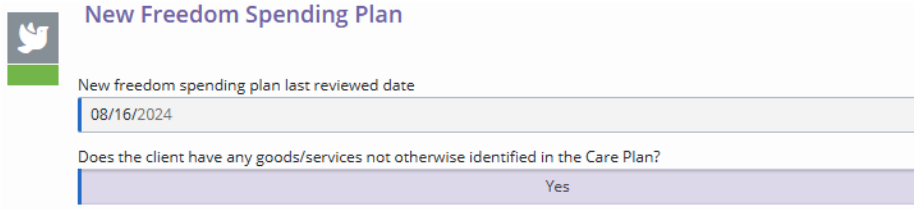
3.
    a. Add at least one approvable (Pending or Active) goods or service that the client has requested (outside of personal care) to the NFSP.
        i. For a list of approvable items, please see WAC 388-106-1400.
    b. Select the plus button
        i. The **Date of Request** will auto generate the current date
        ii. The **Worker Name** will auto generate with the name of the Care Consultant that is logged into CARE.
        iii. Select a **Frequency** of "One-Time" if the purchase is for an item occurring only once (such as an adaptive tablet). If the frequency is recurring (such as home delivered meals or PERS) select a frequency of "Monthly".
        iv. List the **Goods/Services** (up to 128 characters). Only one Goods/Services should be listed in each box.
        v. Select the **Status** as "Active".
4. Approval of the participant regarding the information documented in the CARE assessment that determined their New Freedom budget amount is documented in the Service Summary. The participant needs to approve the plan of care by signing the most recent Initial/Annual/or Significant Change Service Summary, as in all other programs.
    a. Complete and have the participant sign the most recent versions of the standard DSHS enrollment forms and the following forms:
        i. Acknowledgement of Services Form (DSHS Form 14-225).
        ii. The Rights and Responsibilities Form (DSHS Form16-172).
        iii. The New Freedom Participant Responsibility Agreement (DSHS Form 16-244).;
        iv. The Authorized Representative Form (if required).
    b. Complete the Planned Action Notice (PAN) for New Freedom. Assign the total budget amount under the service heading "Individual Directed Goods, Services and Supports".

c. Create New Freedom RAC 3040.

5. Authorizing personal care and goods and services, where applicable.
   a. If the Participant chooses personal care **only**, HCS workers will authorize personal care services using the T1019, U6 service code in CARE.
   b. If the Participant chooses personal care only, HCS workers will still complete the New Freedom Spending Plan (NFSP) section 'Does the client have any goods/services not otherwise identified in the Care Plan?' with the answer of **No**.



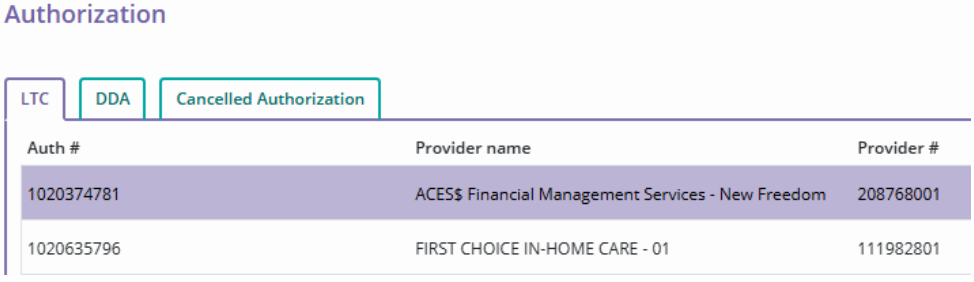
   c. If the Participant **does not** choose personal care (goods and services only) or chooses **both** personal care **and** good and services, the HCS worker will complete the New Freedom Spending Plan section 'Does the client have any goods/services not otherwise identified in the Care Plan?' with the answer of **Yes**.



   d. Notify the Public Benefit Specialist of the begin date of New Freedom services using the DSHS Form 14-143;
   e. Transfer CARE and the case file to the appropriate AAA for on-going Care Consultation Services.

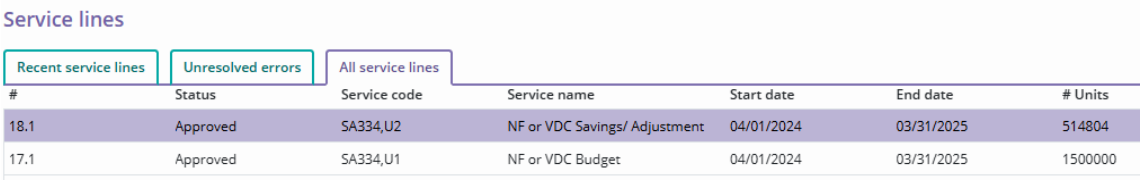
ADDING THE AUTHORIZATIONS FOR NEW FREEDOM IN CARE

   a. When adding the auth be sure to include only ACES$ Financial Management Services – New Freedom and personal care (either IP or agency).



   b. All other authorizations for goods and services such as PERS, home delivered meals etc. will be paid through ACES$.
   c. When creating service lines for SA334 U1 or SA334 U2 these lines must span the plan period and not exceed 12 months. When creating a new plan period authorization for SA334 U1 and SA334 U2 you will need to create 2 new lines. There should only be one of each service code, as applicable, per plan period.

d. Once ACES$ has been authorized, create Service code **SA334, U1** from the Remaining Budget amount from the Care Planning Screen.
    i. If a participant is saving less than $1,250 per month then you will authorize 900,000 units ($9,000.00).
        1. ALTSA-Rate limit for SA334, U1 can be increased at the local level by the supervisor.
    ii. New Freedom Care Consultants should authorize an annual amount of 1,500,000 units ($15,000.00) if a participant is saving $1,250 or more per month.
    iii. The service code SA334, U2 represents funds available to the Financial Management System (FMS) vendor to claim against, during a participant's plan period, based on the FMS' accounting of accrued funds and spending for approved purchases.
    iv. New Freedom budget as determined by participant's functional assessment.



Service lines

Recent service lines | Unresolved errors | All service lines

#	Status	Service code	Service name	Start date	End date	# Units
18.1	Approved	SA334,U2	NF or VDC Savings/ Adjustment	04/01/2024	03/31/2025	514804
17.1	Approved	SA334,U1	NF or VDC Budget	04/01/2024	03/31/2025	1500000

e. Also add Service code **SA334, U2** for 900,000 units. This is the client's accrued savings in the ACES$ portal at the end of the client's care plan.
    v. Any increase in limits due to ETR should be added to the SA334, U2 line.
f. For information related to social service authorizations and payments refer to the Social Services Authorization Manual (SSAM). http://intra.dda.dshs.wa.gov/ddd/p1servicecodes/

Indexing New Freedom Documents and the Document Management System (DMS)

All New Freedom documents will be indexed as a NF type document. HCS/AAA staff must write "New Freedom" and the "ACES Client ID #" at the top of these documents so the HIU can identify them and index them as a NF document.

HCS Public Benefit Specialist (PBS) will:

1. Determine financial eligibility for long-term care services;
2. Advise New Freedom Care Consultant as the authorized representative of any Medicaid eligibility or cost of care changes as they occur. (They will receive the notices of termination, participation changes, eligibility reviews due, etc.)

Once the case has been accepted by the Area Agency on Aging (AAA):

1. AAA supervisor will assign the case to a New Freedom Care Consultant.
2. The New Freedom Care Consultant will complete a 30-day visit.
3. The New Freedom Care Consultant will complete quarterly monitoring calls.

NEW FREEDOM CARE CONSULTATION SERVICES

New Freedom Care Consultation:

Care consultation is provided at the direction of the New Freedom participant and includes providing training and support to assist participants to develop and implement their spending plans to obtain approved services within a fixed monthly budget called the New Freedom Spending Plan (NFSP).

The Care Consultant is responsible to assess and assist the participant to determine the services and supports that will address unmet needs identified in the CARE assessment and maintain or increase their ability to maximize independence based on this chapter and state and federal regulations. They help facilitate the participant's control and selection of services to the greatest extent possible to access preferred services and supports available under the New Freedom waiver. This may include providing assistance to identify costs, manage services within budget, assess risks and assist with problem solving related to the implementation of the NFSP. The Care Consultants reviews and approves all New Freedom program purchases of goods and services. Care Consultants are also responsible for authorizing personal care. AAAs are responsible for monitoring Agency personal care providers to ensure they are in compliance with training and contracting requirements. ALTSA is responsible for monitoring CDE agency personal care providers to ensure they are in compliance with training and contracting requirements.

Roles and Responsibilities:
The Care Consultant ensures that participant's choices of goods/services align with what's allowed and disallowed by the regulations. Care Consultant has authority to approve or deny participant's requests/choices.

The Care Consultant is responsible for sending appropriate Planned Action Notices as described in the LTC Manual, chapter 3.

Orientation to Budget-Based, Participant-Directed Services

The Care Consultant will meet with the participant, and others whom the participant may wish to be present, to explain what participant-direction involves. It is important that the participant understands the responsibilities involved in a participant directed budget-based program. During the first visit the Care Consultant will go over the New Freedom Program and offer to send the client a copy of the New Freedom Participant Handbook, have the participant sign form 16-244 (New Freedom Participant Responsibility Agreement) and provide the Financial Management Services New Freedom Participant Handbook and document the conversation in SER.

An individual Participant's Budget Allocation is calculated using the average individual provider hourly wage (including mileage), multiplied by the number of units generated by the CARE assessment, multiplied by 0.93, plus the average participant expenditures for non-personal care supports. This will generate a dollar amount automatically in CARE.

Creating the Participant's New Freedom Spending Plan (NFSP)

The participant spending plan documents how the participant will spend their approved service budget dollars to address the needs that were identified in the Care Plan.

Within the authorized budget, participants may choose services and supports not already covered by Medicaid State Plan or Medicare under the following categories (as outlined in WAC 388-106-1400):

Personal Assistance Services (PAS)
Supports involving the labor of another person to help participants carry out everyday activities they are unable to perform independently. Services may be provided in the person's home or in the community. Items in this category must be of reasonable cost and meet a therapeutic need identified in the participant's CARE assessment. The following are included in PAS:

- Direct 'Personal care services' defined as physical or verbal assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) due to your functional limitations. Assistance is evaluated with the use of assistive devices. as defined in WAC 388-106-0010); These must be provided by a qualified individual provider or AAA-contracted homecare agency.
- Delegated health-related tasks per WAC 246-841-405. (Providers of direct personal care services may be asked to do nurse delegation under the supervision of a nurse);

Treatment and Health Maintenance Supports
Supports and services defined as treatments or activities that are beyond the scope of the Medicaid State Plan that are necessary to promote the participant's health and ability to live independently in the community and preventing further deterioration of the Participants level of functioning or improving or maintaining your current level of functioning.

This category includes those supports that are typically performed or provided by people with specialized skill, certification or licenses. Items in this category must be of reasonable cost and meet a therapeutic need identified in the participant's CARE assessment. Some examples of these services are:

- Specialized health care, extended therapeutic treatment;
- Dental, vision, audiology;
- Culturally appropriate health services (culturally and linguistically sensitive health care in the areas of primary care, prevention & wellness, e.g. acupuncture, naturopathic medicine);
- Physical therapy;
- Therapeutic massage complementary to physical therapy or provided as a less intrusive alternative.

Individual Directed Goods, Services and Supports
Services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address and support the participant to function more independently, increase safety and welfare, or help the participant to perceive, control or communicate with their environment. Items in this category must be of reasonable cost and meet a therapeutic need identified in the participant's CARE assessment. Some examples of services are:

- Environmental supports (e.g., snow removal, heavy cleaning); Assistive technology, supplies and equipment;
- Adaptive, specialized clothing (not of general utility);
- Specialized diets; home delivered meals;
- Repairs and maintenance of care-related equipment;

- Equipment and services that reduce the need for on-site supervision in an emergency;
- Transportation not provided by a personal assistant.
- Trained Service Animal (See Appendix A): Upkeep expenses related to trained service animals such as food, licensing and routine veterinary services.
    - Routine veterinary care over the cost of $500 per occurrence would require an ETR.
- Assist you to transition from a hospital or nursing facility to your home.

Environmental and Vehicle Modifications

Modifications to a participant's residence or vehicle necessary to accommodate their disability and promote functional independence, health, safety and welfare. Items in this category must be of reasonable cost and meet a therapeutic need identified in the participant's CARE assessment. The alterations cannot be adaptations or improvements that are of general utility or merely add to the total square footage of the home.

Some examples of services are:

- Installation of ramps and grab-bars;
- Widening of doorways;
- Minor household repairs;
- Modification of bathroom facilities;
- Specialized equipment;
- Vehicle modifications include adaptive vehicle controls related to steering, braking, shifting, signaling and acceleration, lift devices, seat adaptations, handrails, and door widening.
    - Vehicles subject to modification must be owned by the Participant or a member of the family that resides with the Participant.
    - Vehicles subject to modification must be in good working condition, licensed, and insured according to Washington state law; and be cost effective when compared to available alternative transportation.

Training and Educational Supports

This service category includes training or education on a client's health issues or personal skill development (in person within Washington state or online). It can also include training to paid or unpaid caregivers related to the needs of the client. Items in this category must be of reasonable cost and meet a therapeutic need identified in the participant's CARE assessment. Some examples of supports are:

- Enrollment in a course addressing self-management of diabetes; Drug and alcohol treatment;
- Mental health services;
- Enrollment in a course addressing self-management or training specifically related to a Participant's Diagnosis.
- Enrollment in a course addressing additional training (new tasks only) specifically related to a Participant's Trained Service Animal.

The Participant, with the approval of the Care Consultant, will authorize all purchases from the budget. The development of the NFSP is meant to be a careful process that requires the participant, with the help of their Care Consultant, and representative (if the participant has chosen someone to act in this

role) to make a very intentional plan that balances immediate needs for services like personal care or other goods and services referenced above that are not covered by some other funding source with goals to save funds for a one-time purchase, like a vehicle modification, related to needs identified in the spending plan.

- A 'planned purchase' is any one approved item (e.g. a service, an assistive device, or piece of equipment) that is described in the NFSP for which the participant is saving.
- A participant is allowed to accumulate up to $3,500 in their account to pay for such a purchase without getting additional approval.
- A participant, with the support of their Care Consultant, may request approval to exceed the $3,500 cap for exceptional, planned purchases with preapproval from the New Freedom Program Manager.
- If a single purchase exceeds $3,500, the Care Consultant must notify the New Freedom Program Manager via email. If the purchase is allowable under WAC, no further action is necessary. If the purchase requires an Exception to Rule because it is excluded by WAC or the participant needs additional funds, follow the process outlined below to complete the Exception to Rule. Create an Exception to Rule in CARE and submit to New Freedom Program Manager as discussed in Exceptions to Rule section.
    - Please Note: Personal Care Exception to Rule's must still be submitted to the Long-Term Care Committee. (See Chapter 3 of the Long Term Care Manual (LTC) for more information on Personal Care Exception to Rules)

The approved purchase NFSP allows participants to identify specific approved planned purchases and the costs associated with the potential purchases. The list is for reference only and is not functionally associated with the budget. Once there is enough funding saved for a specific planned purchase the participant will ask the Care Consultant to create an approved allocation line in the portal so the item can be purchased once the participant submits a completed Participant Purchase/Reimbursement Request Form (PRF) authorizing the Financial Management Services provider to make the purchase.

Once the participant has determined what their spending plan will be the Care Consultant will enter it into the Financial Management Services portal.

The participant's approval of the spending plan verifies his/her involvement in the development of the plan and gives consent to the services and supports outlined in the plan. Obtaining approval of the spending plan is the same process as in other waiver services.

Procuring Providers and Vendors

The Care Consultant and the FMS will be available to assist the participant in selecting providers and vendors. CDWA will facilitate the contracting of the individual provider. For non-personal care services, the Care Consultant will follow the process outlined in the Contracting Non-Personal Care Providers and Vendors section.

Individual Provider (IP) or Home Care Agency Personal Care (HCA)

The New Freedom budget is calculated based on the assumption that a participant will be hiring an IP for personal care services. If the participant wants to be served by an HCA, there will be no additional charge to their budget, nor will there be additional funds provided to the budget. Depending on the participant's choice of personal care provider the Care Consultant will authorize services as described in the enrollment section of this chapter.

Exceptions to Rule (ETR)

- An Exception to Rule, referenced in Chapter 3, (WAC 388-440-0001) is required to authorize a higher budget amount than indicated in CARE. The standard ETR process will be followed by creating a request in CARE and submitting the request to the New Freedom Program Manager via the "NFETRTEAM".
- A one-time Exception to Rule budget amount may be approved if the participant needs a specific support and they do not have savings funds accumulated to purchase the item needed for health or safety concerns. The standard ETR process will be followed by creating a request in CARE and submitted to the New Freedom Program Manager via the "NFETRTEAM".
    - This would be a Waiver Exceeds Limit ETR.
    - This should be set for the plan period and will require annual renewal as needed.
- A one-time ETR may be approved to use participant's existing funds for a service/item which is not usually covered by New Freedom but is needed to address their unique health or safety concerns. The standard Exception to Rule process will be followed by creating a request in CARE and submitted to the New Freedom Program Manager.
- Participants receiving in-home, personal care services may ask for more hours following the standard Personal Care Exception to Rule process and submitting to the Long-Term Care Exception to Rule Committee.
- The New Freedom Program Manager will review the Exception to Rule with the committee within 7 days business days of receipt.
- Upon approval or denial of the ETR, the Care Consultant will send out DSHS Form 15-601 "New Freedom (NF) Notice of Exception to Rule (ETR) Decision (Goods and Services)".

Note: If an Exception to Rule is approved the additional funds must be authorized for the service/support that it was requested for.

Quarterly Contacts

Participants in New Freedom may have little or no experience in assuming responsibility for their own service plan and budget. The Care Consultant might need to spend considerable time helping a participant understand, learn and embrace their role in determining what services will best address their individual care needs in addition to hiring and supervising a personal care provider.

The Care Consultant must make quarterly contacts with the participant to:

- Review budget authorizations;
- Review elections for personal care hours;

- Review NFSP and remove those items/services that are no longer needed/wanted and add additional items if appropriate. Check the priority of the items/services on the NFSP to ensure payments can be made timely once funds have been accumulated.
- Confirm that purchases in the past quarter were received; and

Contacts must be made quarterly from the date of assessment. For example, an assessment is conducted on January 9th and moved to current on January 15th. The next contact must be completed by the end of April with the subsequent contacts required by July and October and face-to-face assessments (annual or significant change) may be substituted for one of the quarterly contacts as long as the spending plan information was discussed as above.

- To help the Care Consultant track if they may be overdue for a quarterly contact, document all contacts considered as quarterly contacts in **SER** using **Purpose Code "Monitor Plan".** This will enable an automated Tickler to notify the Care Consultant if more than 4 months have passed since the last Monitor Plan SER entry.

Institutional Stays

A participant who has been institutionalized for 30 days or less (per WAC 388-106-1422**)** with the intent to return to New Freedom upon discharge may stay enrolled in the program with their budget being temporarily suspended. The service budget dollars cannot be used while the participant is institutionalized. Participant funds will not accrue while institutionalized. Upon return home the budget will be reinstated to the amount that was in place when initially institutionalized.

The Care Consultant will notify the New Freedom Program Manager that the participant's budget must be suspended. The New Freedom Program Manager will notify the Financial Management Services provider not to allow any spending against the budget.

If a participant requires funds to be used during a short institutional stay to prevent additional costs (payment for PERS monthly service vs. payment for reinstallation of PERS unit) or to pay for services already received at the time of institutionalization (Home Delivered Meals), the Care Consultant will need to contact the New Freedom Program Manger to have these expenditures approved.

Challenging Cases Protocol

The Care Consultant should follow the Challenging Cases Protocol for any situation when the spending plan cannot assure the health and welfare of the participant due to participant, environmental, or resource issues (Chapter 5).

A participant's enrollment in the New Freedom program may be ended involuntarily if the participant:

- Moves out of the designated service area or are out of the service area for more than 30 consecutive days; or
- Does not meet the terms for consumer direction of services outlined in the New Freedom Participant Responsibility Agreement when:
    - Even with coaching and collaboration, the participant is unable to develop a NFSP or self-direct services or manage their individual budget or NFSP;
- Any other criteria listed in WAC 388-106-1475.

Skin Observation Protocol

If a participant chooses New Freedom at the time of their CARE assessment (intake/annual/significant change) and the assessment triggers a skin issue, the worker's agency (HCS/AAA) must proceed with the standard skin observation protocol (Chapter 24).

REASSESSING PARTICIPANTS FOR NEW FREEDOM

The Care Consultant *will:*

1. Complete the annual and significant change assessment when applicable in CARE to determine ongoing functional eligibility;
2. Obtain a financial eligibility determination;
3. Offer New Freedom as well as other waiver/state plan options, settings, and providers when the client is determined financially and functionally eligible;
4. If the participant chooses to remain in New Freedom, the Care Consultant will follow the applicable steps under the enrollment section. *(Note: 14-225 does not need to be re-signed at annual/significant change assessments unless; there was a break in services or an updated version of the 14-225 form and an MB states the new version would need to be signed at participants next annual/significant change assessment)*
5. The Care Consultant will review the assessment with the participant and make any applicable updates to his/her spending plan taking into consideration the information in CARE including triggered referrals.
6. If the participant chooses **not** to remain in New Freedom:
    a. Coordinate the transfer to another ALTSA program of choice that the participant is eligible to receive.
7. When a participant is no longer functionally or financially eligible for NF, the Care Consultant will provide timely Planned Action Notice for termination of services.

WHAT ARE FINANCIAL MANAGEMENT SERVICES?

The Financial Management Services provider, ACES$, is the agency that handles payment and contracting matters on behalf of the participants enrolled in New Freedom. Their responsibilities include accessing the monthly goods and services budget from the Department of Social and Health Services (DSHS); setting up individual accounts for each participant; setting up procedures for verifying qualifications and credentials of providers/vendors of service; implementing efficient and timely participant directed purchasing systems; facilitating payment for labor services and other items needed by participants as identified in the spending plan; and developing contracts with non-personal care providers and vendors.

Contracting Non-Personal Care Providers & Vendors

If the participant needs assistance in identifying appropriate services and supports the Care Consultant will be available to help. This could include assisting the participant to find the service/support at the best possible cost to meet the needs of the participant in terms of quality, quantity, and location.

Once the participant identifies a provider, the participant or the Care Consultant will contact Financial Management Services (FMS) customer service to initiate the 'new vendor' process. The FMS provider will ensure the chosen vendor is qualified to provide the service to the participant, including verifying provider credentials and contracting with vendors (if necessary). If a vendor chooses not to contract with the FMS provider or is not eligible to contract with the FMS provider, the participant will need to choose another vendor.

When the contracting and credentialing is complete, the FMS provider will notify the Care Consultant, the participant and the vendor. The participant will then be responsible to send in the Participant Purchase/Reimbursement Request Form and any other required documentation (receipt, invoice, etc.) to the Financial Management Services provider to allow purchase and/or payment.

Payments for Goods & Services

There are three ways in which a New Freedom participant's services and supports can be paid through the FMS provider.

1. Check payable directly to the approved vendor.
2. Online purchases made on the client's behalf by the FMS provider.
3. Client reimbursement for approved services that the participant paid for.

Participants themselves authorize all services and supports, other than personal care. This is done by completing a Payment Request Form and submitting the form to the FMS provider. Payment requests can be completed without the Payment Request Form by using the FMS online portal and uploading any necessary documentation.

Managing & Reporting of Accounts

The FMS provider will document and track all participant payments, excluding monthly personal care, related to individual spending plans. On a quarterly basis the FMS provider will send participants a budget report that contain expenditures and the budget balance. The Web portal is available to all participants who want to view their account on-line. Participants can register for the portal by visiting the ACES$ website: www.mycil.org.

MANDATORY REPORTING

New Freedom Care Consultants and the Financial Management Services provider are mandatory reporters and must follow all of the mandatory reporting laws.
*For additional APS information, refer APS Policy & Procedure.

ADMINISTRATIVE HEARINGS

When a participant disagrees or files for an administrative hearing based on a decision made by a Care Consultant or the Financial Management Services provider, the following processes will be used based on the situations outlined below:

If the participant is not satisfied with the outcome of their New Freedom functional eligibility determination (CARE assessment):

- The Care Consultant will follow the Administrative Hearing Process outlined in the ALTSA Long-term Care Manual Chapter 26.

If the participant is not satisfied with the denial of a provider and they contact the Care Consultant or the FMS provider regarding the issue:

- The Financial Management Services provider will:
  - Offer to mail the participant an administrative hearing request form.
  - If the participant files for an administrative hearing:
    - The Financial Management Services provider will contact the participant to see if they would like to schedule a pre-hearing meeting regarding the denial; and
    - If the pre-hearing meeting does not resolve the issue, the FMS provider will prepare a summary statement of the pre-hearing meeting and send the summary statement, notes and any other applicable information to the New Freedom Program Manager as soon as possible and no later than two weeks prior to the hearing unless the pre-hearing is scheduled within a week of the hearing.

- The Care Consultant will:
  - If the provider is not an IP:
    - Refer the participant to the Financial Management Services Representative regarding the provider denial who will follow the steps above.
    - Document the conversation in SER and notify the FMS representative of the issue.
  - If the provider is an IP:
    - Refer to the ALTSA Long-term Care Manual Chapter 11.

If the participant is not satisfied with the denial of a spending plan service or support:

- The Care Consultant will follow the Administrative Hearing Process outlined in the ALTSA Long-term Care Manual Chapter 26.

HOW DO PARTICIPANTS DISENROLL FROM NEW FREEDOM?

Voluntary Disenrollment

New Freedom is a voluntary program, and a participant may choose to disenroll and move to another Long-Term Care program. If a participant wants to disenroll the Care Consultant will work with them to switch to another program as seamlessly as possible. As a general rule if the participant asks to disenroll before the 15th of the month the disenrollment will be effective the first of the following month; if they ask to disenroll the 15th of the month or later, the disenrollment will be effective the first of the second following month (e.g., the participant calls on September 18th; the disenrollment will occur November 1st). On a case-by-case basis the transition can be expedited in order to support the participant's needs. When a New Freedom participant disenrolls the Care Consultant will contact the Financial Management Services provider to notify them of the disenrollment date.

Involuntary Disenrollment

Participant enrollment in New Freedom may also end involuntarily if:

1. The participant moves out of the designated service area or is out of the service area for more than thirty consecutive days, unless the purpose of the longer absence is documented in the SER; OR
2. The participant does not meet the terms for participant direction services outlined in the New Freedom Participant Responsibility Agreement (DSHS form 16-244). The terms are as follows:
    a. Even with help from a representative, the client is unable to develop a spending plan, direct services or manage his/her individual budget or spending plan.
    b. Any one factor or several factors of such a magnitude jeopardize the health, welfare, and safety of the New Freedom participant or others, requiring termination of services under WAC 388-106-0047.
    c. Misuse of program funds and services.

Additional Process for Involuntary Disenrollment

1. The Care Consultant must compose a written notice to the participant that fully documents that one or more of the conditions exist to justify involuntary disenrollment and forward the notice to the ALTSA New Freedom Program Manager.
2. The ALTSA New Freedom Program Manager will notify the Care Consultant of the approval/denial of the request for disenrollment within 15 days of receipt.
3. The Care Consultant will follow the Challenging Cases Protocol as applicable.
4. If the involuntary disenrollment is approved by the ALTSA New Freedom Program Manager, the Care Consultant will follow the disenrollment process noted above for voluntary disenrollment.

The participant may be eligible for other programs.

Loss of Eligibility

1. Participants must meet the functional and financial eligibility to remain in New Freedom. If a participant is determined to no longer meet program eligibility, the Care Consultant will work with the client on a termination plan.
2. New Freedom is available only to participants who live in their own homes. If a participant wants/needs to move to a residential or long-term placement in a nursing facility, they are no longer eligible for the New Freedom waiver.
3. New Freedom participants who are institutionalized for more than 45 days lose eligibility for the program and must be disenrolled.

RESOURCES

Related WACs and RCWs

Regulation	Description
Chapter 388-106 WAC	Long-Term Care Services

WACs 388-106-1400 through 388-106-1480	New Freedom Budget-Based, Participant-Directed Services
WAC 388-106-1400	What services may I receive under New Freedom consumer directed services (NFCDS)?
WAC 388-106-1405	What services are not covered under New Freedom consumer directed services (NFCDS)?
WAC 182-513-1315	General eligibility for Long-Term Care
WAC 388-106-1435	AREP
WAC 388-106-1458	NFSP
WAC 388-106-0010	ADL/IADL definitions
WAC 388-440-0001	ETR
WAC 388-106-1422	Institutional Stays
WAC 388-106-0047	When can the department terminate or deny long-term care services to me?

Acronyms

- AAA Area Agency on Aging
- ADA Americans with Disabilities Act
- ADL Activity of Daily Living
- ALTSA Aging and Long-Term Support Administration
- CARE Comprehensive Assessment Reporting Evaluation
- CC Care Consultant
- CCG Community Choice Guide
- CFC Community First Choice
- CIL Centers for Independent Living
- CM Case Manager
- COPES Community Options Program Entry System
- DME Durable Medical Equipment
- DMS Document Management Services
- DSHS Department of Social and Health Services
- ETR Exception to Rule
- HCA Health Care Authority
- HDM Home Delivered Meals
- HQ Headquarters
- IADL Instrumental Activity of Daily Living
- LPN Licensed Registered Nurse
- LTC Long Term Care
- MAGI Modified adjusted gross income
- MCO Managed Care Organization
- MPC Medicaid Personal Care
- NFCDS New Freedom Consumer Directed Services
- OAA Older Americans Act

- OT Occupational Therapist
- PA Prior authorization
- PT Physical Therapist
- RN Registered Nurse
- SER Service Episode Record
- SES Specialized Equipment and Supplies
- SLA Service level agreement
- SME Specialized Medical Equipment
- SOP Skin Observation Protocol
- SSAM Social Service Authorization Manual
- SSI Supplemental Security Income
- WAC Washington Administration Code

Glossary of terms specific to New Freedom

WORD	DEFINITION
Care Consultant (CC)	The person responsible to assist and work with Participants to determine the services and supports that will maintain or increase independence, advises Participants on how to access services and supports, assists in developing the NFSP, assists to procure/monitor services and supports on the NFSP, coordinates with the Financial Management Service responsible for managing Participant's service budget allocation based on the NFSP and updates the NFSP as necessary. The CC also authorizes payments for personal assistance services and determines ongoing functional eligibility using the CARE assessment.
Authorized Representative	A person of the Participant's choice who is authorized to complete and sign all necessary paperwork and work with the CC to create the New Freedom Spending Plan on behalf of the Participant. This person cannot be paid to provide care to the Participant.
Financial Management Services (FMS)	The agency that handles payments for approved items and services purchases on behalf of Participants enrolled in NF. The FMS also ensures vendors are qualified to provide the services per Medicaid rules. FMS are currently being provided by ACES$ Financial Management Services. Email contact: goodservicewa@mycil.org
New Freedom Program	A voluntary budget-based program that provides Participants who are eligible for home and community- based services through the Medicaid Waiver Program a choice in how they receive services in their home.
New Freedom Spending Plan (NFSP)	The individual plan created by Participants and their CC at least annually and updated as necessary, which documents Participants' intention to purchase approved services and supports to meet their assessed needs and to help maintain or increase their independence.
Participant Directed Services	A philosophy and orientation to home and community-based services in which Participants are given the authority to make choices about services and supports that work best for them, regardless of the nature or extent of their disability.

Payment Request Form (PRF)	An ACES$ form used by Participants to request payment for an authorized service or item from a qualified vendor/company.
Service Budget (SB)	The amount of service dollars the Participant has available monthly to spend on services and supports to address their care needs.
Services & Supports	Work performed or items that meet an identified therapeutic level of need in a Participants CARE assessment and are documented on his/her spending plan.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
5/20/2025	Darrelyn Nuesca	Update to changes to bring chapter in alignment with current guidance	TBD

APPENDICES

Appendix A - Trained Service Animals

Trained Service Animal Appendix A -

Appendix B - Authorized Representative Form (AREP)

NF Authorized Representative Form

Appendix C - New Freedom Participant Handbook

New Freedom Participant Handboc

Appendix D - New Freedom Participant Responsibility Agreement (DSHS 16-244)

16-244 New Freedom Participant

Residential Support Waiver (RSW)

Chapter 7f describes the Residential Support Waiver (RSW), which is a program that provides clients with Personal Care and Behavior Support services in community residential settings.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

JD Selby Residential Support Waiver Program Manager
360.890.2640 james.selby@dshs.wa.gov

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WHAT IS THE RESIDENTIAL SUPPORT WAIVER (RSW)?

The RSW is a home and community-based waiver designed to provide personal care, community options, and specialized services for eligible clients with co-occurring personal care and behavioral support needs. The RSW provides a cohesive and comprehensive continuum of specialized services targeted to adults with extremely challenging behavior. All clients who receive RSW services should also receive Behavior Support services.

Clients can receive RSW services in a variety of settings. The waiver offers four levels of residential services with progressively intensive supports designed to facilitate successful community living, while providing options based on client need.

The RSW was authorized by the Centers for Medicaid and Medicare Services (CMS) in August 2014.

Guidelines for program eligibility are in WAC 388-106-0336 through 0348. Licensing regulations are found in Chapter 388-107 WAC.

Note: If a client is receiving Expanded Behavior Support (EBS) or Expanded Behavior Support Plus (EBS-Plus) services in a skilled nursing facility, those services are not part of the RSW. Please see Chapter 10 of the Long-Term Care (LTC) Manual for information on EBS or EBS-Plus in a skilled nursing facility.

WHAT IS THE TARGET POPULATION FOR THE RSW?

RSW services are designed for eligible clients who require support from caregiving staff who have completed specialized training for providing personal care, have completed training in how to provide crisis response techniques and are able to implement proactive behavioral support that is otherwise not available outside of nursing facility services or a psychiatric care inpatient setting. The RSW serves clients who are either returning to the community from state or community psychiatric hospitals, have had a single or multiple failed/denied community residential settings, or are at risk of losing their current community residential setting due to behavioral challenges.

Many clients receiving RSW services have, historically, not had the support they needed to safely remain in other community residential settings. In order to provide a stable residential home environment, RSW clients—often with neurocognitive or traumatic brain disorders—require an array of behavioral health support.

HOW IS FINANCIAL ELIGIBILITY DETERMINED?

Financial eligibility and client income requirements for RSW are the same as those for the COPES waiver program. Clients must:

- Meet the Supplemental Security Income (SSI) disability criteria; and
- Be eligible for institutional categorically needy (CN) medical coverage group.

See Chapter 7a of the LTC manual for more information regarding financial eligibility for LTC programs.

Case Managers are required to verify financial eligibility per BARCODE 14-443 communication.

The RSW Medicaid coverage period begins on the first day the client arrives at the community residential setting that is contracted to provide the service. For ECS and SBS services, the Behavioral Support Provider must be confirmed by the social worker in order to initiate services. Prior to service authorization for SBS services, an approved staffing calendar from the AFH is required. Clients admitted to an ESF require coordination with the assigned regional Transitional Coordinator/Specialist to determine authorization start date.

When communicating with Public Benefits Specialists (PBS) regarding RSW clients, Case Managers will use the Financial/Social Services Communication Form (DSHS 14-443). On the form:

- Select the RSW program for all RSW clients
- Select the CFC program if the RSW client is also receiving an ongoing CFC Ancillary service. Do not select CFC if the RSW client is getting a one-time CFC service.

For more information on how financial eligibility is determined, see Chapter 7a: Financial Eligibility of Core Programs of the LTC Manual.

NOTE: For MAGI/N05: Fast Track can be considered for RSW. Review Fast Track (13-713) process outlined in Chapter 7a.

WHAT ARE THE FUNCTIONAL ELIGIBILITY CRITERIA FOR RSW?

The Regional RSW Committee will review referrals and make determinations on eligibility and level of service on the DSHS form 11-130 RSW referral form based on the following eligibility criteria:

- Must be financially eligible **and** must meet ALL the following eligibility criteria, per WAC 388-106-0338:
  1. Meet the Nursing Facility Level-of-Care (NFLOC) per WAC 388-106-0355;
  2. Have been assessed as medically or psychiatrically stable **and** have one or more of the following:
     a. Currently resides at a state mental hospital or psychiatric unit of a hospital, and the hospital has found the client is ready for discharge to the community, **or**
     b. Has a history of frequent or protracted psychiatric hospitalizations, **or**
     c. Has a history of not receiving the level of support needed to remain medically or behaviorally stable for more than six months **and**
        i. Within the last year, has exhibited serious challenging behaviors **or**
        ii. Has had problems managing medications, which has affected their ability to live in the community.

3. Have been unsuccessful in finding a community setting with qualified providers able to support the extensive nature of behavior and clinical complexity,
4. Have behavioral or clinical complexity that requires the level of supplementary or specialized staffing available only in RSW qualified community settings; and
5. Require caregiving staff with specific training in providing personal care and Behavior Supports to adults with challenging behaviors.

ESF-specific Eligibility Criteria

Individuals referred for an ESF must currently:

- Be in a state hospital (Eastern State Hospital or Western State Hospital); **or**
- Be diverting from a state hospital **and** be on a state hospital admit waiting list.

* Special circumstances may warrant the need for referrals from other settings. Case Managers may submit a referral to the Regional RSW Committee with a recommendation of ESF service. The Regional RSW Committee will review the case to determine if the client is appropriate for ESF level of service.

WHAT RESIDENTIAL SERVICE LEVELS ARE AVAILABLE UNDER RSW?

RSW residential services are designed to provide four (4) progressive levels of services based on the client's needs.

Expanded Community Services (ECS)

ECS is the first level of service. All individuals eligible for RSW can receive ECS in residential home settings that have an ECS contract. Individuals receiving ECS are eligible to receive personal care services, medication oversight, and contracted Behavior Support services. Client services and supports are available 24-hours per day by on-site staff for support with crisis response.

Where can individuals receive ECS services?
ECS is available in Adult Family Homes (AFH), Assisted Living Facilities (ALF), and Enhanced Adult Residential Care (EARC) facilities.

What services can be available under ECS?
Personal care services, medication oversight, and contracted Behavior Support services.

Behavior Support services
Clients in ECS-contracted facilities receive support from contracted Behavior Support Providers, (regardless of their ability to fully participate?). Services include:

- Person-centered, on-site training for the client and caregiving staff;
- An individualized crisis response and Behavior Support Plan that is reviewed every six months and is modified as the client's needs change; and
- Monthly psychopharmacological medication reviews, if needed.

All ECS clients should receive Behavior Support services, with these considerations:

- ECS clients who do not want (or decline) to participate in Behavior Support services should be re-assessed to determine what other services are best suited for the client.
- If a client is unable to participate in Behavior Support services but wants to continue receiving RSW, the client may remain on the RSW as an ECS client; the contracted Behavior Support Provider may still support the client by providing training and working with the facility provider and staff.
- If a client needs Behavior Support but is not eligible for the RSW or resides in a facility home without an ECS or SBS contract, the client may access Client Training Behavior Support services through CFC+COPES. See Chapters 7b and 7d of the LTC Manual for additional information.

If the client's behavioral needs cannot be met with ECS services, another service level under RSW should be considered rather than submitting a Personal Care ETR to increase the ~~client's daily rate~~ level of support. See Chapter 3 of the LTC Manual for more information on ETRs.

Specialized Behavior Supports (SBS)

SBS is the second level of service and may only be accessed in an AFH with an SBS contract. Clients receiving this service will get the same support as the ECS level, plus contracted support which includes one-to-one staffing, and an additional 6-8 hours of daily staffing to provide behavioral support for each SBS client.

Where can individuals receive SBS services?
SBS is available in Adult Family Homes (AFH)

What services are available under SBS?
Personal care services, medication oversight, contracted Behavior Support services and one-to-one staffing (6-8 hours).

Behavior support services
Clients in SBS contracted AFHs receive support from contracted Behavior Support Providers, (regardless of their ability to fully participate?). Services include:

- Person-centered, on-site training for the client and caregiving staff;
- An individualized crisis response and Behavior Support Plan that is reviewed every six months and modified as the client's needs change; **and**
- Monthly psychopharmacological medication reviews, if needed.

SBS Staffing Requirements
The provider develops an SBS staffing schedule, reflecting the required 6-8 hours per day of additional staff, and provides it to the case manager.

Prior to the SBS client moving into an AFH (and again when the staffing schedule changes), the provider must submit the planned SBS staffing schedule to the assigned case manager. The staffing schedule **must** reflect the required 6-8 hours per day of additional staff.

A statewide example of an SBS Staffing Schedule (see example in *attachments below*) may be given to AFH providers to assist in understanding what the SBS staffing schedule should include. If the AFH provider chooses not to use the statewide staffing example, the submitted SBS staffing schedule must reflect the assigned caregiver(s) and hours/times of the day that the one-to-one staffing will be provided for each SBS client and must indicate how the additional one-to-one staffing schedule supports the SBS client in accordance with the client's plan of care. Record receipt of the SBS staffing plan in a SER note in CARE and submit a copy to DMS.

Once the SBS staffing schedule is approved by the client, the HCS Case Manager will review the staffing schedule and must confirm with the AFH that the additional staff are included in the client's Negotiated Care Plan (NCP) and hired **prior** to authorizing the additional residential rate in CARE. The HCS Case Manager must document this conversation with the AFH in the CARE SER. The required 6-8 hours per day of 1:1 support to the client must be included in the client's assessment/plan of care in the relevant section(s). Assigned Case Manager will document in CARE (General Comments screen) that client is receiving 6-8 hours of additional support per SBS and copy of staffing schedule is submitted to DMS. The assigned Case Manager will provide the client and AFH provider with the printed CARE assessment that reflects utilization of SBS caregiver supports. The start date for the additional rate in the authorization must be no earlier than the start date of the additional staff.

All SBS clients should receive Behavior Support services, with these considerations:

- SBS clients who do not want (or decline) to participate in Behavior Support services should be re-assessed to determine what other services are best suited for the client.
- If a client is unable to participate in Behavior Support services but wants to continue receiving the service, the client may remain on the RSW as an SBS client; the contracted Behavior Support Provider may still support the client by training and working with the facility provider and staff.
- If a client needs Behavior Support but is not eligible for the RSW or resides in a facility without an ECS or SBS contract, the client may access Behavior Support client training through the state plan as a CFC-COPES client using the Client Training services. Please see Chapters 7b and 7d of the LTC Manual for additional information.

Community Stability Supports (CSS)

CSS is the third level of service that may be accessed and is only available in an Enhanced Adult Residential Care (EARC) setting with a CSS contract. This service is comprised of two tiers and the daily add-on rate paid is based on the level of support the client needs.

This service is appropriate for clients who, due to their behavioral and personal care needs, require a higher level of support than is available in ECS or SBS settings/contracts.

Where can individuals receive CSS services?
In an Enhanced Adult Residential Care (EARC), an assisted living facility contracted to provide CSS services.

What services are available under CSS?
Personal care, medication oversight, and specialized staffing, including on-site nursing 40 hours per week and on-call coverage 24 hours, seven days a week. This service provides additional caregiver staffing and a Behavior Support clinician on-site 40 hours per week. A client-specific Behavior Support Plan is written and implemented by staff. Mental health treatment services are covered and funded by the Managed Care Organization (MCO) as part of their Medicaid benefit and delivered by a Community Behavioral Health Agency provider.

Clients receiving the CSS service will receive person-centered activities. Each client receiving CSS Tier 2 services will receive an individualized monthly activities calendar specifically tailored for them that needs to be included in their record at the EARC and incorporated in their Behavior Support Plan.

Enhanced Services Facility (ESF)

ESF is the fourth and highest level of RSW services available and only provided in an ESF-contracted setting. Priority to receive this service is given for individuals coming out of state hospitals or diverting from going into a state hospital.

Where can individuals receive ESF services?
In a contracted Enhanced Services Facility (ESF)

What services are available under ESF?

Clients in an ESF will receive personal care services, medication oversight, and the highest level of specialized staffing, with 24-hour on-site nursing and 8 hours per day of Behavior Support provided by on-site mental health professionals. ESF staff implement client-specific Behavior Support Plans and provide proactive support and crisis response. Behavioral and mental health services are provided to the client by the local Managed Care Organization (MCO) through the client's private insurance or Medicaid coverage.

WHERE CAN INDIVIDUALS RECEIVE RESIDENTIAL SERVICES UNDER THE RSW?

RSW services are available in contracted Adult Family Homes, Assisted Living Facilities, Enhanced Adult Residential Care Facilities, and Enhanced Services Facilities.

Residential Settings	Expanded Community Services (ECS)	Specialized Behavior Support (SBS)	Community Stability Supports (CSS)	Enhanced Services Facility (ESF)

Adult Family Home (AFH)	Yes, with ECS Contract	Yes, with SBS Contract	No	No
Assisted Living Facility (ALF)	Yes, with ECS Contract	No	No	No
Enhanced Adult Residential Care Facility (EARC)	Yes, with ECS Contract	No	Yes, with CSS Contract	No
Enhanced Services Facility (ESF)	No	No	No	Yes, with ESF Contract

HOW ARE LEVELS OF SERVICE DETERMINED?

The level of service is determined by the RSW Committee through a referral process. The RSW Committee reviews the CARE assessment and considers all information submitted regarding the client's current needs. The RSW Committee also determines service level that incorporates a review of behavioral and clinical complexity and access to supportive services for both the client and provider. The goal is to provide the most cost-efficient services needed to maximize the client's independence and stability in a community setting. Ultimately it is the right of the client to make the choice of setting in which services are delivered.

Utilization of the Service Level Guidance (*attached at the end of the chapter*) relies on a comprehensive evaluation of the client's current behaviors along with anticipated needs for behavioral supports. Additional considerations for determining the service level that most efficiently meets a client's needs include:

- The client's willingness to accept services (but not their ability to participate). This may include willingness to accept CBHS/1915i service for eligible Clients,
- Identifying any concerns for a client's transition into a residential setting, and/or
- Identifying needs around maintaining client stability.

The Service Level Guidance is designed as a reference to assist with reviewing a client's needs to identify which service level best supports a client's behavioral, clinical, and personal care needs. The guidance should also be used for service level determination based on changes in the client's functional status (e.g. SBS to ECS, ECS to CFC+COPES). RSW Committee reviewers may also take into account the need for additional wraparound RSW supports for Clients who are approved for CBHS/1915i service. This review for wraparound supports is intended to identify which level of support (ECS, SBS, CSS, or ESF) that best supports a client's stability in the preferred residential setting by utilizing a combined review of the Service Level Guidance and BHPC/RSW to CBHC/1915i Crosswalk.

Note: Service level determinations for ECS/SBS eligibility may also be met when a Behavior Management Plan is provided through a local community mental health provider (i.e. – PACT, IRT, SUD, out-patient mental services). This provision is created for instances where a client declines a

Behavior Support Provider referral in preference of a Behavior Management Plan from a community mental health provider. In this case, the case the CARE assessment must reflect the use of "Mental Health Therapy/Program" in the Medical Treatment section. Case Managers must ensure that Behavior Support Provider services are not authorized when community mental services are providing a Behavior Management Plan to avoid duplication of services.

It is important to note that client needs change over time and RSW services are not considered lifetime services. Service needs must be evaluated annually to determine the efficacy and whether or not the current level of service meets the current needs of the client. When completing the annual or significant change CARE assessment process, utilize the Service Level Guidance to help identify the most appropriate supportive services. Case Managers must submit a new RSW referral to the Regional RSW Committee if a client's needs exceed the current RSW service determination.

Service level(s) approvals are recorded on DSHS form 11-130 after the individual is determined eligible for RSW. Individuals reviewed by the RSW Committee are evaluated for the most appropriate level of service that can best meet their needs in the community. Individuals may be served with a lower level service, even if they qualify for a higher level, but special considerations may need to be made to address any unmet needs.

HOW TO SUBMIT AN RSW REFERRAL FOR ELIGIBILITY DETERMINATION?

- The Case Manager completes a CARE assessment, in accordance with Chapter 3 and Chapter 8 of the LTC Manual.
- The Case Manager confirms and documents in SER the client is agreeable to an RSW referral.
    - Case Managers will also confirm and document acceptance of CBHS/1915i services for Clients who are eligible for this service. A referral for CBHS/1915i and RSW can occur concurrently with an emphasis that the priority plan for 1:1 staffing support will be CBHS/1915i service which can be augmented with RSW services for additional wraparound supports. Case Managers must reference LTC Manual Chapter 22a for CBHS/1915i referrals.
- The Case Manager submits **region-specific** referral processes utilizing either DSHS form 15-596 via email or online referral to their Regional RSW Committee.

  NOTE: DSHS form 15-596 allows Case Manager Level of Service recommendations specific for RSW Services or Nursing Facility options. Case Managers who indicate Respite, EBS, EBS Plus, EBS Plus Specialized Services as a recommendation must clearly identify challenging behaviors within DSHS form 15-596 to assist the Regional RSW Committee with service level determinations when there isn't a current assessment to review.

  Region 3 does not require HCS staff to submit DSHS form 15-596—challenging behaviors should instead be recorded in a SER note.

Referrals for RSW services are coordinated regionally and shall adhere to the statewide referral standard and be consistent with RSW eligibility requirements per WAC 388-106-0338.

NOTE: Clients approved for EBS services can be concurrently approved for ECS services if financial eligibility is confirmed for waiver services. Additionally, clients approved for ECS services may also be approved for EBS services per the Regional RSW Committee service determination.

HCS Case Managers submit RSW referrals to:
Region 1: hcsrsw@dshs.wa.gov
Region 2: http://region4aasa.dshs.wa.gov/RSW/Main.asp
Region 3: https://stateofwa.sharepoint.com/sites/DSHS-ALT-R3HCS/Lists/RSW%20Referral%20Request/AllItems.aspx

AAA Case Manager emails RSW referrals (DSHS form 15-596) to:
Region 1: hcsrsw@dshs.wa.gov
Region 2: r2rsw@dshs.wa.gov
Region 3: AAARSWReferrals@dshs.wa.gov

- The Regional RSW Committee evaluates the referral to determine eligibility for RSW and/or EBS services.
  - If the client does not meet eligibility, the Regional RSW committee completes DSHS form 11-130 and communicates outcome to the Case Manager.
  - If the client meets eligibility criteria, the Regional RSW Committee proceeds to determine the highest?(are we aiming for the highest level of service or the lowest level of service that meets the client's needs?) level of service, completes DSHS form 11-130 and communicates outcome to the Case Manager. **NOTE**: *see additional steps below for individuals determined to be eligible for CSS level of care.*

    For CSS Tier Determination:
    - The Regional RSW Committee emails the completed DSHS form 11-130 to the HQ SHDD Specialty Settings Committee at specializedsettings@dshs.wa.gov.
    - HQ SHDD Specialty Settings Committee will determine the CSS Tier.
    - HQ SHDD Specialty Settings Committee will check mark on the DSHS form 11-130 which CSS Tier was approved and include their initials on the form next to the approved Tier.
    - HQ SHDD Committee will document in a SER in CARE the approved CSS Tier.
    - HQ SHDD Specialty Settings Committee will email the completed DSHS form 11-130 back to the Regional RSW Committee, Case Manager, and HQ SHDD Transition Coordinator/Specialist.

- The Regional RSW Committee/Case Manager submits completed 11-130 to DMS.

NOTE: For additional RSW level specific RSW and EBS referral process, refer to the RSW/EBS referral workflow located in the Appendix/Attachments section.

HOW TO SUBMIT REFERRALS TO A RESIDENTIAL PROVIDER?

Expanded Community Services (ECS) and Specialized Behavior Support (SBS)

Once the Regional RSW Committee determines a client's care needs appear to meet the ECS and/or SBS level of service, follow these steps to make referrals to contracted residential providers.

- The Case Manager discusses RSW eligibility and level of service outcome with client and documents client's decision/choice of RSW.
- The list of DSHS contracted facilities can be found using the following search tool.
  - AFH Facility Search (wa.gov)
    - Options for Specific Criteria are available to narrow AFH search to facilities that are contracted for ECS, AFH & ECS, Meaningful Day, and SBS.
    - Case Manager's must reference this AFH Locator to confirm and document in a SER that the provider has a specialty contract to provide ECS or SBS services.

Community Stability Supports (CSS)

Once the Regional RSW Committee determines a client's care needs appear to meet the CSS level of service they will forward the RSW Referral to the HQ SHDD Specialty Settings Committee to determine the CSS Tier, and will follow these steps to make referrals to contracted CSS providers:

- The Case Manager discusses RSW eligibility and level of service outcome with client and documents client's decision/choice of RSW.
- The Case Manager and HQ SHDD Transition Coordinator/Specialist will communicate to determine the facility(ies) the client would like to be referred to.
- The HQ SHDD Transition Coordinator/Specialist will pull the Assessment Details and Service Summary from CARE and make the referral to the provider(s) contracted to provide this service.
- The list of DSHS contacted facilities can be found using the following search tool:
  - ALF Facility Search (wa.gov) can be utilized to find all CSS contracted facilities statewide.
    - Options for Specific Criteria are available to narrow ALF search to facilities that are contracted for CSS.
    - Case Manager's must reference this ALF Locator to confirm and document in a SER that the provider has a specialty contract to provide CSS services.
- The HQ SHDD team will communicate with the referring Case Manager on the outcome of the referral.

Enhanced Services Facility (ESF)

Once the Regional RSW Committee determines a client's care needs appear to meet the ESF level of service, follow these steps to make referrals to ESF facilities.

- The Case Manager discusses RSW eligibility and level of service outcome with client and documents client's decision/choice of RSW.
- The Case Manager and HQ SHDD Transition Coordinator/Specialist will communicate to determine the facility(ies) the client would like to be referred to.
- The HQ SHDD Transition Coordinator/Specialist will pull the Assessment Details and Service Summary from CARE and make the referral to ESF contracted facilities to provide this service.
    - ESF Locator is a reference for statewide ESF facilities.
- The HQ SHDD team will communicate with the referring Case Manager on the outcome of the referral.
- Once a referral is accepted by a facility, the HQ SHDD Transition Coordinator/Specialist will work with the client, their Case Manager, and the ESF provider on transition planning.

NOTE: All referrals must include the client's Assessment Details (AD) and Service Summary (SS) to allow the provider to review prior to admission. Additionally, for individuals with challenging behaviors (i.e., assaultive, property destruction, self-injurious, challenging sexualized behaviors, history of arson, and/or history or criminal activity), the assigned case manager or assessor may complete DSHS 10-234a include in the residential provider referral packet per Chapter 9a of the LTC Manual.

Clients authorized for RSW services must have at least one of the following identified in CARE under the Medical Treatment section for all residential settings (AFH, ALF/EARC, ESF):

- Behavior Management Plan (BMP);
- Behavior Evaluation Program (BEP) **or**
- Functional Behavioral Assessment (FBA)

Utilization of BMP or BEP is dependent on the client's specific needs and setting. ESF and CSS providers are required to complete a BEP prior to admission and have a functional BMP for the ongoing supports. AFH providers are required to coordinate with Behavior Support Providers for the completion of a BMP for the entirety of a client's admission.

Regional Teams:

The Case Manager completing the CARE assessment determines if the client meets the RSW functional and financial eligibility criteria and submits the RSW Referral to the Regional RSW Committee that has been designated by regional HCS leadership.

The Regional RSW Committee is comprised of designees from the regional HCS offices which typically includes the local RSW Supervisor, RSW SHPC/PM and associated Case Manager if needed. Other participants for RSW Committee may also include Regional and HQ State Hospital Diversion and Discharge (SHDD) Coordinators, regional contracted Behavior Support Providers, and/or representatives from assigned MCOs.

The Regional RSW Committee or designee reviews each client referral to ensure that:

- The client is eligible for RSW.

- Determines the level of service based on clinical and behavioral complexity.

Note: A client can be eligible for ECS/SBS when the Behavior Management Plan is being provided through local Community Mental Health (i.e., PACT, SUD, out-patient services). If that is the case, document this in CARE by going to the Medical Treatment section and select "Mental Health Therapy/Program". (Please review the details for utilization of BEHAVIOR SUPPORT PROVIDERs to support the AFH provider; this is not applicable for CSS or ESFs.)

WHAT OTHER SERVICES ARE OFFERED UNDER THE RSW?

Adult Day Health (ADH)

Nursing or rehabilitative therapy services are available for clients with medical or disabling conditions that require interventions or services from a registered nurse or a licensed speech therapist, occupational therapist, or physical therapist under the supervision of the client's physician, when required. The need for ADH services must be identified in the client's PCSP.

- Example – an ESF client is eligible for speech therapy from an ADH center because the client's assessment indicates this is needed.

ADH services may not duplicate any other Medicaid service received by the client. See Chapter 12 of the LTC Manual for more information on ADH.

Client Support Training and Wellness Education

This service is for clients who have specific therapeutic training needs identified in CARE or in a professional evaluation. Clients may receive training to assist them in adjusting to impairments, restoring, or maintaining physical functions, learning to self-manage chronic conditions, acquiring skills to address minor depression, managing personal care, and developing skills related to behavior management. Wellness Education materials assist clients to obtain, process, and understand information needed to manage and prevent chronic conditions.

Behavior Support Services

These services are provided through the Client Support Training service. **Behavior Support** is provided by a local DSHS-contracted **Behavior Support Provider**, and is authorized using Service Code T2025, U3. **Behavior Support services** include:

- A professional evaluation to assess the client's **Behavior Support** needs and a written **Behavior Support Plan**;
- A Crisis Plan to address steps for the residential setting staff to take when faced with a crisis situation, including a list of all formal and informal supports, medications, and strategies to use for de-escalation;
- Regularly scheduled **Behavior Support** visits in the client's residence, usually one to two times per week, with no more than ten visits per month (the HCS Field Services Administrator may pre-approve additional visits on a case-by-case basis);

- Specialized training and consultation to facility staff on managing the client's behaviors; and
- Monthly psychopharmacological management to ensure that appropriate levels and types of medications are prescribed.

An episode of service by a Behavior Support Provider must be at least a 15-minute interaction that is usually done in-person but can be done by phone or virtually on a limited basis. If a staff of the Behavior Support Provider is dually credentialed (such as a Prescriber and a Clinician), the Behavior Support Provider may **not** bill for two separate services delivered by a dually credentialed staff on the same day.

Behavior Support Plans and crisis plans must be updated at least every six months. The Behavior Support Provider must provide a copy of all updated Behavior Support and crisis plans to both the residential setting provider and the Case Manager.

Note: The Behavior Support Provider may **provide up to two episodes** of service for individuals who are not in a residential setting, under the following specific criteria:

Criteria #1: The individual has not yet moved into a residential (community?) setting – The Behavior Support Provider would visit potential clients to develop a Behavior Support Plan and prepare the individual to transition into a community setting. These visits would occur in acute care hospitals or institutional settings (such as state hospitals, private psychiatric hospitals, or evaluation and treatment centers). *The Behavior Support provided must not include any duplicative services that would otherwise be available to the individual in this setting.*

If the individual has already moved into a residential setting and subsequently leaves the residential setting for a medical hospitalization in an acute care hospital or community hospital for a temporary stay, the Behavior Support Provider **may** visit the client to provide services in alignment with the Behavior Support Plan.

Criteria #2: If the individual has already moved into a residential setting and subsequently leaves the residential setting for a mental health or behavioral hospitalization by going into an institutional setting (such as a state hospital, private psychiatric hospital, or evaluation and treatment center), the Behavior Support Provider **may not** provide services to the client, as that would be duplicative of the services already available in an institutional setting.

These visits are an important component of the client's Behavior Support services; however, the Behavior Support Provider cannot bill for these visits until the ECS/SBS client moves into (or returns to) the residential setting.

Wellness Education

Wellness Education supports client health literacy and client engagement in healthcare. This service is provided by Smart Source and is authorized using Service Code SA080. If a client chooses to receive Wellness Education, it may be authorized for one unit per month. Wellness Education provides targeted information based on the individual's CARE details and is mailed to the individual's address.

Wellness Education Newsletters are available in the following languages and formats:

- Albanian
- Amharic
- Arabic
- Armenian
- Cambodian
- Chinese
- English
- Farsi
- Hindi
- Ilocano
- Japanese
- Korean
- Laotian
- Punjabi
- Romanian
- Russian
- Samoan
- Serbo-Croatian
- Somali
- Spanish
- Tagalog
- Thai
- Tigrinya
- Ukrainian
- Urdu
- Vietnamese
- Braille

Specialized Equipment/Supplies and Durable Medical Equipment

Specialized Equipment and Supplies (SES) are non-medical equipment and supplies that are never covered by Health Care Authority, such as waterproof mattress covers, handheld showers (when used by the caregiver), urinals, and portable ramps that don't involve any structural modifications to the client's home. These items are:

- Necessary to increase the client's ability to perform activities of daily living; **or**
- Necessary for the client to perceive, control, or communicate with the environment in which the client lives; **and**
- Of direct remedial benefit to the client; **and**
- In addition to any medical equipment and supplies provided under the Medicaid State Plan, Medicare or other insurance.

Maintenance and upkeep of items covered under this service are also available, as well as training for the client and caregivers on how to operate and maintain the equipment. Items reimbursed under RSW exclude items that are not of direct medical or remedial benefit to the client; items requested that are not of a direct medical or remedial benefit are limited to $700 per occurrence without an ETR.

Durable Medical Equipment (DME) as defined under WAC 182-543, include items which are:

- Medically necessary under WAC 182-500-0070;
- Necessary to increase the client's ability to perform ADLs, or to perceive, control, or communicate with the environment in which the client lives;
- Directly medically or remedially beneficial to the client; and

- In addition to, and do not replace, any medical equipment and/or supplies otherwise provided under Medicare and/or Medicaid.

Refer to LTC Manual COPES Chapter 7d for additional directions on durable medical equipment, including how to authorize this service.

Nurse Delegation

This waiver service is authorized under RCW 18.79.260 and Chapter 246-840 WAC, and is available in AFHs with either an SBS or ECS contract. **This service is not available in ESFs.**

Under Nurse Delegation, an RN delegates specific nursing care tasks, which are normally done by a nurse, to a qualified long-term care worker who has completed the required training and is able to demonstrate that they are competent to perform the tasks to the satisfaction of the delegating RN.

Nurse delegation can be provided in ALFs by the facility nurses. **When the ALF provides nurse delegation, it is included in the ALF rate and is not authorized by the Social Services Specialist.**

For more information on nurse delegation, please see Chapter 13 of the LTC Manual.

Skilled Nursing Services

This waiver service is available in AFHs and ALFs, provided it does not duplicate skilled nursing included in the residential service. It is not available in ESFs because nursing services are already provided in this setting. Skilled Nursing Services provide direct skilled intermittent nursing tasks to clients. Registered Nurses (RN), or Licensed Practical Nurses (LPN) under the supervision of a RN, may provide skilled nursing services that is beyond the amount, duration, or scope of Medicaid-reimbursed home health services as provided in WAC 182-551-2100. Skilled nursing services cannot be duplicative of any other waiver or state plan service.

Nursing Services

This is not a specific waiver service but is available to RSW clients. Nursing Services offer clients, providers, and Case Managers, health-related assessment and consultation in order to enhance the development and implementation of the client's plan of care. These services are provided as an administrative function. This service does not require an authorization in ProviderOne since HCS and AAA nursing staff provide this function.

For more information about Nursing Services, including referral process and resources, see LTC Manual Chapter 24 Nursing Services.

CFC Services

CFC services (other than personal care) can be available to RSW clients if the need for a service is identified in the plan of care and the CFC service does not duplicate a service available in the waiver. Note that personal care is provided under the RSW.

WHAT ARE THE RESIDENTIAL PROVIDER CONTRACT REQUIREMENTS?

ECS Contract Requirements

To be eligible for the ECS contract:

- ALFs and EARCs must be licensed under Chapter 18.20 RCW and Chapter 388-78A WAC, meet all qualifications established within this RCW and WAC, and:
  - The license holder must be licensed with the State of Washington for twelve months preceding the application for an AL-ECS or EARC-ECS contract; and
  - The license holder and any affiliates must have no significant enforcement actions during the twelve months preceding the application for the AL-ECS or EARC-ECS contract.
- AFHs must be licensed under Chapter 70.128 RCW and Chapter 388-76 WAC and meet all qualifications established within the RCW and WAC. In addition, AFHs must meet the criteria and qualifications of the Expanded Community Services contract, and:
  - The AFH license holder must be licensed with the State of Washington for twelve months preceding the application for an AFH-ECS contract; and
  - The AFH license holder and any affiliates must have no significant enforcement actions during the twelve months preceding the application for the AFH-ECS contract.

An AFH or ALF Provider must complete ECS Contract Training (provided by the Regional Resource Specialist) prior to receiving the contract.

SBS Contract Requirements

To be eligible for the SBS contract, AFHs must be licensed under Chapter 70.128 RCW and Chapter 388-76 WAC, meet all qualifications established within this RCW and WAC, and:

- The AFH license holder must have a Washington State AFH license for at least 12 months prior to applying for this contract;
- The AFH license holder and any affiliations must have had no significant enforcement actions during 12 months prior to applying for this contract; and
- The AFH license holder must have a demonstrated history of successfully working with people with behavioral challenges.

  Note: A demonstrated history can be either positive or negative. The HCS Regional Administrator may deny an SBS contract if the provider has a **negative** history of working with individuals with challenging behavior that includes any of the following:
  - Not accepting clients back when they go to the hospital;

- Frequently issuing 30-day discharge notices to clients;
- A pattern of disregarding client rights;
- A pattern of not complying with general AFH contract requirements;
- A pattern of not working with the contracted Behavior Support Provider; or
- Declining referrals for ALTSA assistance (RCS Behavioral Health Support Team and/or HCS Behavioral Support Training).

An AFH provider must complete SBS Contract Training (provided by the Regional Resource Specialist) prior to receiving the contract.

Note: An AFH with an SBS contract may only serve up to three SBS residents at any given time. One additional SBS resident may be authorized at the discretion of the HCS Regional Administrator, who must review the performance history of the AFH. If the AFH has a positive history and has had no RCS citations or RCS enforcement actions within the prior 12 months, the HCS Regional Administrator may authorize up to one additional SBS resident for the AFH.
An AFH may not have more than four SBS residents. If the fourth SBS client leaves or is discharged, any new SBS referral for the fourth SBS bed must be staffed with the HCS Regional Administrator. The HCS Regional Administrator will coordinate with the assigned Case Manager to submit documentation of the approval or denial of the specific fourth SBS resident. Documentation may be represented as either email confirmation of approval/denial or formalized regional letter.

CSS Contract Requirements

To be eligible for the CSS contract, ALFs must be licensed under Chapter 18.20 RCW and Chapter 388-78A WAC, meet all qualifications established within this RCW and WAC, and:

- The license holder and any affiliates must have no significant enforcement actions during the twelve months preceding the application for the CSS contract.
- The ALF must have the EARC **and** ECS contracts.
- The ALF license holder must have a demonstrated history of successfully working with people with behavioral challenges.

  Note: A demonstrated history can be either positive or negative. HQ may deny a CSS contract if the provider has a **negative** history of working with individuals with challenging behavior that includes any of the following:
  - Not accepting clients back when they go to the hospital.
  - Frequently issuing 30-day discharge notices to clients.
  - A pattern of disregarding client rights.
  - A pattern of not complying with general ALF/ECS contract requirements.
  - A pattern of not working with the contracted Behavior Support Provider.
  - Declining referrals for ALTSA assistance (RCS Behavioral Health Support Team and/or HCS Behavioral Support Training).
- Have demonstrated ability to provide or arrange for all required staff trainings.
- Ensure that qualified professionals are available as required by the CSS contract to provide direct services and supports to the clients.

NOTE: Providers interested in contracting for CSS should contact the HQ Resource Support and Development team at ResourceDevelopment@dshs.wa.gov.

ESF Contract Requirements

To be eligible for the ESF contract, ESFs must be licensed under Chapter 70.97 RCW and Chapter 388-107 WAC, meet all criteria and qualifications within this RCW and WAC, and must:

- Have demonstrated experience providing services and supports to adults with challenging behavior;
- Have demonstrated ability to serve individuals whose criminal or behavioral history has kept them from being served in the community;
- Have demonstrated ability to provide or arrange for all required staff trainings; and
- Ensure that qualified professionals are available as required to provide the direct services and supports to the clients.

NOTE: An ESF may accept private-pay residents. In doing so, the ESF:

- Nurse will need to assess the individual;
- Must determine, in advance, the payment/rate for private-pay status;
- Must have a clear, documented list of all charges for private-pay status that is provided to the resident;
- Must have a clear, documented list of all charges for private-pay status that is provided to the resident;
- Must have a clear, documented process for private-pay billing; and
- Must utilize an Admission Agreement to ensure the resident understands – and agrees to – why and how the resident's funds are being spent.

HOW ARE CONTRACTS MONITORED?

Contracts with residential settings (AFH, ALF, and ESF) that provide RSW services are monitored. The Behavior Support Provider contracts are also monitored.

The Home and Community Programs (HCP) Contract Monitoring Team is responsible for monitoring ECS, SBS, CSS and Behavior Support Provider contracts. Each team member monitors contracts within a specific region and works closely with the HCS Regional Administrators to prioritize which facilities/agencies will be monitored.

The RSW Program Manager is responsible for monitoring the ESF contracts.

It is important to note that any concerns around contract compliance should be immediately staffed with the local RSW Supervisor to consider appropriate referrals to the Contract Monitoring Team or the inclusion of Behavior Training/Support Team. Referrals for contract monitoring may be submitted via email: hcpcontractmonitoring@dshs.wa.gov.

WHAT IF A RSW CLIENT NEEDS A CFC ANCILLARY SERVICE?

If the need for a CFC Ancillary service is identified in the RSW client's plan of care, the client can access that service when it is not duplicative of a service available through the RSW. To do this, the Case Manager will identify the need in the CARE assessment and authorize the CFC service.

WHAT IF A RSW CLIENT NEEDS HOSPICE?

An RSW client may receive hospice services as long as the hospice services are not duplicative of any service available under the RSW.

CAN A RSW CLIENT RECEIVE COMMUNITY CHOICE GUIDE SERVICES?

A contracted Community Choice Guide (CCG) may be authorized to assist with transitional tasks (such as coordinating items or services) or help stabilize a person currently in a community setting. Finding an appropriate RSW residential setting cannot be assigned to a CCG. It is the responsibility of the case manager, along with the State Hospital Discharge and Diversion (SHDD) team, to find an appropriate RSW residential setting. Case Managers must defer to either supervisory or FSA approval prior to implementation of CCG Services.

Note: Community Choice Guide is one of several stabilization services available to RSW participants. The Washington Roads service package may also be beneficial. See Chapter 5a for more information.

WHAT IF A CLIENT NEEDS WRAPAROUND SUPPORT SERVICES?

Beginning July 1st, 2024, a Managed Care Organization (MCO) will only fund Behavioral Health Wraparound Support (BHWS)--formerly, Behavioral Health Personal Care (BHPC), for additional personal care hours beyond the CARE generated hours for in-home services.

See LTC Manual Chapter 22a – Apple Health Managed Care and Medicare Dual-Eligible Special Needs Plans (D-SNP) to determine if the RSW client meets the criteria for Community Behavioral Health Support (CBHS) services paid by a Managed Care Organization (MCO) or Health Care Authority (HCA). Chapter 22a includes the process for requesting funding from the MCO/HCA if additional supports are needed. CBHS services is a State Plan service and must be utilized prior to authorizing RSW services if the client is eligible.

WHAT ARE THE CASE MANAGEMENT RESPONSIBILITIES REGARDING HOSPITAL DISCHARGES TO AN ESF?

When a client is approved for the RSW, the Case Manager or state hospital assessor will notify the client of their residential options. When the client chooses an ESF, the HQ SHDD Transition Coordinator/Specialist and the Case Manager will coordinate with the ESF Administrator—who is

contractually responsible for oversight of the facility—to ensure all needed supports and services are in place for the client prior to the client moving into the ESF. The ESF Administrator is responsible for coordinating with the local MCO to provide behavioral support and mental health services to the client.

The HQ SHDD Transition Coordinator/Specialist, the Case Manager, and/or the state hospital assessor will also work with the "transferring facility" (state hospital, psychiatric facility, or residential facility) to coordinate details such as medications, appointments with prescribers, equipment, legal issues, etc., in preparation for the client's move into the ESF.

The Case Manager should be involved in all activities and planning for the client's transition to the community and has the following specific duties:

- Review and approve the ESF provider's pre-admission assessment and transition plan prior to admission;
- Ensure the client has an adequate supply of medications prior to discharge;
- Ensure the client has an appointment with a medication prescriber in the community prior to discharge; and

When the client is ready to move to the facility, the Case Manager or hospital assessor will:

- Authorize services;
- Notify the financial worker of the discharge date using DSHS Form 14-443; and
- Authorize the payment to the provider, effective the date the client is to move into the facility.

As best practice, when a client is transitioning to an ESF, the Case Manager must:

- Ensure clients only move into an ESF at the beginning of the week (Monday-Wednesday);
- Visit the client in the facility home frequently;
- Regularly review the Behavior Support Plans;
- Participate in the client's PCSP Team meetings; and
- Conduct the initial client visit within three business days of the client transitioning into the ESF.

WHAT IF A RSW CLIENT WANTS TO MOVE?

If a RSW client wants to voluntarily move out of the community residential setting, the Case Manager will work with the client and provider to address any related issues, and work with the client to find another community residential setting option if issues are unable to be resolved. If case management responsibilities are transferred to another Case Manager, the former and current Case Managers will coordinate to ensure a smooth transition for the client.

WHAT IF A RSW CLIENT'S LESS-RESTRICTIVE ALTERNATIVE (LRA) IS EXPIRING?

Any RSW client who wants to transition from an RSW setting to another living situation should receive support and transition services from the client's PCSP Team. If a client is on a Less-Restrictive Alternative

(LRA), the PCSP Team should begin the transition planning well in advance of the LRA expiration date. The RSW client must be included in all discussions regarding transition planning.

PERSON-CENTERED SERVICE PLANNING (PCSP)

Each RSW client will have a Person-Centered Service Plan (PCSP) Team that will use a person-centered planning process to ensure the client's Behavior Support Plan, Crisis Plan, and PCSP are consistent and will support the client in the community. The goals of person-centered service planning meetings are to identify behavioral support opportunities, monitor current behaviors and the effectiveness of current interventions, and make recommendations to promote client stability. Additionally, these meetings are designed to ensure the client's current CARE assessment aligns with reported information from the client, Behavioral Support Provider, and AFH provider, to monitor for effectiveness of current services, and to identify opportunities to transition to lesser levels of service supports for the RSW client.

PCSP Team meetings have the option of in-person or virtual (Telehealth) meetings that are based on client consent and coordination with the Behavior Support Provider and AFH provider. The determination to utilize telehealth is based on the client's current severity of behavioral concerns with an emphasis on the client's ability to participate during the team meetings. Telehealth meetings are specifically designed for clients who are currently tolerating services well with no immediate concerns for de-stabilization or modifications to the CARE assessment. Additionally, telehealth and in-person meetings require shared coordination between the AFH provider, Behavior Support Provider, and assigned case manager to schedule monthly meetings.

ECS PCSP Teams

Each ECS client will have a PCSP Team to include the client, individuals chosen by the client, HCS regional staff, the contracted Behavior Support Provider, community supports, and facility staff identified by the AFH provider.

ECS client PCSP Team meetings (Either in-person or via telehealth) require shared coordination for **monthly** scheduling between the AFH provider, BSP, and assigned case manager. ECS client case reviews will ensure Behavior Support Plans are relevant and the client continues to need ECS services. This requirement will fulfill re-authorization of services as needed.

SBS PCSP Teams

Each SBS client will have a PCSP Team to include the client, individuals chosen by the client, HCS regional staff, the contracted Behavior Support Provider, and facility staff identified by the AFH provider.

SBS PCSP Team meetings are to occur monthly and require the shared coordination for scheduling between the AFH provider, Behavior Support Provider, and assigned case manager. Scheduling of SBS Team meetings may be adjusted for in-person or via telehealth to correspond to the client's

consent in addition to the provider's, or Behavior Support Provider's expressed needs. The AFH Provider ~~will~~ **may** defer to the assigned case manager to schedule PCSP Team meetings at a time that works best for all parties. Documenting that the case manager will schedule PCSP meetings in lieu of the Provider should be documented in a SER.

Any changes made to the Behavior Support Plan will be shared with the AFH Provider by the contracted Behavior Support Provider. Assigned Case Managers must document person-centered service planning meetings in a SER. Documentation must reflect the client's current behavioral status, need for continued services, and a plan for continuing or transitioning services.

The AFH provider must submit a current copy of the SBS Staffing Schedule to assigned case manager every six months or if a significant change in the client's status is noted. The assigned case manager will submit the copy of the current staffing schedule to DMS.

CSS PCSP/Interdisciplinary Teams

Each CSS client will have monthly PCSP/Interdisciplinary Team meetings.

Clients that are receiving CSS Tier 2 services will have **two** PCSP/Interdisciplinary Team meetings **per month.**

PCSP/Interdisciplinary Team meetings are intended to coordinate the development, implementation, and evaluation of the client's Behavior Support Plan with the goal of maintaining a stable community residential setting. The PCSP/Interdisciplinary Team will include the Behavior Support Clinician, Psychiatric Nurse, Prescriber, Case Manager, Activities Coordinator, nursing staff, Dietician, and anyone else involved in the client's care.

The Case Manager will document all PCSP/Interdisciplinary Team meetings in a SER in CARE.

ESF PCSP Teams

Each ESF client will have a PCSP Team to coordinate the development, implementation, and evaluation of the client's PCSP with the goal of maintaining a stable community residential setting. Per WAC 388-107-0100, the members of the PCSP Team include the client and/or representative, individuals chosen by the client, a mental health professional, nursing staff, and the HCS Social Services Specialist.

The Behavior Support section in each client's Person-Centered Service Plan (PCSP) must include a crisis prevention and response protocol to outline specific indicators that might signal a crisis for the client, as well as a plan to ensure coordination with local community crisis responders.

The PCSP Team will meet at least monthly, with additional meetings held as needed, to address symptoms of decompensation or crisis, to ensure the client is stable and to evaluate that the facility can continue to meet the client's needs.

The Case Manager will document all PCSP Team meetings (including purpose, any changes made to the client's care plan, and which team members are present) in a SER in CARE. The SER note should be titled "PCSP Team Meeting" for easy identification.

AUTHORIZING RSW SERVICES

RACs for RSW Services

ESF	3030
AFH-SBS	3031
Expanded Community Services	3032
ESF Fast Track*	3033
SBS Fast Track*	3034
ECS Fast Track*	3035
CSS Fast Track*	3038
CSS	3039
CFC Ancillary Services	3056
RSW CFC Ancillary Services Fast Track*	3057

*For more information on Fast Track, see Chapter 7a of the LTC Manual.

Note: RSW Fast Track may be utilized for discharge purposes for clients who are currently opened for MAGI-based N05 program. Utilization of this RAC is dependent on Case Manager submission of NGMA application and approval from region RSW Committee for RSW services. By using the Fast Track RACs for these clients, they will be able to receive RSW services as soon as they move into a community setting.

Case Managers are required to monitor for NGMA determinations of clients referred to adjust RACs and authorizations to reflect financial approval for waiver services. Clients who are found ineligible for waiver services because of NGMA denial, require adjustment of RACs to State Only Adjustment of Payment (SOAP) RACs to continue authorizations for RSW services. Utilization of RSW RACs will require supervisory oversight to override mismatch authorization errors. For more information on NGMAs, see LTC Manual Chapter 7h: Appendices. It is important to acknowledge that denied NGMAs will require the Case Manager to convert existing RSW RACs to SOAP RACs for the continuation of RSW Services for the current assessment dates. These instances require review and approval from regional FSA or RA and monitoring for any changes in financial eligibility.

Authorizing Personal Care

In the RSW, personal care services are included in the client's daily rate. When you select one of the RACs listed above, the authorization includes the personal care services. Service codes for personal care are:

EARC	T1020, U3 Personal Care Residential ARC - Enhanced
ALF	T2031, Assisted Living Facility
ECS/AFH	T1020, U1 Personal Care Residential AFH
SBS/AFH	T1020, U1 Personal Care Residential AFH
ESF	T1020, U5 Personal Care Residential ESF (ALTSA-only)*
	SA389, U1 Funded Behavioral Health Wrap-around Support, Residential (MCO funded only)*
	T2033, U9 ESF Add-on (Non-MCO funded)*

*** Note: Effective 7/1/2024 these service codes are being updated to reflect rate tiering structure and the phasing out of SA389, U1 & t2033, U9. Please reference authorization process for ESFs below. After 7/1/2024, SA389, U1 and T2033, U9 authorizations will not be allowable.**

* Please defer to current All_HCS_Rates.xls (live.com) for ECS and SBS add-ons for Personal Care.
* Please reference current All_HCS_Rates.xls (live.com) or the Service Code Data Sheets for CSS and ESF add-on rates, including MCO funded and non-MCO funded clients.

Clients authorized for RSW services must have at least one of the following identified in CARE under the Medical Treatment section for all residential settings (AFH, ALF/EARC, ESF):

- Behavior Management Plan (BMP);
- Behavior Evaluation Program (BEP) **or**
- Functional Behavioral Assessment (FBA)

Utilization of BMP or BEP is dependent on the client's specific needs and setting. ESF and CSS providers are required to complete a BEP prior to admission and have a functional BMP for the ongoing supports. AFH providers are required to coordinate with Behavior Support Providers for the completion of a BMP for the entirety of a client's admission.

Authorizing Behavior Support for ECS or SBS Clients

The maximum number of episodes or units of Behavior Support is 10 per month. The Regional ECS/SBS Coordinator must authorize units in excess of 10 per month (50 per six-month period). Each ECS/SBS client must receive a minimum of 1 unit per month to remain qualified for ECS/SBS.

The contracted Behavior Support service is not available for the CSS service or in an ESF.

When an ECS or SBS client is approved for Behavior Support, the Case Manager will authorize the Behavior Support service using Service Code T2025, U3 Client Training, Intensive Behavior Support.

When an ECS or SBS client is authorized to receive services under the RSW, the assigned Case Manager will work with the Regional RSW Committee to make recommendations for coordinating RSW Services outside of their region following the Region-to-Region transfer process. Coordination includes identifying contact person(s) for communicating intent to transfer, and coordinating with the AFH and Behavior Support Provider services.

Clients eligible for ECS or SBS may receive both Behavior Support services and Mental Health services through the MCO to maintain their community residential setting, if needed.

Document the name and contact information of the client's Behavior Support Provider and Mental Health services provider (if applicable) on the Contact Details CARE screen.

Authorizing the ECS and SBS Add-On Rates

When a client is approved for ECS and chooses a contracted residential provider, the Case Manager will authorize the ECS residential add-on rate using:

- Service Code T2033, U1 for AFHs or
- Service Code T2033, U3 for ALFs/EARCs.

When a client is approved for SBS and chooses a contracted AFH, the HCS Social Services Specialist will confirm that the SBS staffing schedule is completed (Reference SBS Staffing Requirements, page 7) and will authorize the SBS add-on rate using:

- Service Code T2033, U5.

ECS or SBS add-ons may be authorized for AFHs when an eligible client has an assessed need, chooses to receive ECS or SBS and a behavioral health provider is not currently available. The HCS case manager will coordinate with local RSW supervisor to review alterative plans to

- For Non-MCO funded clients or clients that are denied CBHS:
    - These clients will now be funded at the ESF contracted rate of $596.10 with the service code:
        - T1020, U5 for $596.10
            - **Reason Code: No reason code needed**

temporarily meet the client's behavioral health needs until a qualified behavioral health provider is authorized to serve the client. (Per FY2023-2025 AFHC CBA)

Clients with high acuity may have daily rates that exceed the ECS rate based on their CARE assessment. These individuals may still receive ECS services when residing in an ECS contracted facility on RSW. In these cases, the residential provider is paid at the higher CARE rate.

NOTE: If a client is receiving Expanded Behavior Support (EBS) or Expanded Behavior Support Plus (EBS-Plus) services in a skilled nursing facility, those services are not part of the RSW. Please see Chapter 10 of the LTC Manual for information on EBS or EBS-Plus in a skilled nursing facility.

Authorizing CSS Add-on Rates

When a client is approved for CSS and chooses a CSS-contracted residential provider, the HCS Case Manager will:

1. Authorize: T1020, U3 Personal Care Residential – EARC
2. Authorize: T2033, U2 OR T2033, U4 CSS add-on based on the approval of the following (tiers):

    a. If the client formally met eligibility for MCO-BHPC and is now is eligible for Community Behavioral Health Services (CBHS), see Chapter 22a for information on this process.

    b. If the client does not meet eligibility for CBHS, authorize the full HCS portion of the CSS add-on with T2033, U2 or T2033, U4.

**See T2033 U2 and/or U4 Service Code Data Sheet(s) for specific CSS add-on rates.

Authorizing ESF Rates

When a client is approved for ESF level of support and chooses an ESF-contracted residential provider, the HCS Case Manager will authorize the following:

- Personal Care Residential – Enhanced Service Facility – T1020, U5 based on MCO or Non-MCO funding status and approved tiering.

    - **For non-MCO-funded (sometimes called fee-for-service) clients or clients that are denied CBHS**:
        - These clients will now be funded at the ESF contracted rate of $596.10 with the service code:
            - T1020, U5 for $596.10
        - Reason Code: No reason code needed

    - **For MCO-funded clients**:
        - Clients eligible for Community Behavioral Health Support (CBHS) services will receive MCO approval for one of six tiers. Below are the six tiers and the required service codes/lines for each tier of CBHS.
            - **Tier 1**
                - T1020, U5 for $559.80
                    - **Reason Code: MCO Funded Tier 1**

MCO/HCA will directly pay the ESF $36.30 (no service code in CARE)

- **Tier 2**
  - T1020, U5 for $498.09
    - **Reason Code: MCO Funded Tier 2**
  - MCO/HCA will directly pay the ESF $98.01 (no service code in CARE)
- **Tier 3**
  - T1020, U5 for $401.29
    - **Reason Code: MCO Funded Tier 3**
  - MCO/HCA will directly pay the ESF $194.81 (no service code in CARE)
- **Tier 4**
  - T1020, U5 for $390.95
    - **Reason Code: MCO Funded Tier 4**
  - MCO/HCA will directly pay the ESF $303.71 (no service code in CARE)
- **Tier 5**
  - T1020, U5 for $390.95
    - **Reason Code: MCO Funded Tier 5**
  - MCO/HCA will directly pay the ESF $424.71 (no service code in CARE)
- **Tier 6**
  - T1020, U5 for $390.95
    - **Reason Code: MCO Funded Tier 6**
  - MCO/HCA will directly pay the ESF $528.00 (no service code in CARE)

NOTE: Use of Service Code T1010, U5 is allowable for Personal Care ETRs. The tiered rate can be combined with the approved ETR rate for a total daily rate entry. This requires the use of a comment that reflects the total daily rate, e.g.: Comment entry – Tier 1 rate of $559.80 + ETR of $100.00 = $659.80 total daily rate.

RESOURCES

Related WACs and RCWs

WAC 388-106-0336	What services may I receive under the residential support waiver?
WAC 388-106-0337	When are you not eligible for adult day health services?
WAC 388-106-0338	Am I eligible for services funded by the residential support waiver?
WAC 388-106-0340	When do services from the residential support waiver start?
WAC 388-106-0342	How do I remain eligible for residential support waiver services?
WAC 388-106-0344	How do I pay for residential support waiver services?
WAC 388-106-0346	Can I be employed and receive residential support waiver services?

WAC 388-106-0348	Are there waiting lists for the residential support waiver services?
Chapter 388-107 WAC	Licensing requirements for enhanced services facilities
Chapter 70.129 RCW	Long-term care resident rights
Chapter 70.97 RCW	Enhanced services facilities

APPENDIX/ATTACHMENTS

DSHS Form 11-130

RSW and EBS Eligibility Determination form (with 2024 revision date)

DSHS Form 14-443

Financial/Social Services

DSHS Form 15-596

Residential Support Waiver (RSW) Expanded Behavior Supports (EBS) Referral (Home and Community Services)

Specialized Behavioral Supports reference

HCS Specialized Behavior Supports.p

Service Level Guidance for RSW Eligible Individuals

Service Level Guidance for RSW C

Residential Support Waiver – SBS Staffing Schedule Template (*Updated May 2021)*

SBS Staffing Schedule.docx

RSW EBS Referral Flow Chart

RSW EBS referral flow chart 11.27.23.p

BHPC & RSW to CBHS/1915i Crosswalk

BHPC + RSW to CBHS.1915i 2024 cro

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
07/01/2024	JD Selby	• Updated multiple chapter sections to reflect regional feedback to include: • Revisions for RSW referral process and regional contacts for RSW referral submissions and integration of State Hospital Discharge and Diversion (SHDD) teams for ESF & Community Stability Supports (CSS) service coordination, • Updates for RSW Committee review for eligibility and service determinations, • Revised language for RSW Fast Track utilization, • Updates to ECS and SBS Case Management and frequency of monitoring, • Integration of CSS services into RSW chapter, • Updates for Wellness Education newsletter language and formats, • Updates for provider contract requirements section to reflect current contracting agreements, • Updates for contract monitoring • Inclusion of July 1, 2024 1915i waiver/Community Behavioral Health	H24-046

		Support (CBHS) service information to include: • Updates for management of Behavioral Health Personal Care (BHPC) and Managed Care Organization (MCO) utilization of Behavioral Health Wraparound Supports (BHWS), • References for Chapter 22a for coordinating additional MCO behavioral supports, • Updates to CSS and ESF tier CARE authorizations • Corrected all broken or missing links • Added or updated attachments to the appendix: • Service Level Guidance For RSW-Eligible Individuals • RSW and EBS Eligibility Determination form • Repaired links for DSHS forms 11-130, 15-596 • RSW/EBS Referral Flow Chart • BHPC + RSW to CBHS Crosswalk	
12/14/2023	JD Selby	• Updated CMS approval for RSW renewal	H23-086

7/1/2023	JD Selby	• Updated "Ask the Expert" for current RSW Program Manager contact information
		• Chapter section updates for RSW Referrals, RSW Eligibility and Service determinations
		• Inclusion of Community Stability Supports (CSS) information
		• Based on regional feedback, provided clarifying language and references regarding
		  ○ RSW referral and eligibility and service determination
		  ○ Utilization of ALTSA and MCO-funded codes for ESF
		• Corrected all broken or missing links
		• Added attachments to the appendix:
		  ○ Service Level Guidance For RSW-Eligible Individuals	

		○ RSW Referral Requirements Elements ○ RSW-SBS Staffing Schedule Template	
1/8/2020	Sandy Spiegelberg	• Minor content changes and updated to new format	
5/19/2020	Sandy Spiegelberg	• Clarify Wellness Education, add the RSW CFC Ancillary Fast Track RAC, and update the ESF Referral Process to replace the Clinical Review with a review by the Mental Health Nurse Program Manager	
11/1/2020	Sandy Spiegelberg	• Clarify the one-to-one additional support for SBS clients, clarify the use of Behavior Management Plan or Behavior Evaluation Program, update how to access MCO funding, update the Resource list to include additional statutes and the licensing regulations, and update the Table of Contents.	
3/1/2021	Sandy Spiegelberg	• Change ECS monthly meeting requirement to as needed, but at least every six months; add financial eligibility language; clarify that AFH Providers are responsible for scheduling monthly SBS PCSP Team meetings; clarify the services provided by the Behavior Support Provider; and make formatting and grammatical changes	
8/1/2021	Sandy Spiegelberg	• Explain how an AFH can increase the number of SBS clients from 3 to 4; add a limit of 4 SBS clients per home; allow HCS regions to provide SBS staffing schedule examples to AFH providers; require AFHs to receive SBS contract training before receiving the contract; clarify the role of the contracted Behavior Support Provider; and make formatting and grammatical changes.	
3/1/2022	Sandy Spiegelberg	• Clarify that Case Managers must ensure SBS 1:1 staffing is hired before authorizing the service; clarify that a dually-credentialed staff of a Behavior Support Provider cannot bill for two services provided at the same time; provide	

		guidance to HCS staff on AFH Provider eligibility for the SBS contract and the consideration of negative history; provide ESF daily rate; identify contract monitoring responsibilities; and address hospice services for an RSW client.	
6/1/2022	Sandy Spiegelberg	• Update Table of Contents; clarify steps to take when an ECS client refuses services; add new example for SBS Staffing Schedule; add that providers must take ECS Contract Training before receiving the contract; clarify ESF referral process; add requirements for accepting private-pay residents in an ESF; and minor grammatical changes.	

State-Funded Programs

This section will provides an introduction to the state-funded programs currently available to individuals who are not eligible to receive Medicaid funded programs but wish to remain in or return to their own communities through the provision of coordinated, comprehensive and economical home and community-based services.

Ask the Expert

If you have questions or need clarification about the content in these Appendices, please contact the expert(s) listed in each Appendix section.

TABLE OF CONTENTS

CHORE

Ask the Expert

If you have questions or need clarification about the content of Chore, please contact:

Annie Moua HCBS Waiver Program Manager
509.590.3909 Anne.Moua@dshs.wa.gov

What is Chore? WAC 388-106-0600 through 0630

Chore is a program using state-only funds. **Chore was frozen to new applicants as of August 2001.** Do not authorize Chore services for any new clients or clients on other home and community-based services. Current Chore clients have been grandfathered into the program. Chore is the only program that allows a spouse to be a paid caregiver; however, the monthly payment to the spouse CANNOT exceed the monthly income limit for the Medical Care Services (MCS) medical program per WAC 388-478-0090.

A client may remain on the Chore program until he/she:

- Becomes eligible for MPC or CFC;
- No longer meets functional or financial eligibility for Chore;
- No longer has a spouse being paid to provide care and the client is eligible for MPC or CFC;
- Has a break in services; or
- Chooses to terminate services.

Once terminated from CHORE services, clients cannot return to the program.

Who is eligible?

To be eligible for Chore, the client must meet the following eligibility criteria:

- Reside in a private home (not a licensed residential setting);
- Be grandfathered on the Chore program before August 1, 2001, and have continued to receive Chore without a break in service;
- Be 18 years of age or older;
- Meet Functional Eligibility - the participant continues to be functional eligibility for the program based on his/her CARE assessment. To be eligible, the individual must have an unmet or partially met need outlined in WAC 388-106-0610;
- Meet Financial Eligibility ***as determined by the case manager at least annually*** or when there is a change in income. The case manager also determines participation for Chore clients. Instructions for both financial eligibility and determination of participation are provided in Chapter 7a – Core Long-Term Services & Supports Financial Eligibility.

What services are available?

The only service available under the Chore program is personal care services. The monthly benefit is the number of hours generated by CARE up to a **maximum limit of 116 hours**. If it is determined that additional hours are needed, an ETR must be submitted via CARE.

An ETR approved by the HQ ETR committee is required when the number of monthly hours being requested exceed the number of monthly hours generated by CARE.

An ETR approved by the HQ Chore Program Manager is required under the following circumstances:

1. The client is eligible for MPC or CFC but wants to remain on Chore to keep their spouse as the paid caregiver;
2. Authorizing a payment to a spouse provider in excess of MCS standard;
3. Requesting more than the program limit of 116 hours per month, but equal to or less than the base hours generated by CARE.

NOTE: A separate ETR must be submitted for [#1 and/or #2] and #3 of the above three reasons. For example, you cannot submit one ETR to allow payment to a spouse in excess of Medical Care Services (MCS) standard and to request hours above the 116 hour limit. They must be two separate ETRs. You may submit one ETR when the client is requesting to remain on Chore to keep a spouse provider even though they are now eligible for MPC or CFC AND the payment to the spouse provider will exceed the MCS standard.

Who are the qualified providers?

Clients on the Chore program may choose to receive services from the following qualified provider types:

- Individual Provider (IP) who:
  - Has a current contract with DSHS or AAA
  - Passes a BCCU criminal history background check
  - Meets all training and certification requirements outlined in WAC 388-71-0500 through 1006.
- Home Care Agency (HCA) that:
  - Is licensed by Dept. of Health per Chapter 70.127 RCW and Chapter 246-335 WAC
  - Has a current DSHS contract with an AAA

Where can individuals receive services?

Personal care services provided through the Chore program are delivered in the client's home. Personal care services may also be provided for tasks completed outside of the client's home, as specified in the service plan, in order to support clients to access other services in the community. Personal care may be furnished to assist a person to function in the workplace or as an adjunct to the provision of employment services.

MEDICAL CARE SERVICES

Ask the Expert

If you have questions or need clarification about the content of Medical Care Services, please contact:

Emily Watts Residential Policy Program Manager
360.725.3426 emily.watts1@dshs.wa.gov

What is State-funded Medical Care Services? WAC 182-508-0005 and 0150

Medical Care Services (MCS) is a small program funded 100% by state dollars. LTC services are limited and only available in certain residential settings. A person can be placed in these settings on MCS without a NGMA being completed first. Clients on this program are not eligible for waiver services unless there is a change in the client's citizenship status.

MCS clients must pay room and board (R&B). However, ACES does not create and send cost of care letters therefore the case worker must calculate R&B. R&B is determined by subtracting the client's personal needs allowance (PNA) from their countable income. The remaining income is applied to R&B up to the R&B standard. **Case managers must send a copy of DSHS 18-720 Client Responsibility Notice informing clients of their R&B amount.**

Who is eligible?

Individuals may receive services under this program if they are:

1. Immigrants in their 5-year Medicaid bar or lawfully present non-citizens not subject to the 5-year bar (previously known as PRUCOL); and
2. Eligible for aged, blind disabled (ABD) cash program or housing and essential needs (HEN) program; and
3. Determined functionally eligible for MPC or CFC; and
4. Determined to be financially ineligible for CFC or MPC because of their citizenship status.

What services are available?

Available services in this program include:

- Skilled Nursing Facility services
- Personal care services in a residential setting
- Nurse delegation in an AFH or ARC

Who are the qualified providers?

Clients may choose from the following qualified provider types:

- Skilled Nursing Facility that:
  - ✓ Is Medicaid certified
- Adult Family Home (AFH) that has a current:

- ✓ AFH license under Chapter 70.128 RCW and Chapter 388-76 WAC; and
- ✓ Contract with DSHS

- Adult Residential Care (ARC) facility that has a current:
  - ✓ Assistive Living Facility (ALF) license under Chapter 18.20 RCW and Chapter 388-110 WAC; and
  - ✓ Contract with DSHS

Where can individuals receive services?

Under this program, clients may choose to receive services in a nursing facility, adult family home or adult residential care facility. In-home services are not allowed.

LONG-TERM CARE SERVICES FOR NON-CITIZENS

If you have questions or need clarification about the content of Long-Term Care service for Non-Citizens, please contact:

Emily Watts Residential Policy Program Manager
360.725.3426 emily.watts1@dshs.wa.gov

What is State-funded LTC for Non-Citizens? WAC 182-507-0125

The State-funded LTC for Non-Citizens program is available to clients who do not qualify for any other Medicaid program or the State-funded MCS program and have heavy care needs. It is used only as a last resort. There are a limited number of slots statewide for this program. There is a long wait list for this program. Enrollment requires approval from HCS HQ program manager.

ACES calculates Room and Board (R&B) for clients in the L24 coverage group and sends a client letter.

Note: Alien Emergency Medical (AEM) is a separate Medicaid program that offers coverage for qualifying medical emergencies. AEM is overseen by the Healthcare Authority. It does not provide LTC services.
For more information on how to apply and what is covered, please visit the HCA Apple Health Alien Emergency Medical page.

Who is eligible?

Individuals may receive services under this program if they are:

- Age 19 or older;
- Not eligible for federally funded Medicaid or state-funded Medical Care Services (MCS) because of their citizenship status
- Assessed in CARE to meet nursing facility level of care

What services are available?

Available services in this program include:

- Personal care services in a client's own home or a licensed residential setting
- Nurse delegation in an AFH or ARC
- Skilled Nursing Facility services
- Additional services can be found in Column CN 21+ of WAC 182-501-0060. Details on what is included in each service category are available in WAC 182-501-0065.
- Washington Roads Services (available for SNF and acute care clients only)

> Prior to receiving Washington Roads services, case managers must receive HQ approval from the MCS program manager or a delegate. For more information on Washington Roads, please see Chapter 5a.

Individuals on the LTC Non-Citizen Medicaid program are not eligible for:

- Expanded Community Services (ECS)
- Specialized Behavioral Support (SBS)
- Enhanced Service Facilities (ESF)
- Meaningful Day Activities

> If you are looking for information on the 100% state funded GOSH service and subsidy, please see Chapter 5b: Housing Resources for ALTSA Clients.

Who are the qualified providers?

Clients choosing to live in their own home may select from the following qualified provider types:

- Individual Provider (IP) who:
  - Has a current contract with DSHS or AAA
  - Passes a BCCU criminal history background check
  - Meets all training and certification requirements outlined in WAC 388-71-0500 through 1006.
- Home Care Agency (HCA) that:
  - Is licensed by Dept. of Health per Chapter 70.127 RCW and Chapter 246-335 WAC
  - Has a current DSHS contract with an AAA

Clients choosing to live in a residential setting may select from the following qualified provider types:

- Skilled Nursing Facility that:
  - ✓ Is Medicaid certified
- Adult Family Home (AFH) that has a current:
  - ✓ AFH license under Chapter 70.128 RCW and Chapter 388-76 WAC; and
  - ✓ Contract with DSHS
- Adult Residential Care (ARC) facility that has a current:
  - ✓ Assisted Living Facility (ALF) license under Chapter 18.20 RCW and Chapter 388-110 WAC; and
  - ✓ Contract with DSHS
- Enhanced Adult Residential Care (EARC) facility that has a current:

- ✓ Assisted Living Facility (ALF) license under Chapter 18.20 RCW and Chapter 388-110 WAC; and
- ✓ Contract with DSHS

- Assisted Living that has a current:
  - ✓ Assisted Living Facility (ALF) license under Chapter 18.20 RCW and Chapter 388-110 WAC; and
  - ✓ Contract with DSHS

Where can individuals receive services?

Under this program, clients may choose to receive services in their own home, an adult family home (AFH), adult residential care (ARC), enhanced adult residential care (EARC), assisted living (AL), or a nursing facility.

How can a client get added to the waitlist?

An application for long term care services must be submitted by the client or a representative prior to requesting placement on the waitlist.

After the application has been submitted, the PBS or case manager will send an e-mail to emily.watts1@dshs.wa.gov with the following information:

- Client's Name
- Client ID (if available)
- ProviderOne Number (if available)
- Date of Birth
- Current residence or setting, including the address
- Client or representative contact information
- Primary diagnoses or care services required

Once this information is received, the client will be added to the waitlist effective the date of initial request. An e-mail confirmation will be sent once the client's information has been added to the waitlist. The HQ Program Manager will notify the client/representative, Public Benefit Specialist, and Case Manager once a spot becomes available.

GUARDIANSHIP AND CONSERVATORSHIP ASSISTANCE

If you have questions or need clarification about the content of Guardianship and Conservatorship Assistance program, please contact:

Sarah Tremblay Guardianship Program Manager
360.725.3704 office sarah.tremblay@dshs.wa.gov

What is State-funded Guardianship and Conservatorship Assistance Program (GCAP)? WAC 388-106-2100

The State-funded Guardianship and Conservatorship Assistance program is available to LTSS eligible clients who are currently hospitalized in an acute care hospital, have been determined to no longer have decision making capacity, and who do not have an identified legal decision maker needed to access LTSS benefits for hospital transitions. It is used only as a last resort who no other available less restrictive decision maker is available to serve the client. There are a limited number of slots statewide for this program. There can be a wait list for this program, dependent on tier designation required to meet the client's needs. Enrollment requires approval from HCS HQ program manager.

Note: The Office of Public Guardians (OPG) is a separate guardianship and conservatorship program that offers decision maker services for qualifying individuals. OPG is overseen by the Administrative Office of the Courts (AOC).

For more information on how to apply for a public guardian or conservator and to verify what is covered, please visit the OPG website at Washington State Courts - Guardian Portal

Who is eligible? WAC388-106-2110(2)-(3)

At the time of referral and eligibility determination, individuals may receive services under this program if they:

- Are age 18 or older;
- Meet long-term care services and supports (LTSS) Medicaid functional eligibility requirements in chapter 388-106 WAC and financial eligibility requirements in WAC 182-513-1315(1)-(3) or be determined provisionally approved;
- Do not have financial resources to pay for guardianship services, fees, or costs from their estate;
- Are occupying an acute care hospital bed, and not be in a restricted sub-group including current occupancy in a bed readiness program, skilled nursing facility, inpatient rehabilitation, inpatient mental health, emergency department, long-term acute care hospital bed, facility bed under observation status, or in a facility bed under a single bed certification pursuant to a cause under Chapter 71.05 RCW;
- Determined to be non-decisional for consent to LTSS services purposes and have no identified less restrictive legal representative willing or able to provide consent to LTSS services or to serve as guardian or conservator;
- Who have at least one qualifying neuro-cognitive diagnosis as defined om WAC 388-106-2105;
- No longer requires an inpatient level of care at an acute care hospital;
- Likely require the appointment of a guardian or conservator to be able to access and maintain long-term services and supports.

What services are available?

Available services in this program include:

- Professional guardianship services

- Professional conservatorship services
- Limited filing and case related service fees
- Additional services information can be found in WAC 388-106-2100. Details on tier terms are available in WAC 388-106-2105.

Who are the qualified providers? WAC388-106-2110(1)

All GCAP providers:

- Hold a current DSHS GCAP contract and maintain sufficient insurance coverage per contract terms;
- Hold certification Certified Professional Guardians and Conservators approved by the state of Washington supreme court;
- Must be in good standing with the certified professional guardian and conservator review board (CPGCRB); and
- Pass a BCCU criminal history background check.

While every effort is made to ensure client preference and client choice in the nomination of a proposed guardian and conservator contractor, the Court has ultimate determination as to which contractor is appointed, if any.

Where can individuals receive services?

Under this program, clients may choose to receive services in their own home, an adult family home (AFH), adult residential care (ARC), enhanced adult residential care (EARC), assisted living (AL), specialized dementia care program (SDCP) facility, or a nursing facility.

How can a client get added to the waitlist? WAC 388-106-2120

A client will be added to the waitlist by the Guardianship Program Manager after the Acute care hospital has completed the referral procedure outlined in Chapter 388-106-2115 WAC and:

- The individual is determined eligible for GCAP services;
- It is determined that there is not an appropriate GCAP program slot available for the eligible individual based on the client's tier designation;
    a. If a person is found eligible for a tier 2 slot, but at the time of acceptance only a tier 1 slot is available, DSHS will accept the person into the tier 1 slot while simultaneously placing the person on the waitlist for a tier 2 slot. Acceptance into the tier 2 waitlist does not guarantee that a person will be accepted into the program under a tier 2 slot designation.

An e-mail confirmation will be sent once the client's information has been added to the waitlist. The Guardianship Program Manager will notify the client/representative, Public Benefit Specialist, and Case Manager once a spot becomes available.

- ❖ Waitlist priority is determined based on a first-come basis utilizing the date DSHS receives a complete referral packet and DSHS completes an eligibility determination for the person.
- ❖ Being added on the waitlist does not guarantee that a person will be accepted into the program.

RESOURCES

Related WACs and RCWs

Washington Administrative Codes (WAC)

WAC 388-71	Home and Community Services and Programs
WAC 388-76	Adult Family Home Minimum Licensing Requirements
WAC 288-106	Long-Term Care Services
WAC 388-110	Contracted Residential Services
WAC 388-106-2105	Definitions.
WAC388-106-2110(2)-(3)	Eligibility criteria
WAC 388-106-2115	Referral process
WAC 388-106-2120	Acceptance into the program
WAC 388-106-0600 through 0630	Chore
WAC 388-106-2100	What is the home and community services guardianship and conservatorship assistance program?
WAC 388-478-0090	What are the monthly income limits for the aged, blind, or disabled (ABD) cash assistance and housing and essential needs (HEN) referral program?
WAC 182-501-0060	Health care coverage--Program benefit packages--Scope of service categories
WAC 182-501-0065	Health care coverage—Description of service categories
WAC 182-507-0125	State-funded long-term care services
WAC 182-508	Classic and State-Funded Washington Apple Health Eligibility for Adults
WAC 182-513-1315(1)-(3)	General eligibility requirements for long-term care (LTC) programs
WAC 246-335	In-home Services Agencies

Revised Code of Washington (RCW)

Chapter 18.20 RCW	Assisted Living Facilities
Chapter 70.127 RCW	In-Home Services Agencies
Chapter 70.128 RCW	Adult Family Homes
Chapter 71.05 RCW;	Behavioral Health Disorders

Acronyms

AAA	Area Agency on Aging
ABD	Aged, Blind, Disabled
AEM	Alien Emergency Medical
AFH	Adult Family Home
ALF	Assisted Living Facility
ALTSA	Aging and Long-Term Support Administration
AOC	Administrative Office of the Courts
ARC	Adult Residential Care Facility
BCCU	Background Check Central Unit
CARE	Comprehensive Assessment and Reporting Evaluation
CFC	Community First Choice

COPES	Community Options Program Entry System
DSHS	Department of Social and Health Services
EARC	Enhanced Adult Residential Care Facility
ECS	Expanded Community Services
ESF	Enhanced Services Facility
ETR	Exception to the Rate/Rule
GCAP	Guardianship and Conservatorship Assistance Program
GOSH	Governor's Opportunity for Supportive Housing
HCA	Health Care Authority
HCA	Home Care Agency
HCBS	Home and Community Based Services
HCS	Home and Community Services
HEN	Housing and Essential Needs
HQ	Headquarters
IP	Individual Provider
LTC	Long-Term Care
LTC-NC	Long Term Care for Non-Citizens
LTSS	Long Term Services and Supports
MCS	Medical Care Services
MPC	Medicaid Personal Care
NGMA	Non-Grant Medical Assistance
OPG	Office of Public Guardians
PBS	Public Benefit Specialist
PNA	Personal Needs Allowance
R&B	Room and Board
RCW	Revised Code of Washington
SBS	Specialized Behavior Support
SDCP	Specialized Dementia Care Program
SER	Service Episode Record
SNF	Skilled Nursing Facility
WAC	Washington Administrative Code

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
4/2025	Annie Moua	• Update template • Remove CFC from programs individuals on LTC-NC are not eligible for	

Appendices

Chapter 7h describes the various appendices that pertain to Home and Community Based Service (HCBS) programs, services, and case management activities.

Ask the Expert

If you have questions or need clarification about the content in these Appendices, please contact the expert(s) listed in each Appendix section.

TABLE OF CONTENTS

APPENDIX I: COORDINATION WITH DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Ask the Expert

If you have questions or need clarification about the content in Appendix I, please contact:

Melissa Randles State Plan Services Unit Manager
360-407-1515 Melissa.Randles@dshs.wa.gov

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, Home & Community Services (HCS), the Area Agency on Aging (AAA) 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/agencies.

The CFC and MPC programs are managed by DDA for:

- individuals of all ages who have a developmental disability, and
- children 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 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 a 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 ALTSA 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/AAA 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/AAA 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/AAA may occur for the following reasons:

- Adult DDA clients and applicants may request HCS/AAA services;

- Adults with disabilities who are determined to be DDA clients may also gain access to services from HCS/AAA that are not available from DDA (like Adult Day Health). While adults may receive COPES waiver services from ALTSA and state-only funded services (like employment services, State Supplementary Payment (SSP) program 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/AAA 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/AAA will be the primary case manager in CARE when authorizing nursing facility or ALTSA waiver services (such as COPES) to DDA clients.
  - Clients do not have to disenroll with DDA to receive ALTSA services.
  - HCS/AAA may refer clients to DDA for a determination of developmental disability, but long-term care services will be initiated or continued by HCS/AAA pending the DDA determination. Services must not be interrupted during the transition from HCS/AAA 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/AAA 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/AAA will have access to the client's CARE record and assessment.
- HCS/AAA will be able to authorize social service payments as needed.

Process for a DDA client requesting services from HCS/AAA

1. Referral received from DDA case resource manager or DDA client;
2. **Functional Eligibility** – Complete LTC assessment in CARE to establish functional eligibility;
3. **Financial Eligibility** – Notify financial on a 14-443 in Barcode of the DDA transfer so the client's 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 ProviderOne (P1) social service authorization and vice versa.

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

Children who do not meet DDA eligibility criteria but have personal care needs are case managed through DDA until they are 18 years old 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 receiving 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:
    a. make a referral to HCS, and
    b. notify other agencies [e.g., Children's and Health Care Authority (HCA)] as appropriate of the transfer.
2. 30 days prior to the client's 18th birthday, HCS will:
    a. complete the functional assessment in CARE,
    b. confirm the qualified provider,
    c. accept the transfer from DDA, and
    d. 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,
    a. the DDA case resource manager will:
        i. make a referral to HCS, and
        ii. coordinate with Children's Administration throughout the transition.
    b. The HCS worker will:
        i. determine LTC eligibility,
        ii. confirm client's choice of qualified provider,
        iii. authorize services after the 18th birthday, and
        iv. transfer the case per the usual process to the AAA for ongoing case management, if appropriate.
    c. DDA and HCS will coordinate to ensure the transition of services for the client is as 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 Non-Grant Medical Assistance (NGMA) determination will need to be made. See Appendix IV: Non-Grant Medical Assistance (NGMA) for more information.

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.

- **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.

- 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.
- Notify financial 60 days prior to 21st birthday of the need to send a financial packet and determine financial eligibility.

- **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.
  - Verify financial eligibility at review time;
  - Notify financial 60 days prior to 19th birthday of the need to coordinate transfer of the financial record from the MEDS unit within HCA.
- **Medicaid (Title 19**) – Children remain eligible on this medical program until they are 19 years of age.
  - Verify financial at review time;
  - 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.
- **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.
  - Verify financial eligibility when file is transferred from DDA. Financial eligibility is determined by the DDA LTC Specialty Unit.
  - Terminate services on the 19th birthday. There are no other Medicaid services available.
  - Refer to community resources.
  - Authorize services once all program requirements are met.

APPENDIX II: ESTATE RECOVERY

Ask the Expert

If you have questions or need clarification about the content in Appendix II, please contact:

Amanda Aseph Office Chief – Financial Eligibility & Policy
360-725-3406 Amanda.Aseph@dshs.wa.gov

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, 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) 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:

- WashingtonLawHelp.org info on Estate Recovery for Medical Services Paid for by the State and;
- Home and Community Services (HCS) publication: Medicaid and Options for Long-Term Care Services for Adults (DSHS 22-619x)
- Estate Recovery Information Sheet
- Estate Recovery Repaying the State for Medical and Long-Term Care (LTC) 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.
  - 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 Chapter 182-527 WAC.

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.

APPENDIX III: RESOURCES

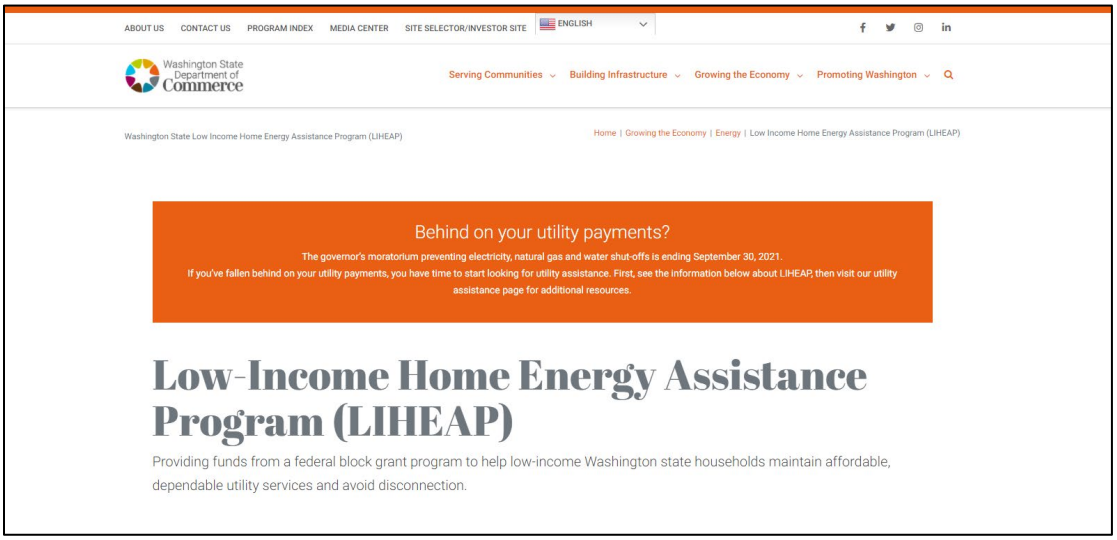
ALTSA and DDA Service Comparison Chart

ACES and RAC codes cheat sheet for all core programs (i.e., CFC, MPC, HCBS waivers, etc.)

Social Service Authorization Manual (SSAM)

Medicaid Programs – LTSS Chart (ACES coverage group cheat sheet)

Low-Income Home Energy Assistance Program (LIHEAP) – Cooling Options for Low Income Households



To apply for LIHEAP, contact the LIHEAP provider in your community. Each agency has its own process for scheduling appointments. Consult the Washington State Department of Commerce LIHEAP website frequently asked questions on eligibility, the services that are available, and who to contact in the community.

With LIHEAP, people can acquire heating or cooling units, pay bills, and receive assistance with repairing or replacing unsafe, inoperative or dysfunctional systems. And people in counties impacted by wildfire smoke may qualify for assistance to receive air purifiers if there is an emergency wildfire proclamation in place.

APPENDIX IV: NON-GRANT MEDICAL ASSISTANCE (NGMA)

Ask the Expert

If you have questions or need clarification about the content in Appendix IV, please contact:

Annie Moua HCBS Waiver Program Manager
509.590.3909 Anne.Moua@dshs.wa.gov

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):

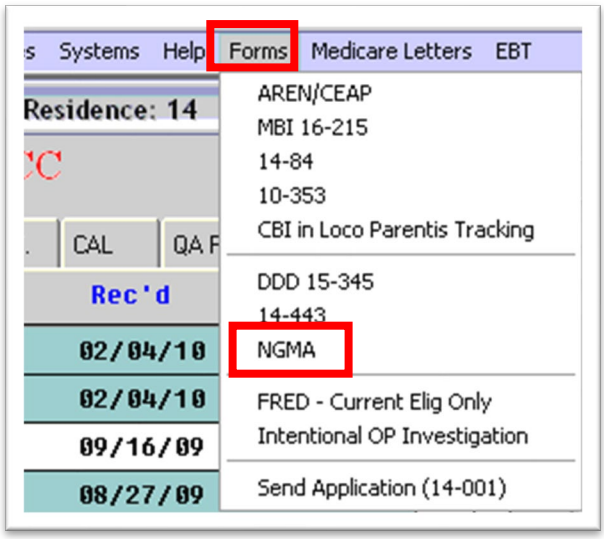
- Blind (as defined in WAC 182-512-0050); or
- Disabled – the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months.

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

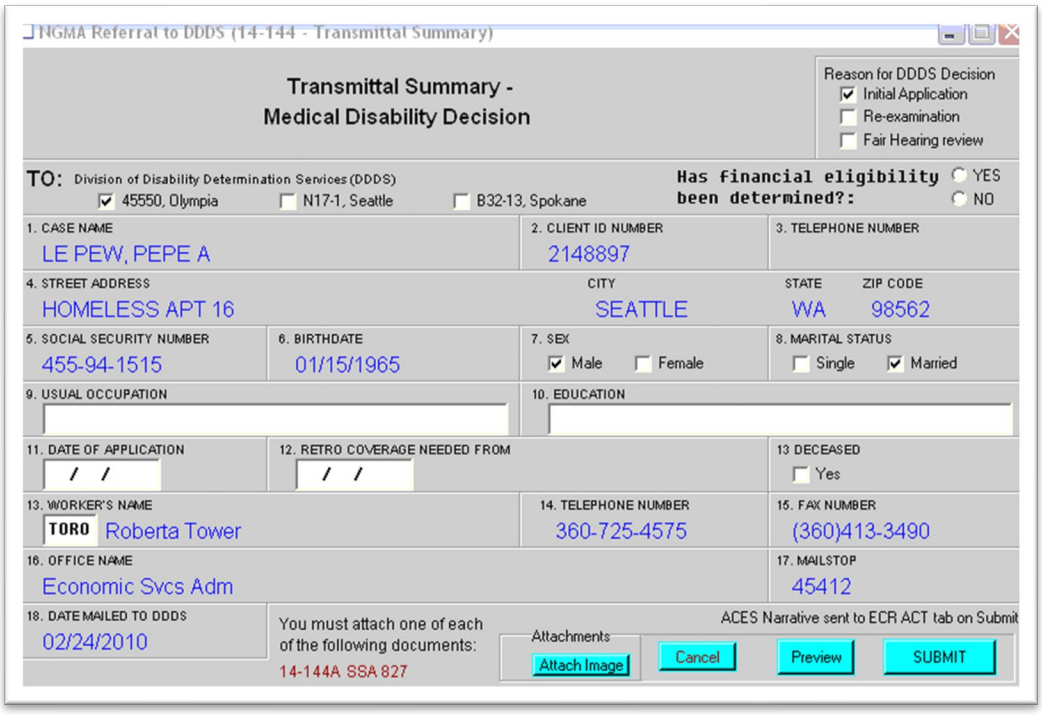
1. Clients who are on SSI/SSA Disability, blind, or 65 or older, are already categorically related and a NGMA is NOT needed:
    a. Determine if a financial application has been submitted (unless already on Medicaid), and
    b. Authorize services – use Fast Track if appropriate.
2. For clients under 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 Electronic Case Record (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.

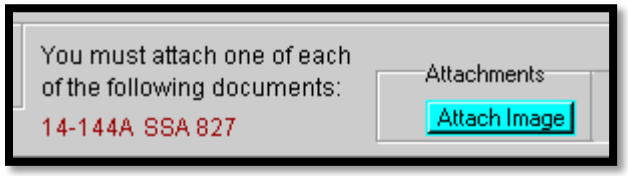
If these dates are entered into fields 11 and 12, an invalid date popup warning will appear.

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.

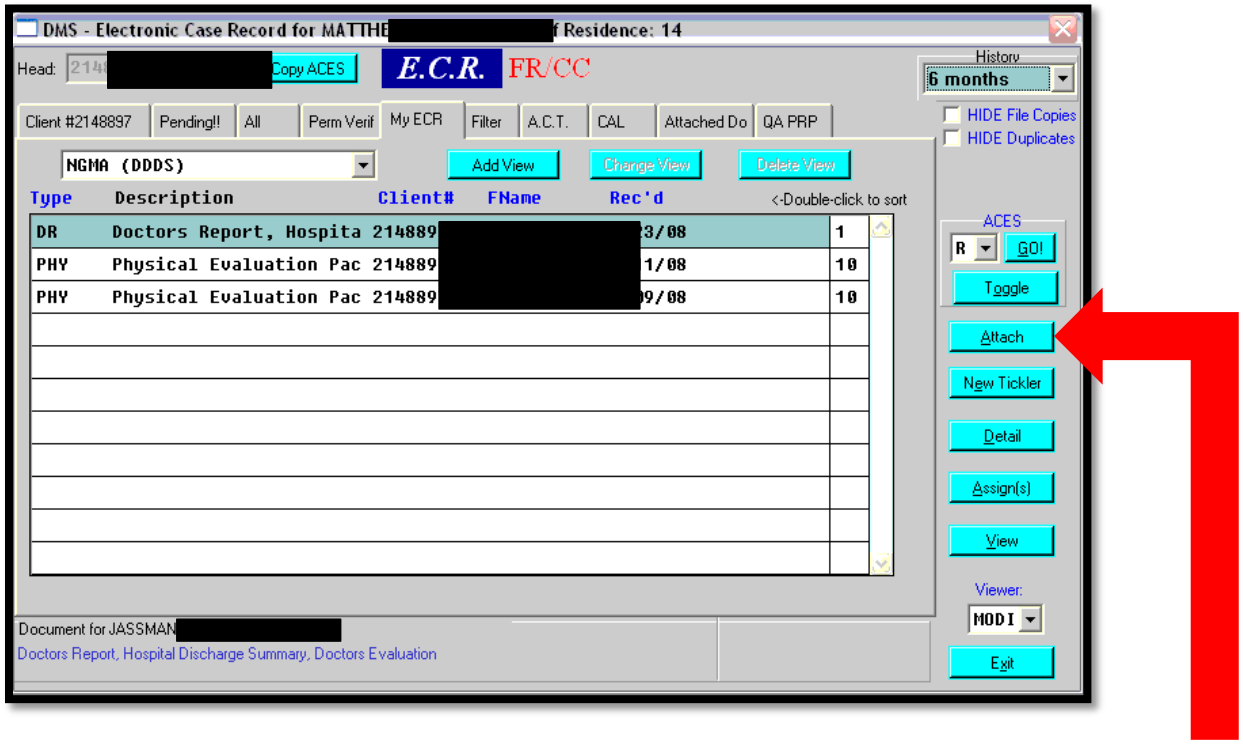
Box 13 has a checkbox to indicate if the client is deceased.
Boxes 14 through 19 include information about who sent the form and the date it was sent to DDDS. Only box 14 can be changed.

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.



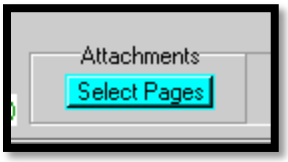
Highlight the documents that you would like to attach to the NGMA Transmittal Summary. On the right-hand side of the ECR there will be a new button above the 'New Tickler' button. Once you have all of the documents highlighted, click the 'Attach' button.

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

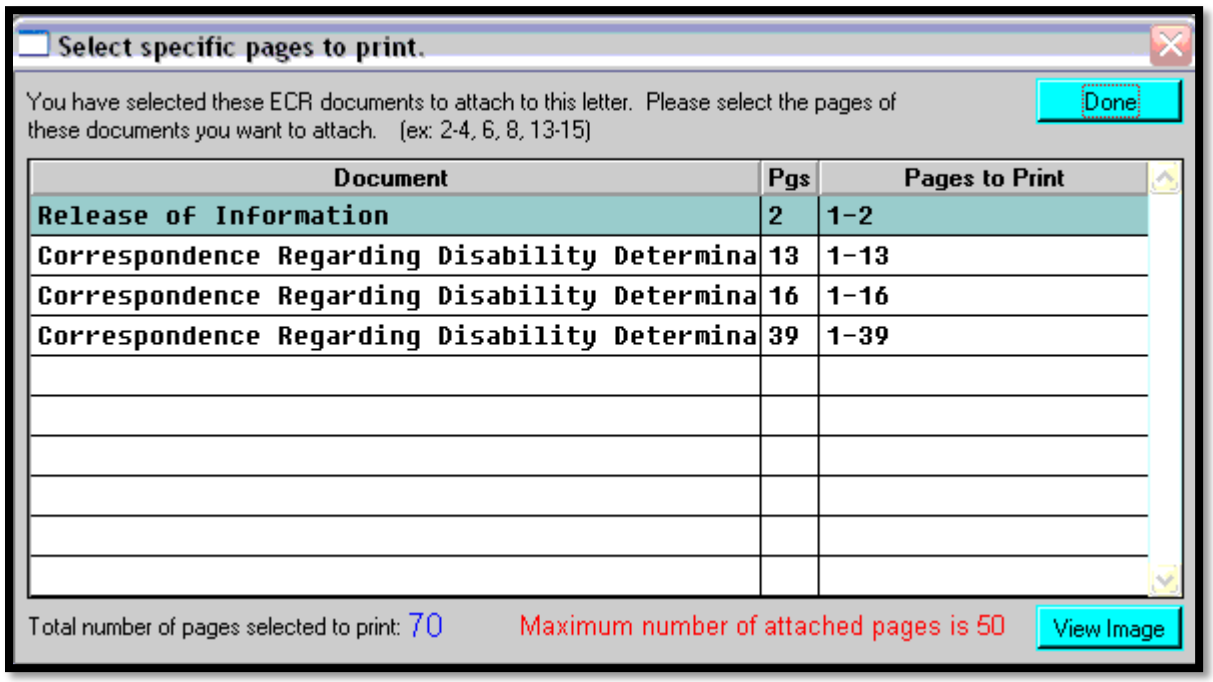
Hit the ECR's 'Exit' button to return to the NGMA screen. If the documents have been attached the document types should have changed from red to green.

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.

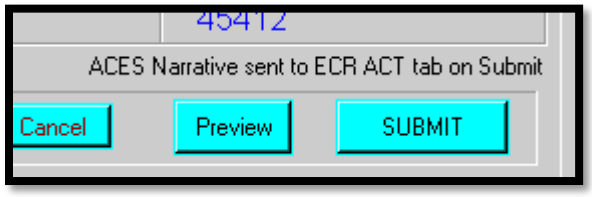


The total number of pages for the documents attached is listed at the bottom of the screen. To only attach a few pages of the document, select the document by highlighting the line the document is on. You may view the document by clicking the 'View Image' button at the bottom of the screen.

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 a NGMA 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)

Ask the Expert

If you have questions or need clarification about the content in Appendix V, please contact:

Annie Moua HCBS Waiver Program Manager
509.590.3909 Anne.Moua@dshs.wa.gov

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.

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

- Restaurant meals
- Home delivered meals
- Laundry
- Service animal food
- Telephone
- Internet
- Transportation
- Dentures
- Optometrists visit for eyeglasses
- Eyeglasses
- Hearing aid(s)
- Veterinary cost for service animals
- Boarding for service animals

Eligibility and Authorization Process

OAR eligibility is determined by the HCS/AAA Social Service Specialist (SSS)/Case Manager (CM) or DDA Case Resource Manager (CRM). A request for OAR from the client can start from the SSS/CM/CRM or the Public Benefit Specialist (PBS).

1. PBS staff will notify SSS/CM/CRM using the DSHS 07-104 when a client is requesting OAR through the PBS.
2. SSS/CM/CRM will use the OAR Service Request Decision screen in Barcode to document pending, approved, and denied OAR service requests when a client requests or the SSS/CM/CRM determines a need for OAR.
    a. SSS/CM/CRM must select one service typer per OAR request in the Barcode OAR Service Requestion Decision screen.

NOTE: OAR ETR requests are to be sent to the SSS/CM/CRM's supervisor. The ETR will automatically be routed to Evelyn Acopan, CSD Social Services Program Manager, after the supervisor reviews and approves the ETR request.

When an OAR service request is **approved**:

1. A begin date is required. This date will be no more than three (3) months from the current month.
2. An end date is required. This date will be no more than 24 months from the begin date.
3. An amount authorized must be entered. This amount must not be more than the approved service limit.
    a. The approved service type cannot exceed the monthly or annual limit.
    b. Do not allow monthly approval for service that are a one-time payment.
4. Barcode will auto-generate an **OAR1 tickler** to the assigned HCS PBS or DDA PBS pool when an OAR service request has been approved by the SSS/CM/CRM.
    a. Tickle Name: OAR1
    b. Tickle Subject: OAR has been approved
    c. Tickle Details: include client name, begin and end dates, service type, one-time or ongoing and amount.
5. PBS will issue OAR benefits in ACES and ACES will issue a letter and document in the ACES narrative.
6. SSS/CM/CRM will get a Barcode **OAR2 tickler** when an approved OAR service needs to be reviewed.
    a. Barcode will auto-generate an **OAR2 tickler** at approval and is set to ready to work 45 days prior to end date for each approved service.
        i. Tickle Name: OAR2
        ii. Tickle Subject: OAR review is needed
        iii. Tickle Details: Review OAR service for: include client name, begin and end dates, service type, one-time or ongoing and amount.

When an OAR service request is **denied**:

1. One denial reason must be selected. That denial reason is inserted into an open letter.
    a. Reasons to choose from:
        i. Max Benefit Received - You already received the maximum benefit in a 12-month period
        ii. Duplicate Service - The service you requested is covered by another program
        iii. Unnecessary Service - The service you requested does not affect your health, safety or ability to continue to live independently
        iv. Missing Information - You didn't provide sufficient verification to support your need
        v. Funds Exhausted - Program funding has been exhausted
        vi. Need not confirmed - At review, we weren't able to confirm you need additional services to continue to live independently
        vii. Other - Text box to insert explanation
        viii. ETR denied by HQ - An Exception to Rule was submitted and denied by Headquarters.

1. For ETR denials, staff need to insert text in the letter based on the ETR decision in Barcode

2. When an OAR request is denied, an Open letter must be sent.

When an OAR service request is **pending**:

1. Select "Pend" and "Save".
2. The status will be displayed as "pending" until SSS/CM/CRM completes the final decision and either approves or denies the OAR service request.
    a. SSS/CM/CRM name and the date the OAR request is saved will be displayed on the OAR request.
        i. There is an optional space for SSS/CM/CRM to indicate date "Information Request letter" was sent and information due date.
3. A Barcode **OAR3 tickler** will need to be manually created with the information below. The ready to work date will be the next day after the information due date entered.
    a. Tickle Name: OAR3
    b. Tickle Subject: OAR Information Due
    c. Tickle Details: Review OAR notes and client ECR for: include client name and due date. Finalize OAR request.

OAR benefits are not approved if:

1. The assistance the individual is requesting is available to them through another program, or
2. The individual lives in a licensed Adult Family Home (AFH), Assisted Living Facility (ALF), or Enhanced Services Facility (ESF).

WAC 388-473-0010 – 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 assistance (RCA);
(e) Aged, blind, or disabled (ABD) cash assistance;
(f) Housing and essential needs (HEN) referral; or
(g) Supplemental security income (SSI).

Authorization of OAR benefits occurs only when it is determined the item is essential to the client. The decision is based on proof the client provides documenting of:

a. The circumstances that create the need; and
b. How the need affects the client's health, safety, and ability to continue to live independently.

Benefit Review Cycle

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

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

WAC 388-473-0020 – When do we authorize meals as an ongoing additional requirement?

Additional requirement benefits for meals will be authorized when all 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 – Assistance for service animals as an ongoing additional requirement.

A "service animal" means any dog or miniature horse, as discussed in RCW 49.60.040, that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability.

Benefits authorized for food for a service animal if it is decided the animal is necessary for the client's health and safety and supports their ability to continue to live independently.

Benefits authorized for future veterinary care for a service animal if it is decided that a service animal has a medical necessity that would require treatment so that the service animal can continue to do the work or task the animal has been trained to perform. Payment for past veterinary bills is not allowed.

Boarding for a service animal for a maximum amount of $300.00 a year is authorized if it is determined that the client needs medical or mental health care and is in a licensed facility in which the service animal cannot reside and there is no one who can provide care for your service animal.

WAC 388-473-0050 – Telephone and internet services as an ongoing additional requirement.

Benefits for telephone services are authorized when it has been determined that without a telephone,

a. The client's life would be endangered, you could not live independently, or you would require a more expensive type of personal care, and
b. The client has applied for telephone assistance through a federal program.

NOTE: telephone services are meant only for landline assistance.

Benefits for internet services are authorized when is it has been determined:

a. Without internet services, the client could not live independently, or they would require a more expensive type of personal care; and
b. The client has applied for low-cost internet and need assistance paying the monthly bill.

NOTE: The client is not eligible for benefits for telephone or internet services if they are receiving these services free of charge.

WAC 388-473-0060 – 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 388-473-0070 – Transportation as an ongoing addition requirement.

Assistance for transportation costs as an ongoing additional requirement may be authorized when it has been determined that the client needs assistance:

a. Getting to and from appointments; or
b. Taking care of activities to continue living independently.

WAC 388-478-0050 – Payment standards for ongoing additional requirements and WAC 388-473-0080 – Medically related items or services as an ongoing additional requirement.

The payment standards for OAR are as follows:

- Restaurant meals: $390.00 per month
- Laundry: $20.84 per month
- Service animal food: $50.00 per month
- Home delivered meals: The amount charged by the agency providing the meals
- Telephone: $4.00 per month
- Internet: Up to $30.00 per month
- Transportation: $40.00 per month
- Dentures: $1,800.00 in a 12-month period
- Optometrists visit for eyeglasses: $200.00 in a 12-month period
- Eyeglasses: $240.00 in a 12-month period
- Hearing aid(s): $1,000.00 in a 12-month period
- Veterinary cost for service animals: $200.00 annual limit
- Boarding for service animals: $300.00 annual limit

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

What is a service animal?

The Americans with Disabilities Act (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.

Reminder: A service animal is not a pet.

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 individuals with hearing impairments to sounds.
- Pulling wheelchairs or carrying and picking up things for individuals with mobility impairments.
- Assisting individuals with mobility impairments with balance.

Case Worker Responsibilities regarding Service Animals:

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

The animal:

a. Must help the individual 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 client. 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 client with their disability.

2. When it has been determined that the above conditions are met, you may approve Ongoing Additional Requirements by using the Barcode OAR Service Request screen.

ADDITIONAL HELPFUL INFORMATION

- Per WAC 388-478-0050, standards that say "in a 12 month period" are services that can be issued less than the maximum amount based on client need. If less than the maximum is issued the remaining up to the maximum amount is available if needed during that 12-month period.

- The Ongoing Additional Requirements section of the CSD Social Services Manual states under the "Clarifying Information - WAC 388-478-0050" section (2): "The following services are issued at a set standard amount as described in WAC even if the need is less: restaurant meals, laundry, service animal food, telephone, transportation, veterinary cost for service animal. **For other services, determine amount based on need not exceeding maximum standard amount** (this would include dentures)."

- Regarding issuances, WAC 388-473-0010 states that OAR benefits are issued by, "Increasing your cash assistance benefit if you receive cash assistance or issuing a cash benefit if you are a HEN referral or SSI recipient." Also, WAC 388-412-0025 includes information on how a client receives their benefits – SSI recipients get OAR benefits via warrant (check) since there is no assistance unit through CSD to be able to issue via EBT card.

APPENDIX VI: REQUESTING FUNDING FROM THE MANAGED CARE ORGANIZATION (MCO) FOR BEHAVIORAL HEALTH PERSONAL CARE (BHPC)

Information and Instructions for MCO-funded BHPC Wraparound Support Services is located in Chapter 22a of the LTC Manual.

RESOURCES

Related WACs and RCWs

Appendix I: Coordination with Developmental Disabilities Administration (DDA)

Chapter 388-823 WAC	Developmental Disabilities Administration Intake and Eligibility Determination

Appendix II: Estate Recovery

Chapter 182-527 WAC	Estate Recovery and Pre Death Liens
WAC 182-527-2746	Estate recovery—Asset-related limitations
WAC 388-96-384	Liquidation or transfer of resident personal funds
Chapter 43.20B RCW	Revenue Recovery for Department of Social and Health Services
RCW 43.20B.080	Recovery for paid medical assistance—Rules—Disclosure of estate recovery costs, terms, and conditions
Chapter 74.39A RCW	Long-Term Care Services Options—Expansion
RCW 18.39.250	Prearrangement contracts—Trusts—Refunds
RCW 18.39.255	Prearrangement contracts—Insurance funded—Requirements
RCW 68.46.050	Withdrawals from trust funds—Notice of department of social and health services' claim
RCW 70.129.040	Protection of resident's funds—Financial affairs rights

Appendix IV: Non-Grant Medical Assistance (NGMA)

WAC 182-512-0050	SSI-related medical—General information

Appendix V: Ongoing Additional Requirements (OAR)

WAC 388-473-0010	What are ongoing additional requirements and how do I qualify?
WAC 388-473-0020	When do we authorize meals as an ongoing additional requirement?
WAC 388-473-0040	Food for service animals as an ongoing additional requirement
WAC 388-473-0050	Telephone and internet services as an ongoing additional requirement
WAC 388-473-0060	Laundry as an ongoing additional requirement
WAC 388-473-0070	Transportation as an ongoing addition requirement
WAC 388-473-0080	Medically related items or services as an ongoing additional requirement
WAC 388-478-0050	Payment standards for ongoing additional requirements

Resources

Ongoing Additional Requirements PowerPoint

Ongoing Additional Requirement 2024.pd

Acronyms

AAA	Area Agency on Aging
ADA	Americans with Disabilities Act
ALTSA	Aging and Long-Term Support Administration
APS	Adult Protective Services
BHO	Behavioral Health Organization
BHPC	Behavioral Health Personal Care
CARE	Comprehensive Assessment and Reporting Evaluation
CFC	Community First Choice
CHIP	Children's Health Insurance Program
COPES	Community Options Program Entry System
CTS	Community Transition Services
DDA	Developmental Disabilities Administration
DDDS	Department of Disability Determination Services
DSHS	Department of Social and Health Services
ECR	Electronic Case Record
HCA	Health Care Authority
HCBS	Home and Community Based Services
HCS	Home and Community Services
LTC	Long-Term Care
LTSS	Long Term Services and Supports
MCO	Managed Care Organization
MPC	Medicaid Personal Care
NGMA	Non-Grant Medical Assistance
OAR	Ongoing Additional Requirements
OFR	Office of Financial Recovery
P1	ProviderOne
RCL	Roads to Community Living
RCW	Revised Code of Washington
RSW	Residential Support Waiver
SER	Service Episode Record
SCOMIS	Superior Court Office Management Information System
SSA	Social Security Administration
SSAM	Social Service Authorization Manual
SSI	Supplemental Security Income
SSP	State Supplementary Payment
WAC	Washington Administrative Code
WTAP	Washington Telephone Assistance Program

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
4/2025	Annie Moua	• Update template • Update Appendix V: OAR – provide clarifying information • Minor formatting updates and updated links	
10/2024	Annie Moua	• Added OAR ETR process	H24-062
04/2024	Annie Moua	• Update to Appendix V: OAR – addition of several OAR benefits, eligibility expansion, and new authorization process through Barcode OAR Service Request Decision screen.	H24-018
05/2023	Victoria Nuesca	• No content change • Advising that information and instructions for appendix VI on MCO-funded BHPC Wraparound Support Services is now in Chapter 22a of the LTC Manual • Update to the contacts for the different appendices and links	
01/2021	Jamie Tong Kelli Emans	• MCO funded BHPC support clarification and instructions regarding wraparound support and ESF services.	
10/2020	Victoria Nuesca Jamie Tong	• New template revision and updated policy related to MCO funding of wraparound support.	H20-094
09/2019	Jamie Tong	• Update to Appendix VI – criteria, policy and instructions for requesting and authorizing funding from BHO/MCO	H19-050

Residential Services

Chapter 8 gives an overview of residential services to include licensing requirements, contract types, and determining eligibility for a residential setting. The chapter also provides information on Community Integration, Specialized Dementia Care Program, client rights and bed holds.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Emily Watts Assisted Living Facility Policy Program Manager
360.725.3426 Emily.Watts1@dshs.wa.gov

If you have questions or need clarification about the content in this chapter, please contact:

Anna Cavanaugh Adult Family Home Policy Program Manager
360.725.2535 Anna.Cavanaugh@dshs.wa.gov

If you have questions or need clarification about Enhanced Services Facilities, please contact:

James (JD) Selby Residential Support Waiver Program Manager
360.890.2640 James.Selby@dshs.wa.gov

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LICENSING REQUIREMENTS FOR RESIDENTIAL SERVICES

All residential facilities provide a package of services including personal care services and room and board. There are three types of licensed residential settings: Adult Family Homes, Assisted Living Facilities, and Enhanced Services Facilities.

The Residential Care Services Division (RCS) of Aging and Long Term Support Administration (ALTSA) is responsible for licensing and monitoring all Adult Family Homes, Assisted Living Facilities, and Enhanced Services Facilities in Washington State.

Adult Family Home (AFH)

A residential home in which a person or persons provide personal care, special care, and room and board to more than one, but not more than eight adults, who are not related by blood or marriage to the person or persons providing the services.

Adult Family Home may also be designated as a specialty home (on their AFH license) in one or more of the following three categories: Developmental Disability, Mental Illness, and Dementia when they meet all certification and training requirements. See Chapter 388-76 WAC for more information on Adult Family Home licensing requirements and Chapter 388-112A WAC for residential training requirements.

Note: When a Medicaid client is related to the AFH provider and is residing in a licensed and contracted room; the CM/SSS must authorize AFH services using the daily rate based on CARE classification (the same as an unrelated client).

Assisted Living Facilities (ALF)

A facility, for seven or more residents, with the express purpose of providing housing, basic services (assistance with personal care and room and board) and assumes the general responsibility for safety and well-being of the resident. See Chapter 388-78A WAC for more information on Assisted Living Facility licensing requirements.

Enhanced Services Facilities (ESF)

An Enhanced Services Facility provides 24-hour personal care and behavior support services to a maximum of sixteen residents who have complex personal and behavioral care needs that exceed the capacity of other residential settings. See WAC Chapter 388-107 WAC for more licensing requirements. For additional information on ESF please see LTC Manual Chapter 7f for information.

Note: Adult Family Homes, Assisted Living Facilities, and Enhanced Services Facilities may choose to serve private pay residents, Medicaid residents, or a combination of both.

CONTRACTS

Contract Types

If a residential provider wants to serve a Medicaid client, the provider must also have a current Assisted Living, Adult Residential Care, Enhanced Adult Residential Care, Enhanced Servies Facility, or Adult Family Home contract with ALTSA. The types of contracts are listed below.

The **Assisted Living Facility** (ALF) contract requirements are outlined in Chapter 388-110 WAC. There are three types of assisted living contracts:

- Adult Residential Care (ARC)
- Enhanced Adult Residential Care (EARC)
- Assisted Living Services (AL)

There are three Assisted Living Subcontracts:

- Enhanced Adult Residential Care - Specialized Dementia Care:
  EARC-SDC contracts are available only to Assisted Living Facilities with a designated separate dementia care unit and ALFs dedicated solely to the care of individuals with dementia that have been approved by ALTSA to deliver SDCP services.

  The Specialized Dementia Care Program (SDCP) is based on Standards of Care specified in WAC 388-110-220 (3). DSHS contracts with licensed and qualified assisted living providers throughout all regions in the State to provide Specialized Dementia Care Program in Assisted Living Facilities. Services are provided in:

  - A facility dedicated solely to the care of individuals with Alzheimer's disease/dementia; or
  - A designated, separate unit/wing dedicated solely to the care of individuals with Alzheimer's disease/dementia located within a larger facility.

  For more information on the Specialized Dementia Care Program in EARC-SDC/ALF, go online to: Specialized Dementia Care Program in Assisted Living Facilities.

- Expanded Community Services (ECS) – see LTC Manual Chapter 7f for more information

- Community Stability Supports (CSS) – see LTC Manual Chapter 7f for more information

The **Adult Family Home** requirements are outlined in Chapter 388-76 WAC. There are three types of Subcontracts in AFH:

- Expanded Community Services (ECS)
- Meaningful Day Activities (MDA) - see LTC Manual Chapter 8a for more information
- Specialized Behavior Support (SBS)

**Please note in the past there was an HIV/AIDS specialty contract. This contract is no longer available, but two AFHs remain, and they are eligible to receive the published HIV/AIDS rates [Three Cedars (Tacoma) and Sean Humphries (Bellingham)]. No other facilities in the state may receive the HIV/AIDS rate.

The **Enhanced Services Facilities** contract requirements are outlined in Chapter 388-107 WAC and LTC Manual Chapter 7f.

Contract Requirements

AL, ARC, EARC, EARC-SDC, AFH, and ESF contracts are legal agreements between contractors and ALTSA. The contract describes the contractor's legal obligations and responsibilities in the statement of work and conditions for receiving payment for services provided.

Facility requests to voluntarily withdraw a Medicaid contract.

If the residential facility is requesting to voluntarily withdraw their Medicaid contract, but continues to provide personal care services, the facility's voluntary withdrawal from participation is not an acceptable basis for the transfer or discharge of residents of the facility. The facility is required to maintain a Medicaid contract as outlined in RCW 18.20.440 to permit the following residents to remain in the facility and not transfer or discharge them:

- Residents who were receiving Medicaid on the day before the effective date of withdrawal (except as described in RCW 70.129.110, Disclosure, transfer, and discharge requirements), and
- Residents who have been paying the contractor privately for at least two years and who will become eligible for Medicaid within 180 days of the date of withdrawal.

To ensure the resident's rights are protected, the contractor may not evict a resident without (1) complying with the transfer and discharge requirements under RCW 70.129.110 and (2) using any appropriate legal processes, including but not limited to unlawful detainer in RCW 59.16 prior to evicting a resident.

Note: If you receive a written or verbal request from a facility for a voluntary withdrawal of a Medicaid contract, forward a copy of the written request to the ALTSA Contract Unit or have the facility contact the ALTSA Contract Unit directly. By RCW 18.20.440 (5), the facility must give the department and its residents 60 days' advance notice of the facility's intent to withdraw from participation in the Medicaid program.

Change of Ownership (CHOW)

There may be times when there is a Change of Ownership, and the new licensee does not enter into a Medicaid contract which may result in the discharge or transfer of clients (please see Appendix below for AFH CHOW Flowchart):

- RCW 18.20.440 does not apply to assisted living facilities that change ownership.
- Instead, WAC 388-78A-2785 requires the facility to give 90 days' notice to the residents of a facility undergoing a change of ownership if the change is anticipated to result in the discharge or transfer of any residents.
- If the facility does not want to participate in a state Medicaid program, the CM/SSS's will assist residents to move and terminate the Medicaid payment effective the day prior to the move or the same date as the contract termination date.
- If the new owner wants to participate in the Medicaid program; the facility will be asked to sign a Medicaid contract to be paid for Medicaid residents.

Expired Contracts

The ALTSA contract department will send the contractors a notice 2-3 months before the contract expires. If the contractors' do not renew their contract within 30 days prior to the expiration date, or the contract ends during the mid-month, the authorization in ProviderOne will have a taxonomy error and not be payable to the contractors.

Case Managers/Social Service Specialists **who receive an error message in ProviderOne may need to review the taxonomy error in the ProviderOne authorization to determine whether an expiring contract is the cause of the payment error.** If so, the CM/SSS will need to notify the contractor of their expiring contract and have the contractor renew their contract before payment can be re-authorized.

Note: The contractors cannot admit new Medicaid clients until they have a signed Medicaid contract in place. For existing Medicaid clients, the contractors will not be able to receive payment until their contracts are renewed and are in signed status.

Medicaid Contract Requirements in Residential Facilities

This chart (below) shows what is required in each licensed facility type as required by contract.

REQUIREMENTS BY LICENSE and/or CONTRACT					
MEDICAID SERVICES AVAILABLE IN ADULT FAMILY HOMES AND ASSISTED LIVING FACILITIES	**Adult Family Home License**	**Assisted Living Facility (ALF) License**			**Enhanced Services Facility License**
	AFH contract (ECS)(SBS)	ARC Contract	EARC Contract (ECS) (SDC) (CSS)	AL Contract (ECS)(SDC)	ESF Contract
Facility Assessment	Yes	Yes	Yes	Yes	Yes
Negotiated Care Plan (NCP)	Yes	N/A	N/A	N/A	N/A
Negotiated Service Agreement (NSA)	N/A	Yes	Yes	Yes	N/A
Person Centered Service Plan (PCSP)	N/A	N/A	N/A	N/A	Yes
Personal Care and Supervision	Yes	Yes	Yes	Yes	Yes
Medication Administration	Yes w/RND	No	Yes	Yes	Yes
Medication Assistance	Yes	Yes	Yes	Yes	Yes
Room & Board	Yes	Yes	Yes	Yes	Yes
Activities	Yes	Yes	Yes	Yes	Yes
Private apartment-like unit	No	No	No	Yes	No
Private bathroom	No	No	No	Yes	No
Private kitchen area	No	No	No	Yes	No
Personal care supplies	No	No	Yes	Yes	No
Awake staff 24 hours a day	No	No	Yes w/SDC & CSS	Yes w/SDC	Yes
Secured accessible outdoor area with environmental & safety requirement	No	No	Yes w/SDC	Yes w/SDC	No
Staff training	Yes	Yes	Yes	Yes	Yes
Coordinate Behavior Support & Team Meetings	Yes w/ ECS and SBS contract	No	Yes w/ECS & CSS	Yes w/ECS	Yes
Individual Crisis Plan	Yes w/ ECS and SBS contract	No	Yes w/ ECS & CSS	Yes w/ECS	Yes
6-8 hours of additional staff time per day	Yes w/SBS contact	No	No	No	No
Quality Improvement Committee	No	Yes	Yes	Yes	Yes

Note regarding Assessments: Prior to admitting Medicaid clients in ALF, AFH, ESF; CM/SSS are required to complete CARE Assessment to determine functional eligibility. Provide a copy of assessment details and service summary to the provider. The following assessments are required in these facilities.

Assisted Living Facilities (ALF) are required by (WAC 388-78A-2060) to complete their own preadmission assessment using a Qualified Assessor (WAC 388-78A-2080) prior to admitting any resident and complete a full assessment (WAC 388-78A-2090) at least annually or when the NSA no longer meets the resident's care needs.

Adult Family Home (AFH) are required to obtain a written assessment that contains accurate information about the prospective resident's current needs and preferences before admitting a resident to the home (WAC 388-76-10330). The AFH assessment must be completed by a Qualified Assessor (WAC 388-76-10150) or the department case manager/social service specialist for Medicaid residents (WAC 388-76-10345)

Enhanced Services Facility (ESF) must have an initial person-centered service plan developed for each resident prior to admission to the ESF (WAC 388-107-0110). The plan must include immediate specific support needs and directions to staff and caregivers relating to those needs. The resident must give written informed consent to the content of the plan. The initial comprehensive person-centered service plan must be completed within 14 days of the resident's move-in date, as outlined in (WAC 388-107-0120).

All residential contracted providers (except ESF) are required to update the assessment at least annually, when there is a significant change in client's physical or mental conditions, when the NSA/NCP no longer reflects the current needs of the client, and at the client's request (WAC 388-78A-2100 (ALF) and WAC 388-76-10350 (AFH)). ESF is required to update the assessment every 180 days (WAC 388-107-0080) or when there is a significant change in client's conditions.

Negotiated Care Plan (NCP), Negotiated Service Agreement (NSA), or Person-centered service Plan (PCSP)

All providers, except ESF, must develop and complete the NCP/NSA within 30 days of the client's admission. The initial comprehensive person-centered service plan for ESFs must be developed and completed within 14 days of the client's admission. The NCP/NSA must be reviewed and revised at least annually, when there is a significant change in client's physical, emotional, mental, behavioral functioning; or any time it no longer addresses the needs and preferences of the client.

For detailed information regarding Adult Family Home Negotiated Care Plan refer to WAC 388-76-10355 through 388-76-10385; Assisted Living Negotiated Service Agreement WAC 388-78A-2130 through 388-78A-2160); and Person-centered service plan for Enhanced Service Facility WAC 388-107-0110 through 388-107-0130.

Nursing Services Available in Each Licensed/Contracted Residential Setting

NURSING SERVICES AVAILABLE IN EACH LICENSED, CONTRACTED SETTING					
Services Provided	**Assisted Living Facility**	**Adult Residential Care**	**Enhanced Adult Residential Care**	**Adult Family Home**	**Enhanced Services Facility**
Intermittent Nursing Services (INS)	Yes	No	Yes	*No	Yes
	Daily Rate, provided by facility	n/a	Daily Rate, provided by facility	n/a	Daily Rate, provided by facility
Nurse Delegation	Yes	Optional	Yes	Optional	Yes
	Daily Rate, provided by facility	Contracted RN	Daily Rate, provided by facility	Contracted RN	Daily Rate, provided by facility
Waiver Skilled Nursing	No	Yes	Yes	Yes	No
	n/a	*DDA Only	Contracted RN	Contracted RN	n/a
24-hour Nursing Services	No	No	No	No	Yes
					Daily Rate, provided by facility
Nursing Services	Yes	Yes	Yes	Yes	Yes
	Referral to Nursing Services Staff, no additional payment				

* Adult Family Home (AFH) may provide intermittent nursing services if the provider is a licensed nurse or use a contracted nurse with a current license in the state of Washington to provide nursing services (WAC 388-76-10405).

Intermittent Nursing Services

Intermittent Nursing Services may include, but is not limited to: Medication administration, Administration of health treatments, Diabetic management, Nonroutine ostomy care, Tube feeding Nurse delegation consistent with Chapter **18.79** RCW.

- Assisted Living Facilities (ALF), and Enhanced Adult Residential Care (EARC's) are required to have intermittent nursing contract so nursing staff is in place to provide nursing care to meet the needs of residents (WAC 388-78A-2310).
- Adult Family Home may provide intermittent nursing services if the provider is a licensed nurse or use a contracted nurse with a current license in the state of Washington to provide nursing services (WAC 388-76-10405).
- Enhanced Services Facility (ESF) are required to have a licensed nurse on-site in the facility 24 hours per day, with a Registered Nurse on-site in the facility at least 20 hours per week. Nursing services will be provided as necessary (WAC 388-107-0240).
- Adult Residential Care facilities are not required to provide intermittent nursing services by contract.

Nurse Delegation

Nurse Delegation is provided by a registered nurse delegator who assesses a client to determine whether they are in a stable and predictable condition; then teaches, evaluates the competency and supervises limited nursing tasks to nursing assistants or home care aides who meet the requirements of a certified home care aide, nursing assistant certified and/or nursing assistant registered in the State of Washington (WAC 388-76-10405).

In Adult Family Homes (AFH), the cost of nurse delegation can be covered by the CFC program or the Residential Support Waiver for Medicaid residents or using state funds when a resident is not a Medicaid client. AFH providers may choose to admit or retain residents requiring nurse delegation. Nurse delegation can occur in ALFs and EARCs, but it is not a reimbursable function. Since ALF and EARC have intermittent nursing services by contract, their nursing staff may delegate if they choose (WAC 388-110-150 and WAC 388-110-220).

Note: Refer to LTC Manual Chapter 13 for additional information regarding Nurse Delegation.

24-hour nursing services

Enhanced Services Facility (ESF) is required to always have a licensed nurse on-site. A Registered Nurse is on-site in the facility 20 hours per week and on-call the remainder of the week to meet any specific nursing needs that cannot be addressed by the licensed nurse on-site (WAC 388-107-0240).

Waiver Skilled Nursing

This waiver service is available in all waiver settings if it does not duplicate a service that is already provided by contract or another source. Skilled Nursing Services provide direct skilled intermittent nursing tasks to clients. Registered nurses, or Licensed Practical nurses under the supervision of a RN, may provide skilled treatment that is beyond the amount, duration, or scope of Medicaid-reimbursed home health services as provided in WAC 182-551-2100.

Nursing Services

Nursing services are available in all residential settings, when the service does not duplicate a service that is already provided by contract or another source. The frequency and scope of the nursing services is based on individual need as determined by the CARE assessment and additional collateral contact information (WAC 388-106-0200, WAC 388-106-0300, and WAC 388-107-0070 for ESF). Services include:

(a) Nursing assessment/reassessment,
(b) Instruction to client or providers,
(c) Care coordination, file review and referral to other health care providers,
(d) Skilled treatment only in the event of an emergency that would require authorization, prescription, and supervision by an authorized practitioner prior to its provision by a nurse and/or,
(e) Evaluation of health-related care needs affecting service plan and delivery.

Note: For additional information regarding Nursing Services refer to LTC Manual Chapter 24

DETERMINING PROGRAM ELIGIBILITY FOR RESIDENTIAL SETTING

All ALTSA clients in any residential setting must meet the functional and financial eligibility program requirements before being placed in the facility. Eligibility is determined simultaneously between the Public Benefit Specialist for financial eligibility and by CM/ SSS for functional eligibility. Individuals who do not qualify for CFC, the Residential Support Waiver or RCL can only be placed in contracted AFH or ARC. The following chart shows which residential facility types can be offered to client based on the financial program they are eligible for:

PROGRAM AVAILABLE IN EACH CONTRACTED FACILITY					
Program	**AFH**	**ARC**	**EARC**	**AL**	**ESF**
Community First Choice (CFC)	Yes	Yes	Yes	Yes	No
DDA Waivers	Yes	Yes	No	No	No
Medicaid Personal Care (MPC)	Yes	Yes	No	No	No
New Freedom	No	No	No	No	No
COPES Waivers	Yes	No	Yes	Yes	Yes
Residential Support Waivers	Yes	No	Yes	Yes	Yes
Roads to Community Living (RCL)	Yes	Yes	Yes	Yes	No
State-funded Medical Care Services (MCS)	Yes	Yes	No	No	No

MCO Funded Community Behavioral Health Support (CBHS)

Beginning July 1st, 2024, Managed Care Organization (MCO), Behavioral Health Personal Care (BHPC) will be replaced by Community Behavioral Health Support (CBHS). CHBS will only fund additional personal care rate reflected in an increase beyond the CARE generated rate. For more information see LTC Manual Chapter 22a.

Authorizing/Determining the payment rate for residential services.

Authorization for residential services should be entered/complete prior to the client being admitted to the residential setting.

1. Prior to authorizing payment to a provider; the CM/SSS must obtain the client's approval on the plan of care (Refer to LTC Manual Chapter 3). The CARE Assessment is not complete until it is moved to current. This includes assessments that are completed for a client converting from private pay to Medicaid in a residential setting. The client must also be financially eligible for residential care services or on Fast Track.
2. The CM/SSS must verify the correct amount of the daily rate identified in the CARE Classification for the geographic location of the provider. Current payment rates for Adult Family Homes and Assisted Living Facilities can be found at: Office of Rates Management.
3. In addition to the CARE-determined payment rate, some ALFs with an assisted living contract may receive an additional payment amount called a Capital-Add-on Rate. The ALTSA Rates staff determines if an ALF qualifies for the Capital-Add-on rate annually, each July. The CM/ SSS will receive notification from headquarters of qualifying facilities and are responsible for adjusting the payment rates for Medicaid clients. ALFs may receive Capiral-Add-on Rate for both clients when in a shared room. Details on the Capital-Add-On program can be found in WAC 388-105-0035. A current list of Capital Add-On providers can be found through the Office of Rates Management page under "Home and Community."

Supplementation of the Medicaid rate is not allowed (only by exception in some limited circumstances). Please see the Supplementing Medicaid Rate part of this chapter.

COMMUNITY INTEGRATION

Under federal rules, individuals who live in residential settings must have opportunities to engage in community life and not be isolated from their community or other people who do not live in a residential facility.

In contracted AFHs, the Collective Bargaining Agreement provides an increase to the daily rate for community integration of Medicaid residents who have an assessed need for assistance to access and participate in the local community. This does not include PACE clients. To be considered community integration, activities must:

- Be individualized and chosen by the resident based on their interests and preferences,
- Include opportunities to engage in the community with other community members, and

- Occur in the resident's local community.

See AFH Provider Community Integration FAQs for more information.

If there is a cost to the activity, the cost of the activity is covered by the resident or with assistance from the resident's friends, family, or other community resources.

Activities Not Included Under Community Integration:

- Medical and dental appointments
- Essential shopping
- Adult Day Health
- DDA Community Inclusion and employment services.

Community Integration Eligibility Criteria in AFHs:

To be eligible for Community Integration an individual must be assessed in the comprehensive assessment reporting evaluation tool (CARE) as needing assistance to access and participate in activities in the community.

If the client's current assessment does not reflect the need for assistance with community integration and the client is requesting assistance with community integration; the CM/SSS can create an Interim assessment to include the CI rate adjustment and the CI mileage reimbursement prior to the next annual assessment due date.

- AFH Providers must include documentation of the client's choice to participate in community integration activities in the client's Negotiated Care Plan (NCP) when the need is also identified in the client's CARE assessment.

Community Integration Reimbursement:

Adult Family Home providers who have a contract with the State to provide services to residents with an assessed need for support to access and participate in the community will receive an adjusted daily rate to provide four (4) hours of community integration per month.

The rate adjustment for community integration may include the following supports provided by the AFH:

- Assisting the resident to select what they want to do and where they want to go in the community.
- Assisting the resident to plan how they will get to the activity.
- Assisting the resident before the activity to problem solve any issues that may come up.
- Assisting the resident to become members of community organizations that interest them.

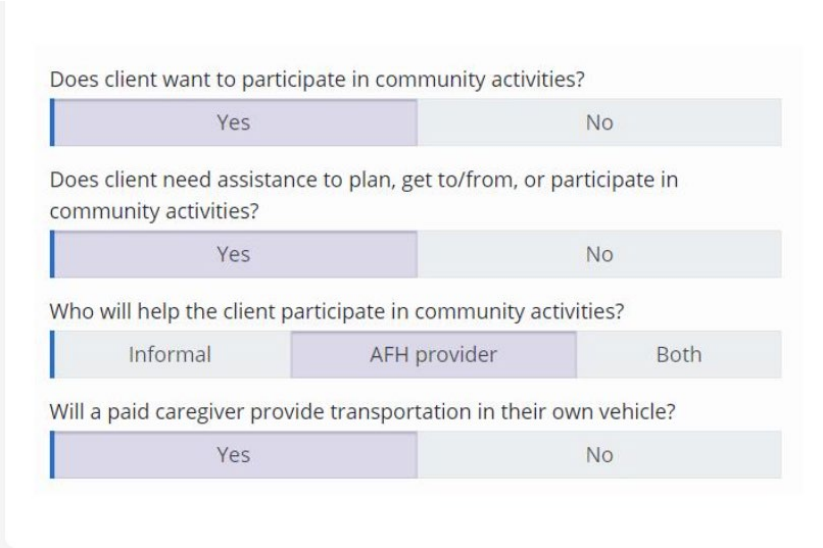
- Assisting residents to identify other people in the community who can accompany them at the event or provide support with transportation.
- Arranging for or providing transportation to and/or from the activity.
- Accompanying the resident during the event to provide personal care assistance.
- Looking for additional opportunities in which the resident may want to participate.

Note: Community Integration may be authorized for residents who receive:

- Specialized Behavior Support
- Meaningful Day Activities
- DDA Community Guide Service
- Expanded Community Services (Refer to LTC Manual Chapter 7f when authorizing ECS)

The AFH daily rate generated in CARE will include community integration when a resident:

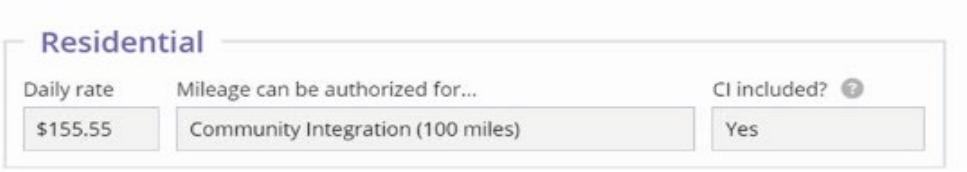
- Has an unmet or partially met need for assistance with community integration; and
- Chooses to receive assistance with community integration from the AFH provider.



The AFH daily rate generated in CARE will NOT include community integration when a resident:

- Does not need assistance because their informal supports provide all the CI assistance needed,
- Can independently access the community and does not need assistance, or
- Does not want to access the community.

- When community integration is assessed as a need in CARE, the CI adjusted rate will be automatically calculated when the authorization is created in CARE. ***Do not attempt to add rate manually (exception: if client is a resident in an approved HIV/AIDS AFH, case manager should add the CI rate to the published HIV/AIDS rate).***



- Community Integration rate adjustments and Community Integration mileage reimbursement is not available for PACE clients.

AFH Providers are expected to maintain documentation on the provision of assistance with community integration and this documentation must be made available to the CM/SSS upon request.

Community Integration Mileage Reimbursement

Adult Family Home providers who transport clients to access and participate in the community as authorized in the client's CARE assessment will be reimbursed per mile driven for up to 100 miles per month, per participating client based on the standard IRS mileage rate. This does not include PACE clients.

The Community Integration mileage reimbursement will be authorized when the AFH resident:

- Meets eligibility for Community Integration and the AFH provider or employee will be providing transportation in their vehicle; and
- Chooses to receive transportation from the AFH to and/or from community integration activities.

The Community Integration mileage reimbursement will NOT be authorized when the AFH resident:

- Does not need assistance because their informal supports provide all the assistance needed,
- Can independently arrange for all transportation needs,
- Does not want to access the community, or
- Is not driven to and from chosen activities by the AFH provider or employee.

Medical Mileage Reimbursement

Reimbursement is available to an Adult Family Home Provider who transports a resident to medical providers as outlined in the Department's service plan generated by CARE.

Reimbursement is available when Medicaid brokerage transportation will not meet the resident's needs.

- The AFH resident must have an assessed need for medical transportation as documented in the CARE service plan.
- Compensation will be paid on a per-mile-driven basis at the standard IRS mileage rate, up to a maximum of fifty (50) miles per month per resident.
- Mileage reimbursement for travel to medical appointments is different from Mileage reimbursement for community integration. Authorization for one does not preclude authorization for the other.
- Mileage reimbursement for travel to medical appointments is not available to AFH providers in the PACE program.

Medical Escort Fee

AFH providers will be able to request reimbursement for providing a medical escort to a Medicaid resident when all other means of both escort and transportation have been exhausted. In accordance with the CBA, AFHs who provide transportation and accompany an individual resident to a medical appointment will receive a rate of nineteen dollars and fifty-six cents ($19.56) per hour, up to a maximum of twenty-four (24) hours per client per calendar year for medical escort reimbursement.

When a client has a need for transportation documented in CARE and the AFH provider submits a request for reimbursement, the request must include:

- Documentation of the medical appointment,
- Documentation that informal supports were unavailable,
- The date the transportation was provided, and
- The actual start and stop time that was spent to provide an escort and transportation.

Upon receiving the request from the AFH provider, the CRM/SSS will:

- Note in an SER that the required documents have been received from the AFH provider including verification that informal supports were not available.
- Authorize payment for time spent escorting the resident to and/or from the medical appointment in ProviderOne using the Medical Escort Care code T1019 U5.
    - The authorization for payment must be submitted after the service was provided.
    - The Start Date and End Date must be the date the escort was provided.
    - The authorization will result in an auto-generated payment to the AFH provider.

Notes:

- Non-emergency medical transportation is a covered service under Apple Health; therefore, if informal supports are not available to provide transportation, an AFH provider must not be authorized for medical transportation or escort if that service is available through the Medicaid transportation broker.
- An AFH provider must submit documentation of the medical appointment and documentation that informal supports are unavailable for each appointment.
- The Medical Escort Care Fee is limited to 24 hours per calendar year. No duplicate authorizations are allowed.

SPECIALIZED DEMENTIA CARE PROGRAM

SDCP Eligibility Criteria

The eligibility for the SDCP program is defined in WAC 388-106-0033. To be eligible for the SDC program an individual must be:

- Financially eligible for CFC as defined in WAC 388-106-0277.
- May not be participating in the PACE Program or on a Residential Support Waiver (RSW).
- Functionally eligible for CFC as defined in WAC 388-106-0277.
- Be assessed by the comprehensive assessment reporting evaluation tool (CARE) as having a cognitive Performance Score of 3 or above.
  - Have a current or past with current intervention qualifying Behavior listed in WAC 388-106-0033 or a self-performance code of supervision, limited assistance, extensive assistance or total dependence in eating.
- Have written or verbal confirmation from a health care practitioner of an irreversible dementia diagnosis (such as Alzheimer's disease, Frontotemporal dementia (Pick's disease), Lewy Body dementia, Vascular dementia, Multi-Infarct dementia, Alcohol-related dementia, or Major Neurocognitive Disorder) or a diagnosis of Wernicke-Korsakoff syndrome.

Specialized Dementia Care Program Authorization

Any new authorizations for Specialized Dementia Care Program (SDCP) must have prior approval from ALTSA headquarters staff. New authorizations do not include extensions of current services.

As the diagnosis is irreversible, CM/SSS also do not need to obtain any additional approvals for SDCP when a client moves to another SDCP facility even if the client moves to another setting and then returns to a SDCP Facility.

SDCP Case Manager/Social Service Specialist Responsibilities:

- When a facility requests an SDCP approval for a current Medicaid client or a client converting from private pay that resides in the EARC-SDC section of the facility, and meets the eligibility criteria; the client must not be referred for the SDC program until:
  - A facility provides a copy of the NSA or NCP with clear documentation explaining what positive interventions and supports were used prior to placing a resident in an area that is restricted. An explanation of less intrusive methods of meeting the need were tried that did not work.
  - Document approval from the client or legal guardian to continue to reside in the SDC facility.

- If a facility did not provide a copy of the NSA or NCP; CM/SSS will need to request a copy.

- The CM/SSS must review the NSA or NCP to make sure that the facility is following Code of Federal Regulations (CFR) §441.301 (4)(F)(1) through (8) federal rules regarding the resident's rights and has documented any restriction or modification in the resident's Negotiated Service Agreement or Negotiated Care Plan. Send a copy to DMS.

- CM/SSS will need to complete initial CARE assessment for a conversion with documentation explaining what less intrusive methods and positive interventions of meeting the resident's needs that have been tried but did not work. Or an Interim assessment if client is currently on Medicaid services. Note: If the Interim assessment created to add required documentations results in a change in CARE classification a face-to-face Significant Change assessment will need to be completed.

- ***To document the modification of the resident's rights for SDCP:***
  The **Alzheimer's/dementia special care program** must be selected in the CARE/Treatment screen with the following documentation on the comment section explaining:

  - The specific client's need that is being addressed by moving the resident to an area with delayed egress. (It is not acceptable to state see behaviors in assessment, the need must be specific to the client and identified).
  - The positive interventions and supports as well as their location that were used prior to address with this need before placing the client in an area with delayed egress that were unsuccessful.
  - The informed consent of the resident/guardian agreeing to living in a setting with delayed egress. *Client must be asked regardless of cognition and response noted even when there is a durable power of attorney or power of attorney*.

- Verify that the Assisted Living Facility has a current EARC-SDC contract using the ALF Locator for Professionals & Providers.
- Preference is that the CARE Assessment be finalized, however, to support and facilitate successful transition planning assessments may be approved in pending status.
  - When the assessment is approved in pending status it is the SSS/CM's responsibility to ensure the client is still eligible once the assessment is finalized and prior to authorizing services.
  - If the client does not transition to a SDC facility based on a pending approval, the client will need additional approval in the future.

- Send the SDCP eligibility checklist form DSHS 14-534 to SDCP@dshs.wa.gov.

- When the CM/SSS receives an approval for SDCP authorization, the CM/SSS will need to send a copy of SDCP Eligibility Checklist form to DMS as part of client's record.

- Send a Planned Action Notice to the client or his/her representative of approval for Specialized Dementia Care Program using the SDCP rate.

- Complete the Financial/Social Services Communication 14-443 in barcode to notify Public Benefit Specialist of SDCP authorization rate approval.

Note: Federal rules also require periodic reviews to determine if the modification is still effective, necessary, or could be terminated. At annual review CM/SSS will need to:

- Re-assessed the need for and effectiveness of the restriction or modification with the client; and
- The modification or restriction continues to be necessary and effective or
- Should be discontinued (e.g., in the SDCP, this documentation could include that the setting with restricted egress continues to be the appropriate setting to meet this resident's needs and that the resident benefits from the services provided in this setting).

For more detailed information regarding modification to a Medicaid resident's rights and where to documents modification in CARE; refer to the Client Rights in HCBS Settings in this chapter.

The approval process:

- When approved or denied, the SDCP Program Manager will post SERs in CARE and will also notify CM/SSS via-email of the approval or denied.

- When CM/SSS received an approval for SDCP authorization; CM/SSS will need to send a copy of SDCP Eligibility Checklist form to DMS as part of client's record.

- Send a Planned Action Notice to the client or his/her representative of approval for Specialized Dementia Care Program using the SDCP rate.
    - Mark as "Approved" and check "other" in reason.
        - Write in SDC Program
        - In the "other comment" write "You are functionally approved for Specialty Dementia Care Program at a rate of $X.XX."

- Complete 14-443 to notify Public Benefit Specialist of SDCP authorization rate approval.

SDCP Authorization Process:

- When authorizing SDCP service in ProviderOne; CM/SSS will need to use SDCP approval rate with:
    - RAC Eligibility 3052 – CFC-Specialized Dementia Care Program

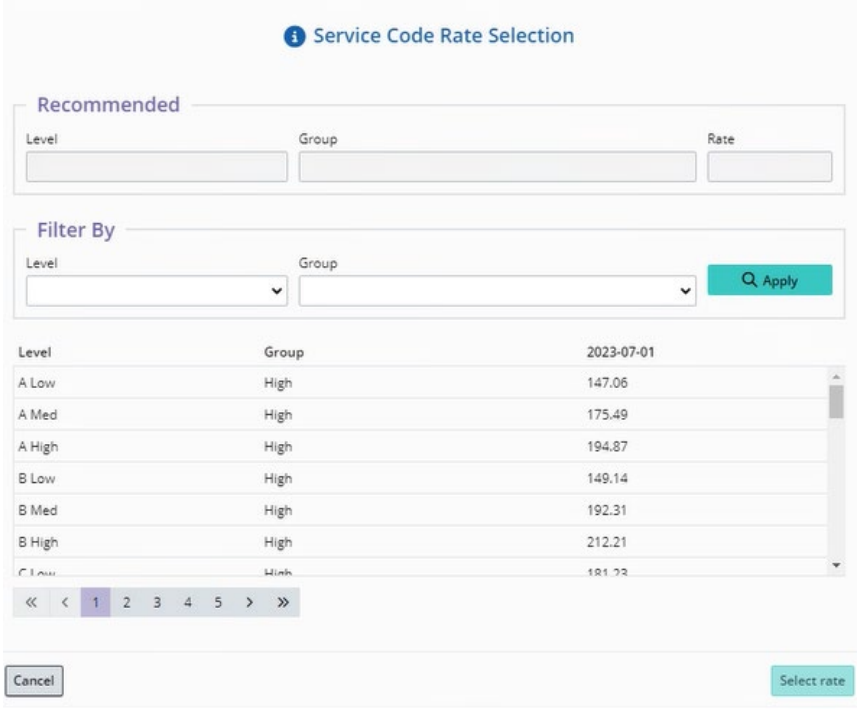
- RAC Eligibility 3002 – CFC plus COPES-Specialized Dementia Care Program

- Service code of T1020_U4 (Special Dementia Care Services).

- Select the Reason Code based on the service or rate of the SDCP being authorized:
  - Specialized Dementia Care
  - Specialized Dementia Care Plus
  - Specialized Dementia Care Enhanced
  - Specialized Dementia Care Acute Care – Reminder this rate is only for the facility the client discharges directly to from an Acute Hospital Bed. The rate does not continue if the client changes SDCP-ALF or any other settings.

For more information on SDCP Reason Codes please review HCS Management Bulletin H24-021.

Rates are now showing in CARE when you select the "Lookup rate" button on the authorization. To select the correct rate the CARE Classification Leve and the Cost Service Area will be needed:



- If a client transfers to another Specialized Dementia Care facility, the CM/SSS is not required to send another SDCP eligibility checklist. The CM/SSS will need to check if the facility has EARC-SDC contract via the ALF Locator for Professionals & Providers.

- The department **will not approve retroactive payments** unless the client is converting from private pay to Medicaid, the assessment has been completed and in current showing the individual is eligible, and the individual was waiting for a Public Benefit Specialist eligibility determination that was delayed.

- It is permissible to authorize Fast Track on CFC with Specialized Dementia Care. When a client is eligible (and for Fast Track we are presuming eligibility), the client is eligible for all services they are assessed for.

The daily reimbursable rate for this service is set by the Legislature and based on an individual's CARE Assessment Classification and the High Cost or Standard Cost Area they are receiving services. Rates can also be found at Office of Rate Management under Home & Community Services Rates Excel | PDF.

DETERMINING ROOM AND BOARD

Determining a client's room and board, and client responsibility towards the cost of their personal care. Clients are required to pay towards the cost of their room and board and may be required to pay towards the cost of their personal care services. Clients may keep a personal needs allowance (PNA) for clothing and personal, incidental items. Refer to Social Services Authorization Manual and Program standard for income and resources | Washington State Health Care Authority for detailed information regarding the determination of client's PNA, room and board, and client responsibility towards the cost of their personal care for CFC, CFC+COPES, MPC, and RSW clients in residential settings.

For MAGI clients in residential setting (AFH, ARC, EARC, and AL), CM/SSS will need to determine the amount of R&B. The Client Responsibility Notice Client Responsibility Notice (DSHS 18-720) must be completed and sent to clients or client representatives.

The HCS MAGI Room and Board Calculator can be found under **Resources** on the Affordable Care Act Resources.

For more information with R&B calculation refer to Social Services Authorization Manual.

SUPPLEMENTING THE MEDICAID RATE

- Supplementation of the Medicaid daily payment rate is an additional payment requested from a Medicaid recipient or a third-party payer by an Adult Family Home (AFH) contractor or a licensed Assisted Living (AL) contractor with a contract to provide adult residential care (ARC), enhanced adult residential care (EARC), assisted living (AL) services, or an enhanced services facility (ESF).
By federal rule (42 CFR 447.15), the state must limit participation in the Medicaid program to only providers who accept the Medicaid state payment and client participation as payment in full.

Supplementation for services or items

The AFH, AL, ARC, ESF, or EARC contractor **may not** request supplemental payment of a Medicaid recipient's daily rate for services or items that are covered in the daily rate, and the contractor is required to provide:

A. Under licensing Chapter 388-76 WAC, Chapter 388-78A WAC, Chapter 388-107 WAC, and/or
B. In accordance with his or her contract Chapter 388-110 WAC with the department; and
C. As outlined in the resident's CARE plan.

Supplementation for a unit or bedroom

When a contractor only has one type of unit or all private bedrooms, the provider may not request supplementation from the Medicaid applicant/resident or a third party, unless the unit or private bedroom has an amenity that some or all the other units or private bedrooms lack e.g., a bathroom in the private bedroom, a view unit, etc.

A facility cannot request supplementation for a private room when the room is only large enough for one person.

Adult Family Homes are required to provide a minimum of 80 square feet for single occupancy rooms. Double occupancy rooms must be at least 120 square feet. More information on bedroom space in Adult Family Homes can be found in WAC 388-76-10690.

Sleeping rooms within EARCs and ARCs must be no less than 80 square feet for a one-person room and no less than 70 square feet per person for a two-person room. Private units within an ALF must be a minimum of 220 square feet. More information on Resident Units can be found in WAC 388-78A-3010.

When a contractor may request supplemental payment

A. Before a contractor may request supplemental payments for items **not covered in the Medicaid rate**, the contractor must have a supplemental payment policy that has been given to all applicants at admittance and to current residents. The policy must be in accordance with WAC

388-105-0050 and WAC 388-105-0055 and must follow the department contract per WAC 388-76-10205 and WAC 388-105-0050. The Contractor may not request supplemental payment of a Medicaid recipient's daily rate for services, items covered by the Medicaid daily rate, move-in fees, and/or refundable or non-refundable deposits, in accordance with Chapter 388-76 WAC, RCW 70.129.030 (4), RCW 74.39A.901, this Contract, and the Client's NCP.

B. The Contractor must disclose in the Admission Agreement per WAC 388-76-10540 and the 'Policy on accepting Medicaid as a payment source' WAC 388-76-10522, any changes that could occur if a resident becomes eligible for Medicaid funding. The Contractor shall refund to the Client, on a prorated basis, the amount prepaid for care of that Client if the Client becomes eligible for Medicaid funding or moves out of the home before the end of the month.

C. If a family member or friend purchases additional items or services through the contractor that are not provided for under the Medicaid contract, he or she must pay the Contractor directly to avoid jeopardizing the resident's financial eligibility.

In all cases of supplementation, the contractor is required to notify the department case manager of the additional charges, what they are for, and who is paying them. Violations of the supplementation rules will be reported to the Complaint Resolution Unit (CRU). The CRU will investigate and refer to the Medicaid Fraud Unit if appropriate. The Complaint Resolution phone number is: **1-800-562-6078**.

Examples of supplementation

1) If a residential room is approved by Residential Care Services (RCS) for double occupancy and a Medicaid resident's family wants to pay extra for a private room, the contractor can charge extra if the facility has included this in their supplementation payment policy. The exception would be when the facility agreed in the NSA/NCP to provide a private room to meet the resident's needs. If the room is a single occupancy room, the provider is not allowed to charge extra for the room. The extra fee associated with a double occupancy room should be a reasonable amount. If the resident or family feels it is not a reasonable amount, they should be directed to call the CRU. If the family chooses to pay this extra amount, they must pay the provider directly.

2) In the case of a Medicaid client who is assigned participation greater than the cost of care, and the individual wishes to use their excess income to purchase additional care and/or services from the provider, the resident can use his own financial resources to hire additional assistance following the same guidelines for supplementation. The services must be above and beyond what the facility is already contracted to provide for any resident in the facility under their Medicaid contract. The facility cannot stop providing any current level of services to the resident nor have the person hired by the resident take over any services required under the contract and the client's CARE plan.

3) If resident prefers a brand name incontinent brief rather than the generic brand the home provides. The client would be expected to pay the difference in price.

Note: When a Medicaid client is related to the AFH provider and is residing in a licensed and contracted room; the CM/SSS must authorize AFH services using the daily rate based on CARE classification (the same as an unrelated client).

CASE MANAGERS/SOCIAL SERVICE SPECIALISTS RESPONSIBILITIES

An AAA or HCS CM/SSS may assist a client to enter a residential facility. HCS provides initial and ongoing case management to all Medicaid clients in residential facilities. The CM/SSS is responsible for:

- Completing Initial, Annual, and Significant Change Assessments,
- Doing a 30-day contact,
- Assisting the client with identifying residential setting options,
- Coordinating admissions with providers,
- Reviewing the assessment, service summary, and negotiated service agreement/ negotiated care plan,
- Ensuring Client Rights,
- Requesting Necessary ETRs,
- Completing Bed Hold requests,
- Monitoring Social Leave,
- Coordinating with RCS, and
- If necessary, helping to coordinate a client's move.

NOTE: If a copy of the NCP or NSA has not been returned within 30 days but has been requested by the CM/SSS, make a report to the Complaint Resolution Unit (CRU) by phone at 1-800-562-6078 or online.

Assisting a client to move into a residential setting.

Prior to the move the CM/SSS must:

- Complete a CARE Assessment to determine functional eligibility.
- Discuss/Review with the client, and/or his/her representative the Client's Rights and Responsibilities Form 16-172 and answer any questions about the client's rights and responsibilities. Have the client or the client's representative sign two copies of the form when

completing the initial CARE assessment. File one copy in DMS and give the other copy to the client.

- Discuss with the client, and/or his/her representative, client's rights in HCBS settings and Long-Term Care Resident's rights as outlined in Chapter 70.129 RCW and the Client's Rights Section of this chapter.

- Discuss with the client, and/or his/her representative about Medical/Social Leave Policy as outlined in WAC 388-105-0045 and WAC 388-110-100. For detailed information, refer to the Bed Hold and Social Leave Policy section of this chapter (Bed Holds for Medical Leave).

- Provide information to clients so they can make informed choices about residential options.

- Discuss with the client his/her preferences identified on the Care Plan screen in the CARE assessment and then assist the client in selecting a residential setting that will meet his/her needs. Document in the SER the client's choice of long-term care setting and provider.

- Ensure that the client meets the functional and financial eligibility for HCS programs.

- Coordinate with the HCS residential CM/SSS assigned to the facility. For details information refer to LTC Manual Chapter 5.

- Review and provide copies of the Assessment Details and Service Summary to the provider prior to a client's admission and document in SER.

- Have the client approve and sign the Department's plan of care and inform the client and/or their representative of any client responsibility and room and board. Document plan approval in the SER. For addition information refer to LTC Manual Chapter 3.

- Verify if the AFH/ALF is licensed and contracted by clicking the following link:
    - AFH Lookup
    - ALF Lookup

Verify Specialty Designation

Clients who have a developmental disability, mental illness, or dementia can only be served in facilities with a specialty designation. Case Managers/Social Service Specialists are required to verify if the provider has the correct Specialty Designation training by going to the RCS "AFH Look-Up" to verify if the provider has completed the Specialty Designation training. This look-up is not always up to date. *If the provider has proof of a certificate* but is not listed on the lookup as having completed the specialty designation, follow these steps:

1**. To check for Mental Health or Dementia Specialty Training:**

Go to the Providers and Professionals page on the ALTSA website at:
https://fortress.wa.gov/dshs/adsaapps/Professional/training/training.aspx

- On Find a Training Class Section
- Check both boxes in the Mental Health and Dementia Specialty section, then clicks on **Find Instructors box** (at the bottom)
- Once you click on Find Instructors box; you will find the list of approved instructors in the training class search results section.
- Review the list to verify the name of the instructor who signed the certificate.

2. To check for Development Disability Specialty Training: To find Development Disabilities Specialty Training, please go here.

Note: DDA, MH or Dementia. If the person who signed the certificate's name appears on the list of approved instructors, the CM/SSS will need to document in the client's SER verifying that the provider does have the specialty designation required to care for client with Developmental Disability, Mental Health or Dementia diagnosis.

Adult Family Homes/Assisted Living Facilities Specialty Training Requirements must be the Manager Specialty Training. Manager specialty training is required for assisted living facility administrators (or designees), adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that serve residents who have one or more of the following special needs: developmental disabilities, dementia, or mental health per RCW 18.20.270 and RCW 70.128.230 and WAC 388-112A-0400.

If a resident develops special needs while living in a facility without a specialty designation the provider, entity representative, resident manager and facility administrator (or designee) has 120 days to complete manager specialty training or developmental disability caregiver training, and demonstrate competency per WAC 388-112A-0490.

Providers serving residents with different specialty needs. When providers serve two or more residents with different specialty needs, they must obtain a separate specialty designation for each of the specialty needs. CM/SSS are required to verify if the provider has the correct Specialty Designation training.

Providers serving residents that have more than one special need. When a provider serves a resident that has needs in more than one of the special needs areas, by WAC 388-112A-0410, the AFH, ALF, or ESF must determine which of the specialty training classes will most appropriately address the overall needs of the resident and ensure that the appropriate specialty training class is complete. If additional

training beyond the specialty training is needed to meet all the resident's needs, the AFH, ALF, or ESF must ensure additional training is completed.

If a resident has more than one specialty needs, CM/SSS must document in SERs which specialty training the AFH, ALF, or ESF has determined to meet all the resident's needs.

DSHS form 10-234a, Individual with Complex Behaviors (Aging ang Long Term-Support Administration) applies to HCS and DDA clients in all residential settings. Send the original copy of the form to the provider and a copy to the Hub Imaging Unit (HIU) to become part of the client's record.

Note: Assisted Living Facilities are required by (WAC 388-78A-2060) to do their own preadmission assessment prior to admitting any resident. Adult Family Homes are NOT required to do the same. AFH providers are however required to obtain an assessment completed by the CM/SSS, or a qualified assessor that documents the prospective client's needs and preferences before admitting the client to the home, (WAC 388-76-10330)

Once admission is approved the CM/SSS will need to:

1. Help coordinate the client's move, if needed.

2. Notify the Public Benefit Specialist of the date of admission, the program authorized, and any other pertinent information using the Financial/Social Services Communication Form 14-443.

3. When client's responsibility and room and board is determined, authorize the payment in ProviderOne to the provider effective the day the client moves into the facility. Refer to Social Services Authorization Manual.

4. Notify the receiving CM/SSS of the admission date to the new facility. Inform the receiving CM/SSS that a 30-day contact is required within that timeframe. Refer to LTC Manual Chapter 5 for additional clarification on when a 30 day visit is required instead of a telephone contact within 30 days of admission.

5. CM/SSS must complete the Individuals with Complex Behaviors (DSHS 10-234a) form for clients with challenging behaviors (assaultive, destructive, self-injuries, inappropriate sexual behaviors, or history of misdemeanor behavior). Refer to LTC Manual Chapter 5; under resources for additional information.

6. Transfer the client's file and CARE assessment using instructions found in the Assessment Chapter of the LTC Manual Chapter 3.

Assisting with community integration in AFHs

CM/SSS responsibilities include:

- Assessing the need for assistance with community integration,
- Assessing the need for assistance with community integration mileage reimbursement for AFH providers,
- Authorizing community integration mileage reimbursement for AFH providers, and
- Completing planned action notices.

ASSISTING A CLIENT WITH RELOCATION

Clients may be required to move for several reasons. This section outlines the responsibilities for RCS, HCS and providers when a facility is requiring residents to move.

When a client wants to move out of the facility, the facility will need to assist and coordinate the client's transfer or discharge. Clients may move at will and are not required to give notice.

RCS responsibilities

As a result of a facility inspection/survey, Residential Care Services can:

(a) Issue a statement of deficiency.
(b) Stop the admission of new residents in facilities. When RCS determines the need for a Stop Placement, they will notify appropriate local entities and governmental organizations of the decision.
(c) Suspend or revoke a facility's license. When RCS decides to revoke or suspend the license of a facility, both HCS and RCS work together to ensure the transfer of Medicaid clients to another residential setting.
(d) Close a facility.

Be aware that **notices from RCS are confidential** when related to potential or planned closures, License Revocations, and Summary Suspensions. Also note that the facility administration, clients and families will not be advised of pending action.

HCS responsibilities

When an ALF, AFH, or ESF is closed, HCS is responsible for assisting clients to relocate in a timely manner. Moving can be a stressful time for any client. When assisting a client to move, you may need to use other resources such as:

A. The Long-Term Care Ombudsman Program,
B. The regional RCS staff assigned to that facility,
C. The RCS Complaint Resolution Unit,
D. Your supervisor or Regional Administrator; and
E. The headquarters Residential Program Manager.

When a Medicaid client requests to move, you will need to:

1. Work with the facility staff.

2. When eligible, consider using the discharge resources if the client is moving to a less restrictive setting. See LTC Manual Chapter 10 more information on relocation resources.

3. Coordinate with other CM/SSSs, if necessary (e.g., DDA or BHA).

When a provider wants a client to move

1. Review or complete an assessment and review the current Negotiated Service Agreement/Negotiated Service Plan/ Person Centered Service Plan to determine if there is a legitimate reason for the move that is consistent with RCW 70.129.110. If after reviewing/completing the assessment and reviewing the NSA/NCP/PCSP:

    a. You find the facility has tried to reasonably accommodate the client's care needs and the care needs still exceed the license or contract limit of the facility; you will need to coordinate the relocation of the client to a different setting. If necessary, contact the RCS District Manager to obtain clarification of any license or contract requirements.

    b. You find there is no valid reason for discharge and the client wants to stay, try to resolve the issue with the provider. If you are unable to resolve the conflict, consult with your supervisor about referring the case to the Residential Care Services Complaint Resolution Unit at: **1-800-562-6078.** Also, let the client know he/she can contact the Ombudsman or file a complaint with RCS.

Note: Be aware that periodically facilities may require the residents to sign new/revised admission agreements. Residents and informal supports should carefully read these agreements to ensure that rules surrounding reasons for eviction are still acceptable. Residential facilities cannot discharge a resident simply because their status changes from private pay to Medicaid unless it is spelled out in the admission agreement and resident signs agreeing to it.

Other situations where moving the client is problematic may occur when the:

a. Client wants to move from the facility and the family/alternate decision maker does not want the client to move, or

b. **F**amily or alternate decision maker wants the client to move and the client desires to remain in the facility. In these situations, refer the situation to the Ombudsman for resolution.

For any change in setting, you will need to update payment information:

1. The department does not pay for the last day of service if a client moves out of the facility unless the last day of service is the date of death.

2. The CM/SSS must terminate the P1 authorization line using the date before the client moved out of the facility.

3. Notify the Public Benefit Specialist via the electronic DSHS 14-443 of the change in client residence, circumstance, date of the action and other pertinent information.

When a facility voluntarily closes or does not renew their contract:

WAC 388-76-10615; RCW 70.129.110; RCW 18.20.440.

1. For facilities that have a large number of clients, develop a plan with the Regional Administrator to locate new facilities and relocate the clients. This effort may involve several CM/SSSs from around the region.

2. Work with the facility staff when transferring/moving a client.

3. If a client is moving to a less restrictive setting, consider using the residential discharge allowance for relocation. Follow the discharge allowance procedures outlined in LTC Manual Chapter 10.

4. If the client is case managed by DDA or BHA, coordinate the move with other CMs.

For additional information regarding termination of a Medicaid contract; refer to section II. **Contract Types** of this chapter.

When the facility's license is suspended and/or revoked, or there is an involuntary closure:

1. The CM/SSS will need to coordinate with RCS to ensure the clients move in a timely manner.

2. Provide assistance in relocating private pay residents if they request it.

When there is a Stop Placement:

Get RCS approval for any clients who are hospitalized or in a nursing facility for a short stay and want to be readmitted to the facility with the Stop Placement. A private pay resident converting to Medicaid is not considered a new resident.

Provider responsibilities

Before transferring or discharging a client, the provider must:
First, attempt, through reasonable accommodations, to avoid the transfer or discharge, unless agreed to by the client.

a. In SDCP contracted facilities, a provider is required to have a policy to obtain consultative resources to address behavioral issues for residents prior to discharge.

2. Notify the client, and representative, and make a reasonable effort to notify of the transfer or discharge and the reasons for the move in writing, and in a language and manner he/she understands, 30 days prior to the discharge date, unless:
   a. There is an emergency per RCW 70.129.110; or
   b. The client has been in the facility less than 30 days.

3. Record the following in the client's record:
   a. The reason for transfer or discharge,
   b. The effective date of transfer or discharge, and
   c. The location to which the client is transferring or discharging.

4. Refund any unspent participation within 30 days of the client's move. The provider and the client will receive correspondence from ProviderOne notifying them of the change in client responsibility. Providers are required to refund the difference between the amount paid and the new amount identified in correspondence to the client. If the client or client's family notifies you that they have not received the expected fund, report the incident to the RCS Complaint Resolution Unit at: 1-800-562-6078.

Residential Facilities, including ESFs, are required to:

1. Document the significant changes in a client's condition in the NSA, NCP and PCSP and provide a copy a to the department CM/SSS.

2. Notify a resident's next of kin, guardian, or other individuals or agencies responsible for, or designated by, the resident as soon as possible regarding:

   a. A serious or significant change in a resident's condition.
   b. The relocation of a resident to a hospital or other healthcare facility.
   c. The death of a resident. In case of death, the facility must notify the coroner, if required by RCW 68.50.010.

3. AFHs should notify the CM/SSS by submitting DSHS form 15-558, Adult Family Home (AFH) Resident Significant Change Assessment Request if there has been a significant change in the client's care needs, whether or not related to a medical discharge.

   When Notified of a Change in Resident Condition Case Managers/Social Service Specialists are required to:

   1. If requested by an ALF, AFH, or ESF, prior to completing a significant change; the CM/SSS must request a copy of the NSA, NCP, and/or PCSP from the facility with documentation of the changes in the client's care needs. The CM/SSS will need to review the client's NSA, NCP, or PCSP to determine if the changes meet the criteria of a significant change as defined in WAC 388-76-10000 for AFH, WAC 388-78A-2020 for ALF, and WAC 388-107-0060 for ESF.

   2. Perform a Significant Change assessment if there has been a change in the client's condition that warrants a new assessment.

   3. If the new assessment results in a change to the daily rate, remember that the new payment cannot be earlier than the date the assessment was finalized. Also, staff cannot authorize payment until they have obtained the client's consent, and the assessment is in **Current status**.

Refer to Chapter 3 for additional information regarding Significant Change Assessments and Getting Approval on the Plan of Care.

For PACE clients, please note that each PACE organization is autonomous and has their own internal procedure for monitoring significant change requests. PACE contracted providers are to submit their significant change requests to the PACE organization, as the case management entity, not directly to HCS and then follow the prescribed communication protocol required by the PACE organization for those requests.

Reviewing the Negotiated Service Agreement/Negotiated Care Plan

Negotiated Plans between the resident and the facility.

Assisted Living Facility:

- The Assisted Living Facility (ALF) per WAC 388-78A-2130 (2) is required to develop a negotiated service agreement (NSA) for each resident using the resident's preadmission/full assessment and using the CARE assessment for Medicaid residents, within 30 days of the resident's admission. The NSA must include a list of

the care and services to be provided, with details on the resident's preferences and choices, and how services will be delivered to accommodate these preferences and choices.

- The ALF per WAC 388-78A-2120, is required to review and update each resident's negotiated service agreement (NSA) annually, when there is a significant change in resident's physical, mental, or emotional functioning, or when the negotiated service agreement no longer adequately addresses the resident's current care needs and preferences. The Assisted Living Facility (ALF) must involve the resident, the resident's representative to the extent he or she is willing and capable, the department's case manager/social service specialist for a Medicaid resident, and facility staff when developing the resident's negotiated service agreement.

Adult Family Home:

- The Adult Family Home (AFH) per WAC 388-76-10355, is required to develop the negotiated care plan (NCP) by using the resident assessment, or CARE assessment for Medicaid residents. The NCP must include a list of the care and services to be provided, with details on the resident's preferences and choices, and how services will be delivered to accommodate these preferences and choices.

- Per WAC 388-76-10360, the AFH must ensure the negotiated care plan (NCP) is developed and completed within 30 days of the resident's admission. When developing the NCP per WAC 388-76-10370, the AFH must involve the resident, the resident's representative, professionals involved in the care of the resident, and the department case manager/social service specialist for Medicaid clients. Per WAC 388-76-10375, the AFH must ensure that the negotiated care plan is agreed to and signed and dated by the resident and AFH provider.

- The AFH per WAC 388-76-10380, is required to review and update each resident's negotiated care plan (NCP) annually, when there is a significant change in the resident's physical, mental, or emotional functioning, or when the negotiated care plan no longer adequately addresses the resident's current care needs and preferences, or at least every twelve months.

- For Medicaid clients (WAC 388-76-10385), the Adult Family Home must give the department case manager/social service specialist a copy of the negotiated care plan each time the plan is completed or updated, and after it has been signed and dated. The AFH has 30 days from the time the assessment is moved to current to return the NCP, regardless of the reason for the update. The AFH provider can send a copy of their negotiated care plan through email or fax to the department case managers/social service specialists.

Enhanced Service Facility:

- The Enhanced Service Facility (ESF) must develop an initial Person-Centered Service Plan (PCSP) as a replacement for the Negotiated Service Agreement/Service Plan for each resident prior to the admission as outlined in WAC 388-107-0110, a Comprehensive Person-Centered Service Plan within 14 days of the move-in date per WAC 388-107-0120, upon significant change in the client's condition, upon the client's request, or at least every 180 days if there is no significant change in condition per WAC 388-107-0130.

Case Managers/Social Service Specialist are required to:

- Review the NSA/NCP/PCSP for Initial, Annual, and Significant change assessments and compare it to the current CARE assessment. If the NSA/NCP/PCSP does not address all the client's current care needs, the CM/SSS must have a discussion with the Assisted Living Facility staff, Adult Family Home provider, or Enhanced Services Facility staff regarding how the client's current care needs will be met.

- If there are changes in the client's needs that would affect the CARE classification and/or change to the caregiver instructions, the CM/SSS must complete a Significant Change Assessment.

Send NSA/NSP/PCSP to the HIU:

- When the NSA/NCP/PCSP has been reviewed and finalized by the CM/SSS, make a copy and send the original back to the facility.

- Send the copy of the NSA/NCP/PCSP to the Hub Imaging Unit (HIU) to become part of the client's record.

Additional information regarding Residential Case Management Responsibilities can be found in LTC Manual Chapter 5 – Case Management.

CLIENT RIGHTS

All residents living in licensed assisted living facilities, and adult family homes are protected by the rights granted in Chapter 70.129 RCW, Long-Term Care Residents Rights**.** SSS/CMs need to be familiar with the rights outlined in Chapter 70.129 RCW. As an SSS/CM, you are responsible for reporting any significant or repeated resident rights violations to the RCS Complaint Resolution Unit (CRU) for review and investigation. A provider's failure to respect these rights is a violation of licensing requirements.

ESF residents have specific rights, as outlined in WAC 388-107-0190.

Abuse, Neglect, Abandonment, or Exploitation

All DSHS employees are mandatory reporters. When you have reasonable cause to believe that abuse, neglect, abandonment, or financial exploitation of residents in facilities that are currently licensed/contracted (or required to be licensed/contracted) has occurred, you must report the concern to CRU. Residential Care Services (RCS) is responsible for the intake, screening, and investigation. In addition, under certain circumstances you are also required to call law enforcement. See the Adult Protective Services APS Policy & Procedure site for more information about mandatory reporting requirements.

Client Rights Violations

Single incidents, not classified as abuse, neglect, abandonment, or financial exploitation, may be handled through consultation and education with the provider or by involving the Long-Term Care Ombudsman Program. The Ombudsman program is responsible for protecting the rights of all residents and handling complaints from facility residents. The Long-Term Care Ombudsman can be contacted at **1-800-422-1384.**

CLIENT RIGHTS IN HCBS SETTINGS

The federal rules regarding Home and Community Based Settings (Medicaid contracted ALFs, AFH, and ESFs) mandate basic participant rights in all home and community-based settings. These are the rights listed in the federal rule:

- Full access to the greater community,
- Receive services in the community,
- Control over personal resources, and
- Autonomy and independence in making life choices, including but not limited to daily activities, physical environment, and with whom to interact.

In addition, in provider owned and controlled residential facilities, participants have the right to have:

- A lockable entry door
- A choice of roommate
- Control of her or his own schedule
- Access to food at any time
- Visitors of their choosing at any time
- Protections from eviction comparable to landlord tenant law

Documenting modifications to Client Rights:

Any time clients are not afforded all the rights required in federal rule, the rules require specific documentation. To meet these federal requirements with any modifications to a Medicaid resident's rights, the following conditions must be met and documented in the Negotiated Service Agreement, Negotiated Care Plan, or Person-Centered Service Plan and in CARE assessment. The documentation must include:

- Identify a specific and individualized assessed need for this restriction or modification (Example – Unsafe wandering behavior).
- The positive interventions and supports that were used prior to placing this restriction or modification on the resident.
- Less intrusive methods that have been tried but did not work to meet the need (What accommodations or strategies were made to address the behavior prior to this that did not work).
- A clear description of the restriction or modification.
- An assurance that the interventions and supports will cause no harm to the individual.
- The informed consent of the resident for the use of this restriction or modification.

Note: Prior to moving a resident to a facility or an area within a facility with delayed egress, the CM/SSS must ensure that all the conditions above are met and documented. If a facility is requesting the move, request a copy of their NSA/NCP/PCSP indicating the changes of client's care needs with the above documentation. The CM/SSS must also document the reason for the move in the CARE assessment as described below.

Where to document modifications to Client Rights in CARE:

The CM/SSS must provide clear documentation by explaining the reason of any modification to client rights in the most relevant location:

- In the intervention screen for a behavior, if the modification is relevant to any of the behaviors,
- In the comments/caregiver instructions section, if it pertains to the one of ADL or IADL screens,
- In the pertinent medical history screen or
- In the psych/social screen if there is no other applicable location,
- In the comments/caregiver instructions section if it pertains to the Specialized Dementia Care for Alzheimer's/dementia special care program.

Review the Plan and a need for modification:

Federal rules also require periodic reviews to determine if the modification is still effective, necessary, or could be terminated.

The plan must be reviewed and revised at least:

- Every 12 months, or
- When the client's circumstances or needs change, or
- At the client's request

Facilities must document the following in the annual NSA/NCP/PCSP and as indicated by a significant change in the resident's condition that the facility has reviewed the need for and effectiveness of the restriction or modification with the resident; and

  - The modification or restriction continues to be necessary and effective **OR**
  - Should be discontinued.

For example, for the Specialized Dementia Care Program, this documentation could include whether the setting with restricted egress continues to be the most appropriate setting to meet this resident's needs and that the resident continues to benefit from the services provided in this setting.

Note: If the client or client's family notifies you of any violation of HCBS rules, you must report the violation to the RCS Complaint Resolution Unit at: 1-800-562-6078.

EXCEPTION TO RULE

You may need to request an Exception to Rule (ETR) for some of your clients. ETRs for increases in the daily rate related to personal care, must be approved by the HQ ETR committee. For related policy see Chapter 3. All requests related to a daily rate increase must be completed on the ETR/ETP screen in the Client Details folder of CARE and processed electronically for review and approval. For instructions related to the functionality in CARE Web, refer to the CARE Web help files (Assessors Manual).

For AFH Provider post card notices about ETR requests; refer to LTC Manual Chapter 3.

Bed Hold ETRs may be requested; please submit ETR requests to the AFH or ALF Policy Program Manager for consideration. For more information, see the Bed Hold section of this chapter.

RESIDENT CHOICE REGARDING ALF ROOM EXEMPTIONS

Physical Plant Exemptions in an AL Room

Only RCS may grant an exemption to the requirements provided in WAC 388-110-140 in accordance with WAC 388-78A-2820. If any of the items listed in WAC 388-110-140 are not present in the Medicaid resident's room, and an exemption has not been granted by RCS, report this to CRU.

- According to WAC 388-110-140, (2) (a), and (b) a facility with an AL contract is required to provide each resident a private apartment-like unit that is a minimum of 220 square feet.

Examples of exemptions in Assisted Living settings are included below:

- Residing in a room that does not meet the physical plant requirements identified in WAC 388-110-140; or
- According to WAC 388-110-140, (2) (a), and (b) a facility with an AL contract is required to provide each resident a private apartment-like unit that is a minimum of 220 square feet.

The provider must offer the client a choice of units that meets contract requirements. The request to remain in a unit that does not meet the contract requirements or to share a unit must be the client's choice. The client must be advised of the physical requirements (under WAC 388-110-140) that they are entitled to have.

When a client is residing in an exempted room, the CM will continue to authorize the ALF rate.

Sharing an AL Room

Residents residing in AL rooms are entitled to private units. Clients may choose to share their room with another resident, either related or unrelated.

Through June 30, 2022, when two clients are sharing a room, the CM will authorize payments for the EARC daily rate effective the day that the second resident moves into the shared room. **July 1, 2022**, the AL daily rate and the EARC daily rate are now equal. CMs do not need to make any authorization adjustment when two clients are sharing a room.

When two residents reside in a two-bedroom apartment-like unit, each resident has their own bedroom, and they share other amenities such as kitchen area with refrigerator, microwave oven, range or cooktop, bathroom, etc., the CM/SSS may authorize the AL rate using the AL service code.

Documenting Resident Choice:

Once the HCS CM/SSS has been notified that a client would like to share a room or is residing in a room that does not meet physical plant requirements, the HCS case manager will meet with the client or their representative to notify client of their room rights.

Use DSHS Form 15-447, Resident Choice Regarding Assisted Living Facility (ALF) Room Requirements (Home & Community Services) to document your discussion with the client and the client's choice regarding:

1. Residing in a room that does not meet the physical plant requirements,
2. Residing in a room that has been granted an exemption from RCS when the client is converting from private to public assistance.; or

3. Sharing an AL room with another resident.

When completing DSHS Form 15-447:

1. Enter the specific room number.
2. For a room that does not meet physical plant requirements:
    a. Check which of the listed items are missing from that room.
    b. Select the client's choice to remain in a room that does not meet the contract requirements for an AL under WAC 388-110-140 (listed on the back of the form)
3. When a client wishes to share an AL room with another resident:
    a. Select the name of the resident that will be sharing the room
    b. If two Medicaid residents are wishing to share a room, separate forms will need to be completed for both clients.
4. Have the client sign the document.
5. Send the form to HIU to be placed in the client's file.

The Resident Choice Regarding Assisted Living Facility (ALF) Room Requirements (Home & Community Services) form only applies only to the specific room number and only for the resident(s) listed on the form. The agreement does not permit other Medicaid residents to occupy the room, nor does it permit the residents listed on the form to be relocated to another "non-qualified" room. If either resident chooses to relocate within the facility listed, arrangements should be made for each of them to move into a room that meets the Assisted Living Facility physical plant requirements.

The DSHS form 15-447 not required for married couples who request to share an apartment-like unit under an assisted living contract if both residents understand that they are each entitled to live in a separate private unit; and both mutually request to share a single apartment-like unit.

Note: If a facility wants to request more money for non-contracted room; please follow the supplementation policy.

Documenting the client's approval in CARE:

1. Enter the room number in "ALF/ESF Room #" box located on the Residence screen in CARE.
2. For clients, including married couples, wishing to share an AL room, select "Shared Room in AL" Category and Type in the ETR/ETP screen. This selection documents the client's approval.
3. Submit the ETR request to the supervisor or SHPC for field review and approval.
4. Document in the SER the actions taken and the client's approval.

BED HOLD FOR MEDICAL LEAVE

Per WAC 388-105-0045 (2), residential facilities (ESF, AFH, ARC, EARC, or AL) are required to hold a client's bed for 20 days when the client is discharged for medical reasons to a nursing home or hospital.

Per WAC 388-105-0045 (6), a Medicaid resident's discharge for a short stay in a hospital or SNF must be longer than 24 hours before a bed hold can be authorized. This only applies to the following residential facilities: ESF, ARC, EARC, and AL.

Per WAC 388-105-0045 (5):, Adult Family Homes (AFH) may be authorized Bed Hold for a Medicaid resident's discharge for a short stay in a hospital or SNF lasting less than 24 hours, as long as all other criteria are met.

Per WAC 388-105-0045 (8), if a resident is discharged back to the facility and returns to the hospital, the Medicaid resident must be back in the facility for 24 hours prior to being discharged again on medical leave to begin a new 20-day hold period.

Notification Process for Medical Leave and Return

- According to WAC 388-105-0045 (7), residential facility (ESF, AFH, ARC, EARC, or AL) contractors must notify the Department Case Manager/Social Service Specialist by e-mail, fax, or telephone within one working day whenever the resident is discharged from the facility for more than 24 hours on medical leave to a nursing home or hospital.

- Facilities may use the Adult Residential Care Services Notice of a Change form (**DSHS 05-249**), to notify the CM/SSS of a client's discharge and return to the facility. This form can be faxed to (855)635-8305 or mailed to DMS at P.O. Box 45826 Olympia, WA 98599-5826.

- Timely notification of discharges and returns remains critical in reducing overpayments.

Authorizing Bed Holds

When the department Case Manager/Social Service Specialist received notification from a facility reporting that the client has been discharged to the hospital or nursing home; within two working days of learning of a client's discharge, the CM/SSS must determine whether or not the client is likely to return to the residential facility by verifying with the hospital staff or nursing home staff if hospital or nursing home stay may be less than 20 days.

1. If the client will likely return to the facility, the Residential CM/SSS will:
   a. End Date residential services service line in P1.
   b. End Date other open service lines in P1. Please note special instructions exist in the SSAM for Wellness Education, PERS Units/Add-ons, and Nurse Delegation.
   c. Use DSHS 14-443 to send required notification to the Public Benefit Specialist.
   d. Document all related bed hold actions in SER.
   e. Once the client's outcome is known (meaning they have returned to the residential facility, died, or discharged to an alternate setting) then authorize the bed hold.

2. If the client has already returned to the facility, the Residential CM/SSS will:
   a. Split the residential services service line in P1 as of the last full day prior to admission in the institution, then remove the dates the client was institutionalized.
   b. Split other open service lines in P1. Please note special instructions exist in the SSAM for Wellness Education, PERS Units/Add-ons, and Nurse Delegation.
   c. Authorize the bed hold.
   d. Use DSHS 14-443 to send required notification to the Public Benefit Specialist
   e. Document all related bed hold actions in SER.

3. If the client is unlikely to return to the facility, the Residential CM/SSS will:
   a. End Date all open service lines in P1. Residential services should be ended as of the last full day prior to discharge from the residential facility. Other services may be ended on the date of discharge. Please note special instructions exist in the SSAM for Wellness Education, PERS Units/Add-ons, and Nurse Delegation.
   b. Notify the client and the provider of the department's decision to terminate of payment. Document in the SER related actions taken in regard to terminating the authorization of services.
   c. Notify the Public Benefit Specialist (PBS) by completing an electronic DSHS 14-443 in Barcode. The HCS PBS will receive this as an assignment on their To-Do-List and can review the action.
   d. Per federal HCBS rules, a client is entitled to the same eviction rights as any renter residing in a private unit. This is called out in HCBS settings rule- 42 CFR § 441.530, Section (a)(1)(vi)(A). RCW 70.129.110 requires a provider to meet before discharging or transferring a resident, including first attempting through reasonable accommodations to avoid the transfer or discharge and giving at least 30 days' notice before the transfer or discharge.

When a client is hospitalized and unlikely to return to the facility, please see LTC Manual Chapter 9a page 13 "What is the Role of Residential Case Managers in Transitioning Clients Back to Residential Settings?" for further instruction.

The CM/SSS will be responsible for determining and processing an overpayment if the client does not return to the facility and the providers continue to claim for services. For detail information on an overpayment process; refer to Social Services Authorization Manual.

What is the payment for Bed Hold?

From the:	The department:
Date of discharge through the 7th day	Pays 70% of the daily rate for ARC, EARC, ALF, and AFH. (WAC 388-105-0045) (4), (5)
8th through the 20th day	Payment reduced to $11.66 per day for ARC, EARC, and ALF. $15 per day for AFH, except ESFs, which are paid at 70% of the daily rate for days 1-20 (WAC 388-105-0045) (3). See current rates on the ALTSA website. These rates are subject to legislative action.
Date of discharge through the 20th day	Pays 70% of the daily rate for ESF (WAC 388-105-0045 (3).
21st day forward	No longer pays for the bed hold. The provider may seek a third-party payment or no longer hold the bed

The date of discharge entered in the bed hold data base is the date the client left the residential facilities (AFH, EARC, ARC, ALF or ESF) on medical leave.

- Bed Hold days are not processed until there is an outcome.
- In case of client's death, the last date of payment for bed hold is the day of death.
- Client Responsibility is never counted toward bed hold days.

SOCIAL LEAVE

Social Leave is defined as planned leave that is for recreational or socialization purposes, not for medical, therapeutic, or recuperative purposes nor for incarceration.

- ALTSA permits Social Leave in all residential settings. Social Leave is limited to no more than **18 days per calendar year per WAC 388-110-100** (2).
- Residential Facilities are responsible for self-reporting and self-tracking Social Leave for their clients.

When do I authorize this service and for how long?

If a client takes Social Leave, the residential facilities are required to notify the department Case Manager/Social Service Specialist within **one working day**. Upon receiving the notification from the residential facilities; CM/SSS must:

- Maintain the current P1 authorization.
- Evaluate the need for social leave beyond 18 calendar days per year.
- Discuss with the provider how the client's personal care needs will be met while the client is out of the facility on social leave. Document in the SER actions taken relating to social leave.

Note: Facilities should use the Adult Residential Care Services Notice of a Change DSHS form 05-249, to notify the CM/SSS of a client's discharge and return to the facility from social leave.

Are ETR's allowed for Social Leave?

Evaluate whether there is a need for an ETR and consider the following questions:

- Do the additional days meet the client's needs and desires?
- Is there a person willing and able to meet the client's care needs while the client is out of the facility?
- Is there a temporary service plan in place to meet the client's needs during his/her absence?
- If you determine the need for additional days, submit an ETR in CARE for your Appointing Authority (FSA/RA) for review/approval.
- Evaluate if the client's continued residence in the AFH, ALF, or ESF is the most appropriate option.

RESOURCES

Rules and Policies

The following rules apply to clients receiving care in residential facilities. RCS and HCS work in partnership to provide quality service delivery in all residential care settings. HCS is responsible for the assessment and case management of residential clients; accurate payments to the providers and complying with state and federal regulations. RCS is responsible for the licensing, inspection, and surveying of all licensed Adult Family Homes, Assisted Living Facilities, and Enhanced Services Facilities. HCS and RCS work together to resolve issues for residents.

RCW	
Chapter 70.129 RCW	LONG TERM CARE RESIDENT RIGHTS
Chapter 70.128 RCW	ADULT FAMILY HOMES
Chapter 70.97 RCW	ENHANCED SERVICES FACILITIES
Chapter 43.190 RCW	LONG TERM CARE OMBUDSMAN PROGRAM
WAC	
Chapter 388-76 WAC	ADULT FAMILY HOMES MINIMUM LICENSING REQUIREMENTS
Chapter 388-78A WAC	ASSISTED LIVING FACILITY LICENSING RULES
Chapter 388-107 WAC	ENHANCED SERVICES FACILITIES
Chapter 388-105 WAC	MEDICAID RATES FOR CONTRACTED HOME AND COMMUNITY RESIDENTIAL CARE SERVICES
Chapter 388-106 WAC	LONG TERM CARE SERVICES
Chapter 388-110 WAC	CONTRACTED RESIDENTIAL CARE SERVICES
Chapter 388-112 WAC	RESIDENTIAL LONG TERM CARE SERVICES (TRAINING)
Chapter 182-515 WAC	ALTERNATE LIVING – INSTITUTIONAL MEDICAL
Chapter 182-527 WAC	ESTATE RECOVERY

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
	Anna Cavanaugh/ Emily Watts	• Added wording to SDC process to include approval of pending assessments • Added PACE process for monitoring significant change assessments • Added DSHS 15-558 Adult Family Home (AFH) Resident Significant Change Assessment Request to steps for monitoring significant change assessment requests. • Added reference to Chapter 9a for further instruction when a client is hospitalized and not returning to facility • Updated Nursing Services Chart • Updated template and branding	
11/8/24	Anna Cavanaugh/ Emily Watts	• Update Medical Escort Fee rate & documentation • Clarified client cannot participate on RSW while on SDCP • Edit to CBHS to correct language	H24-062
8/7/2024	Emily Watts	• Addition of MCO Community Behavioral Health Support reference • Updating of SDCP to add Reason Codes • Updated all links to forms and chapters	H24-044
4/16/24	Emily Watts	• Update staff assigned • Removal of Meaningful Day • Reformatting to move SDCP items into one section. • Update on share ALF rooms	H24-018
10/13/2023	Emily Watts	• Revised formatting, including moving some items to the Appendix • Updated service area information for SDCP • Community Stability Supports (CSS) information added • Clarified SDCP Referral Process • Clarified HIV/AIDS rate information, including for Community Integration • Clarified Meaningful Day Process • Added Revision History	H23-071
6/14/2023	Emily Watts	• Updated contact information	H23-039
3/28/2023	Natalie Lehl	• Clarify room sizes	H23-017

		• Update SDC guidance	
12/22/2022	Natalie Lehl	• Updated contact information • Added additional language to "Social Leave"	H22-064
9/14/2022	Natalie Lehl	• Updated guidance on Specialized Dementia Care Program referrals • Title change for MPC Calculator • Enhanced Services Facilities (ESF) subject matter expert name and contact information updated	H22-042
6/21/2022	Natalie Lehl	• Removed use of "placement" throughout the chapter • Updated Specialized Dementia Care Program instructions	H22-028
4/12/2022	Natalie Lehl	• Adding Meaningful Day Program Manager • Update process for Meaningful Day approval (VI, E) • Meaningful Day Checklist added	H22-020

APPENDIX

AFH Providers FAQs about Community Integration

Community Integration FAQs.pdf

AFH CHOW Flowchart

AFH CHOW Flowchart.pdf

Meaningful Day Activities

Chapter 8a provides guidance on contracting requirements, eligibility criteria and authorizing services for Meaningful Day Activities.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Thoko Kamwanja-Struss AFH Meaningful Day Manager
360.725.2541 Thoko.Kamwanja-Struss@dshs.wa.gov

TABLE OF CONTENTS

OVERVIEW

Meaningful Day provides a person-centered approach to designing and delivering meaningful activities for eligible DSHS clients. Providers supporting clients to participate in Meaningful Day activities will utilize tools and approaches to assist clients to manage significant challenging behaviors that pose a barrier to successful community living. One of these tools is the facilitation of activities that the client has identified as personally meaningful. Activities may be directly led by the AFH Provider in a one-on-one format or a group format, or the client may be assisted through set up and coaching to engage in the activity independently.

The daily add-on rate is intended to provide funding for supplies, staffing and other costs that are essential for the planned activities. The Provider and client (and/or client representatives) must agree in writing how the daily add-on rate will be allocated to support planned Meaningful Day Activities. In all cases, selected activities must be realistically available within the resources available to the client.

Adult Family Home providers who are trained, have a contract with the State to provide meaningful activities, and have an eligible resident with an assessed need for meaningful activities to assist with managing challenging behaviors, will receive a Meaningful Day Activities add-on rate of forty dollars ($40.00) per day. There is no limit to the number of DSHS residents who can receive this service/intervention in the home if each resident meets the eligibility criteria.

Adult Family Home (AFH)

A residential home in which a person or persons provide personal care, special care, and room and board to more than one, but not more than eight adults, who are not related by blood or marriage to the person or persons providing the services.

The Meaningful Day Activities add-on rate includes the following supports provided by the AFH:

- Utilize the resident's CARE assessment to identify the targeted challenging behaviors to be addressed.
- Collaborate with the resident(s) and their representatives to develop a Meaningful Activity Plan (MAP) based on the resident's goals, interests, and abilities.
- Create a client-specific activity calendar to document the resident's planned activities and events.
- Implement the Person-Centered Activities as outlined in the MAP and Negotiated Care Plan. This includes home-based and community activities (this may vary depending on residents' ability to participate, goals and interests).
- Use the DSHS provided behavior chart (tracking tool) to observe, and record identified targeted challenging behavior(s) identified in the CARE Assessment. Providers will document each participating resident Meaningful Day service delivery on separate documents.

AFH providers must include targeted activity goals derived from the Meaning Activities Plan (MAP) in resident's Negotiated Care Plan (NCP) in the "Activities/Social Needs" section. The updated NCP must be returned to the CM/SSS within 30 days.

Providers are expected to maintain documentation of Meaningful Day Activities; Meaningful Activity Plan (MAP), Monthly Calendars, Monthly Activities and Challenging Behavior Log. This documentation must be made available to DSHS staff upon request.

Meaningful Day Specialty Contract

Meaningful Day Activities is one of the three Subcontracts in AFH:

- **Meaningful Day Activities (MDA)**
- Expanded Community Services (ECS)
- Specialized Behavior Support (SBS)

NOTE:
The Meaningful Day Specialty contract is available to AFH Providers with a Medicaid contract who meet eligibility requirements for the specialty contract. When CM/SSS submit eligibility referrals, utilize the online AFH Lookup Tool.

MEANINGFUL DAY ACTIVITIES ELIGIBILITY CRITERIA IN AFHS

To be eligible for Meaningful Day Activities an individual must:

1. Reside in or be moving to an AFH with a current HCS Meaningful Day contract.
2. Be financially eligible for CFC or CFC + COPES.
3. Have a minimum Behavior Point Score of 12 or higher as determined by the CARE assessment OR irreversible dementia (such as Alzheimer's, Multi-Infarct or Vascular dementia, Lewy Body, Pick's, Alcohol-related Dementia, or Major Neurocognitive Disorder) OR Wernicke-Korsakoff Syndrome **with at least one current challenging behavior that is not easily altered**, as reflected in the CARE assessment. See next page for dementia diagnosis confirmation guidance.

Written or Verbal/Email Confirmation of Dementia Diagnosis

➢ **CM/SSS will utilize the following guidance regarding confirmation of dementia diagnosis to complete eligibility and service authorization for HCS Meaningful Day.**

- **CM Observation or receipt of written confirmation of an irreversible dementia diagnosis**: MAR, Visit or Discharge Summary, Neuropsychologist evaluation report, Telemedicine report, Primary Care Physician progress notes OR thorough examination of other medical documents within the EPIC System that cite the dementia diagnosis. Observation of written documentation shall be noted in a CARE SER AND on the Meaningful Day Checklist including the date and type of document the CM reviewed to confirm a dementia diagnosis.

- **Verbal / Email Confirmation of irreversible dementia diagnosis from a health care professional**: In-person, email or telephone call with a Primary Care Physician, Nurse or Nurse Practitioner, Physician Assistant, Neuropsychologist, Neurologist. Verbal confirmation shall be noted in a CARE SER note AND on the Meaningful Day Checklist including the name of the health professional, title, and the date of confirmation of a dementia diagnosis.

If a client's BPS falls below 12 or a client's targeted challenging behavior is altered after they begin receiving Meaningful Day Activities, they may continue receiving Meaningful Day Activities if they remain eligible for Community First Choice and reside in an AFH that has a

Note:
Client's receiving Expanded Community Services (ECS), Specialized Behavior Supports (SBS)are NOT eligible to receive Meaningful Day services**.**

MEANINGFUL DAY ACTIVITIES AUTHORIZATION

Meaningful Day Activities can't be authorized until there has been an assessed need in CARE. The HCS Meaningful Day authorization start date is on **or** after the Headquarters approval date (posted in CARE SER note). Meaningful Day Service authorizations cannot be backdated. CMS/SSS shall complete the following steps to complete the initial service authorization process.
DSHS will not approve retroactive payments or Fast track for Meaningful Day Activities.

If Meaningful Day Activities is requested by the resident, a resident's representative, or the AFH provider on behalf of a resident, and the resident meets the criteria and wants to participate, case managers may update assessments to include Meaningful Day Activities using an Interim assessment prior to the next full assessment.

The assessment must be in "current" status to be considered for Meaningful Day eligibility. CMs need to move the assessment into "current" BEFORE sending the Meaningful Day referral to HQ for review and

approval, except in cases where an individual is transferring from in-home to an AFH or discharging from an acute care hospital to an AFH. Assessments may be in "pending" only in the cases of hospital discharge and transfer from in-home to an Adult Family Home.

The planned AFH residence must have a Meaningful Day contract for services to continue without interruption. Otherwise, Meaningful Day Activities will not be able to be delivered until the AFH has obtained a Meaningful Day contract.

Clients who receive services under PACE organizations do not require HQ approval **except** when the client is returning from PACE to HCS services.

Initial Service Authorization Process

- Obtain client's or client's representative(s) verbal agreement to Meaningful Day services and document on DSHS 10-672 (Meaningful Day checklist).
- Review the CARE assessment to confirm the client meets all eligibility criteria. The CARE assessment must be moved to "current" prior to submitting the referral checklist. See note below for in-home to AFH and hospital discharge referrals.
- Confirm that the client is on either CFC or CFC +COPES.
- Observe or receive written confirmation of an irreversible dementia diagnosis from a qualified medical professional (such as a geriatric psychiatrist, neuropsychologist, geriatrician) OR acquire verbal confirmation of an irreversible dementia diagnosis (such as Alzheimer's, Multi-Infarct or Vascular dementia, Lewy Body, Pick's, Alcohol-related Dementia, or Major Neurocognitive Disorder) OR Wernicke-Korsakoff syndrome from a qualified health care practitioner.
- Utilize the AFH Locator List to identify HCS Meaningful Day contracted homes to ensure that the client resides in (or is moving to) an AFH that has a valid Meaningful Day contract.
- If the AFH Provider has a current contract:
    - Select AFH Meaningful Day in the CARE Treatment screen.
    - Move CARE assessment to current.
    - Complete the HCS Meaningful Day Checklist (DSHS 10-672).
    - Submit Meaningful Day Checklist to meaningfulday@dshs.wa.gov for review.
    - The Meaningful Day Manager will post SER in CARE and notify CM/SSS via-email of the approval or denial.
    - Select the AFH Meaningful Day Add-On in P1 using service code T2033, U6

- In the line data screen, authorize the add-on rate of $40 per day.
- After authorizing, CM/SSS will notify the AFH Provider that they can start to bill for Meaningful Day services.
- Complete a 14-443 to notify the Public Benefit Specialist (PBS) of the Meaningful Day authorization rate approval. The rate submitted to the PBS must include the total daily rate, including the Meaningful Day add-on.
- Send a copy of MD Eligibility Checklist form to DMS as part of client's record.

If a client is considering transferring to an alternative AFH, CM/SSS will need to verify that the AFH has the HCS Meaningful Day contract.

If the new AFH does not have a Meaningful Day contract, the AFH will not be reimbursed for any Meaningful Day activities that are provided to the client after transfer.

CM/SSS is not required to send another Meaningful Day referral/eligibility checklist when a client is transferring to a new AFH.

For in-home clients planning to transition to an AFH setting, CM/SSS should note this when sending in the MD checklist for HQ to review. Do not make any changes to the CARE assessment or service authorizations until the resident is ready to relocate as changes may affect billing for CDWA.

Note:
Per ALTSA's Strategic Objective to support and facilitate successful transition planning from acute care hospitals to residential settings, referrals for Meaningful Day from Acute Care hospital CM/SSS will receive priority consideration. CARE assessments do not need to be in "current" status. Assessments may be in "pending" status.

Annual Renewal Service Authorization Process

- Complete annual CARE assessment.
- Authorize Meaningful Day services by entering **a new service** line for the current plan period, do not extend Meaningful Day service lines.
- For extension of services or annual renewals, an updated Service Summary will need to be reviewed and signed by client/client representative and designated AFH representative.

- Complete a 14-443 to notify the Public Benefit Specialist (PBS) of the Meaningful Day authorization rate approval. The rate submitted to the PBS must include the total daily rate, including the Meaningful Day add-on.
- Send a copy of MD Eligibility Checklist form to DMS as part of client's record.

Note: A PAN is not required for Meaningful Day Activities

Change of Ownership (CHOW) Service Authorization Process

- Confirm the new owner of the AFH has a current Meaningful Day contract.
- Email MeaningfulDay@dshs.wa.gov and request to reinstate Meaningful Day services for previously approved clients. (Include client's ACES ID and AFH License Number. **You do not need to submit a new MD checklist.**
- The AFH Meaningful Day Manager will enter a SER note with a service start date and notify CM/SSS via email.
- CM/SSS will authorize Meaningful Day services by entering **a new service line** using the provided service start date and notify the AFH Provider that they can start to bill for Meaningful Day services. Without the completion of CHOW service authorizations, the AFH will not be reimbursed for any Meaningful Day activities that are provided to the client.

NOTE:
The current adult family homeowner must provide written notice of Change of Ownership (CHOW) to the department and residents or applicable resident representative sixty calendar days prior to the date proposed change of ownership. The department and CM/SSS will work together to complete contract and service authorization activities to avoid service disruptions for clients approved to receive Meaningful Day prior to a change in ownership.

Contacting the Meaningful Day Manager

The MeaningfulDay@dshs.wa.gov e-mail is monitored by the HCS Meaningful Day Manager. All inquiries should be sent to MeaningfulDay@dshs.wa.gov

If a provider is interested in learning more about HCS Meaningful Day services requirements and/or contract specifics, please request that they send an email to MeaningfulDay@dshs.wa.gov for more details about eligibility and training.

RESOURCES

Meaningful Day Eligibility Checklist

HCS Meaningful Day Eligibility Checklist Fo

Sample AFH Provider Forms

Meaningful Activity Plan.docx

Monthly Calendar.docx

Monthly Activities Behavior Log.docx

Acknowledgement statement_PDF 27-20

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
5/2024	Thoko Kamwanja-Struss	• Clarifying "written" and "verbal" confirmation of diagnosis • Pending assessments for eligibility referrals if discharging from hospital or transferring from in-home to AFH • Client's receiving Expanded Community Services (ECS) or Specialized Behavior Supports (SBS are **NOT** eligible to receive Meaningful Day services. Eligibility Checklist Updated	

Hospital Assessments and Transitions

The purpose of this chapter is to clarify hospital assessment activities to ensure smooth transitions of those individuals in a hospital to in-home, community residential settings, or to skilled nursing facilities. The goal and focus of hospital assessment activities is to:

- Proactively engage with individuals seeking long-term care services to provide up to date information about Medicaid funded long-term care options.
- Assist and educate hospitals in working with Medicaid eligible patients to access long-term services and supports (LTSS) to avoid staying in the hospitals when they no longer need acute care services.
- Prioritize assessment and expediting authorization of long-term care services for individuals once they are referred for services and anticipate transitioning from the hospital to a less restrictive setting.
- Develop rapport and supportive relationships with local hospital discharge planners and long-term service and support providers in the community.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Jody Gasseling Acute Hospital Systems Change Manager
360.522.0456 Jody.gasseling@dshs.wa.gov

Erika Gustafson Acute Hospital Systems Change Manager
360.870.9794 Erika.gustafson@dshs.wa.gov

For questions related to guardianship or decision making please contact:

Sarah Tremblay Guardianship Program Manager
564.999.1032 Sarah.tremblay@dshs.wa.gov

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BACKGROUND

Many acute care hospital patients who are referred to the Department's Home and Community Services (HCS) division are new to long-term care services and will require a functional and/or financial eligibility determination. Ensuring timely transitions to services is essential in reducing the number of days patients spend in acute care settings when they no longer meet medical necessity. Aging and Long-Term Support Administration must coordinate transitions with border acute hospitals and more than 50 acute care hospitals statewide. Successful transition planning requires robust collaboration and partnership with regional staff, hospitals, managed care organizations, providers, and communities. This collaboration aims to deliver suitable services and community options that respect client preferences and decrease medical expenses while enhancing individual wellbeing and quality of life. Completing hospital assessments and coordinating transitions planning involves a great deal of data collection, analysis and creative problem solving for systems of care to be better aligned and responsive to unique individual needs.

ASSESSING AND TRANSITIONING CLIENTS FROM THE HOSPITAL

HCS hospital assessments for individuals eligible for Medicaid must follow policy established in Chapter 3 of the Long-term Care Manual. It is the goal of HCS that all hospital referrals for LTSS receive a hospital assessment unless the individual:

- is discharged or the hospital withdrawals a referral prior to an assessment being completed.
- refuses the assessment.
    - In addition, the client must meet conditions for conducting an HCS assessment in the hospital outlined in this chapter.

What Conditions Must Be Met for HCS to Conduct a Hospital Assessment?

For HCS to conduct and complete a hospital assessment, the individual in an in-patient setting must meet the following:

1. Medically stable—the individual at this point is close to baseline functioning and their immediate medical needs, treatments, and therapies have been achieved.
2. Individual, guardian, or legal decision maker is aware of the referral to HCS and agrees to assessment. If there are questions on client's capacity, see "What is the Role of HCS Case Managers in Determining Decision Making Capacity". Please refer to Chapter 3 for performing a CARE assessment.

3. Psychiatrically stable —the individual at this point is close to baseline functioning and their immediate psychiatric needs, treatments, and therapies have been achieved, evidenced by no use of physical or chemical restraints in the past 3 days prior assessment and transition.

- ❖ Medically Stable individuals for example, are not in ICU, their conditions are predictable and stabilized.
- ❖ If the client does not have capacity to make their own decisions, and no authorized representative is in place, a legal decision maker designated as a Durable Power of Attorney (DPOA), Power of Attorney (POA), or guardian will have to be established before the client can be transitioned out of the hospital.
- ❖ HCS hospital case managers MUST consult with informal decision makers/collateral contacts and medical records to determine whether the client lacks capacity to make their own decisions for LTC services and develop a plan of care if the client is unable to make their needs known. The case will stay pending until a guardian or a legal decision maker is in place.
- ❖ For clients determined to lack decisional capacity, case manager should consult with a guardianship case manager by submitting an inquiry through the escalation pathway inbox. Appendix VII

When is an Individual Not Ready for a Hospital Assessment?

1. When the individual declines to have an HCS hospital assessment done to explore LTSS options they might be eligible for, and this is documented in CARE.
2. Not medically stable—the individual still needs acute care medical intervention and is not back to baseline functioning or no new baseline has been identified; immediate medical needs, treatments, and therapies are not yet in place.
3. Not psychiatrically stable---the individual continues to require in-patient psychiatric services and are not back to baseline functioning or no new baseline has been established; immediate needs, treatments and therapies are not yet in place.
4. Combative and/or behaviorally compromised e.g., client who is actively physically assaultive.
5. Client is being chemically or physically restrained.
6. Individuals on frequent use of intermuscular medications (IM) that cannot be replicated in a community setting. e.g., the individual is given psychotropic IM medication that is ordered as needed or PRN for behavioral management.
7. Individuals who are non-decisional, cannot execute a DPOA or POA, and who lack a decision maker with LTSS authorities.

- If an individual is being held in isolation, they **must** be medically/psychiatrically stable, and predictable for an assessment to occur.
- For individuals on contact precautions like COVID-19, MRSA and other infectious diseases, staff will assess them following established universal precautions and safety standards.
- In addition, for individuals who are in physical restraints or being held in isolation rooms, consult medical records, hospital staff, and informal decision makers/ collateral contacts before considering CARE assessment completion. Discuss with hospital staff on measures and approaches being taken to wean an individual off these restraints which will allow HCS to pursue transition options for less restrictive settings.
- For clients on frequent use of PRN IM, when a case manager is in doubt, they should consult with a Nursing Care Consultant (NCC) or Hospital Transition Support Unit RN to review the situation.
- For clients determined to lack decisional capacity and do not have a decision maker with LTSS authorities, case manager should consult with a guardianship case manager by submitting an inquiry through the escalation pathway inbox.
- For clients determined to lack decisional capacity and do not have a decision maker with LTSS authorities, case manager should consult with a guardianship case manager by submitting an inquiry through the escalation pathway inbox. Appendix VII

What Assessments Need to Be Prioritized Among Hospital Referrals?

Sometimes hospital staff will notify HCS of the need to prioritize certain referrals. For such cases, the assigned HCS hospital case manager will work with the hospital to determine the order of assessment.

A hospital referral that is considered a priority over other hospital referrals may have the following conditions:

1. Individuals who are already financially eligible for Medicaid long-term care services
2. APS is involved.
3. Hospice is involved and they are requesting HCS to take the lead in finding a community setting.
4. Department of Correction referral requesting HCS to take lead in finding a community setting for a client who is medically complex.
5. Individual's planned hospital discharge is imminent; it is in a few days not weeks; and
6. The individual can consent to services or has a representative to consent to services.

What is the Role of HCS When Receiving an Acute Hospital Referral?

HCS is responsible for initiating functional assessments and financial eligibility determination of referred Medicaid applicants who have indicated a preference for community-based (home or residential) LTSS services.

The HCS intake unit:

1. Receives and conducts an initial screening of the referral and/or long-term care service application (request for long-term care services).
2. Enters applicant in CARE within one working day following guidelines in Chapter 3 of the Long-term Care Manual.
3. Assigns the case to the HCS hospital case manager and
4. Performs case transfers when appropriate.

HCS hospital case manager will:

1. Make contact with the client within two working days of receipt of referral as outlined in Chapter 3 of the Long-term Care Manual.
2. Triage cases to determine the appropriate time for an assessment.
3. Update the Acute Hospital Screen in CARE Web to start tracking the referral and keep the client record up to date. Barriers should be removed when they are resolved.
4. Complete a full initial, initial/reapply or significant change assessment in CARE to determine care needs, and present appropriate service options to the client, family, and/or decision maker or guardian, and authorize personal care services within 30 days from the date of receipt of the referral.
5. Provide information about long-term care services and supports to hospital staff, patients, and families.
6. Discuss MAC/TSOA as option if the client declines HCS Services
7. Assist with developing multiple potential transition plans into LTC care settings concurrently, including finding a provider.
8. Identify, document, and address barriers to transition as early as possible.
9. Collaborate with hospital staff on discharge planning.
10. Coordinate with transitions of care planners at Managed Care Organizations (MCOs).
11. Submit Non-Grant Medical Assistance (NGMA) applications for those who will benefit from Waiver services and do not meet the Aged/Blind/Disabled criteria to access Waiver services.
12. Utilize Fast Track for community services, if appropriate
13. Submit transfer requests to HCS intake unit or direct supervisor for clients who will be receiving long-term care services in their homes for ongoing AAA case management as soon as the:
    - Referrals for services are made.
    - Services are authorized.
    - Service plan is implemented.
    - Provider service contracts are arranged, if appropriate
    - RAC are entered in CARE.
    - ProviderOne authorization is “error free” and in CARE,
    - The client and provider have signed the service summary and returned it to the relevant HCS staff for review and signature.
    - If Fast Track has been used, the Medicaid application has been submitted with the appropriate documentation to the local financial worker.
14. Likewise, follow above procedures outlined from 1(i) through (xii) for transferring client cases to an HCS Residential case manager for clients who will receive services in residential settings.

For hospital clients who are discharged from Acute care hospitals before an HCS hospital assessment and/or LTC service plan is in place; the HCS hospital case manager or supervisor will submit a transfer request for the individual to be followed up by the HCS in-home unit, or HCS residential unit to conduct an assessment and/or set up of services for appropriate LTC community options. When these cases are transferred it should be noted that they were discharged from the hospital before assessment or service planning could be established and that these cases may need to be expedited by the receiving team.

What is the Role of HCS Case Managers in Determining Decision Making Capacity?

Until a Court determines that an individual lacks decision-making capacity, the individual still retains their civil right to make their own decisions. It is important for the client to participate in person-centered planning and to honor their choice of representative. Since HCS is not a health care provider, it must follow Medicaid law when looking for client consent to provide Medicaid long-term care services. As such, a healthcare directive or healthcare power of attorney is generally not sufficient for obtaining consent for HCS LTSS services outside of a medical setting unless it contains an additional provisional clause specifying authority to consent to services.

The case manager should interact with the individual to determine if the individual can consent to HCS services or can select a representative to provide consent. In addition to consulting with the hospital on the individual's capacity, the case manager should see if the individuals can answer simple questions and understands the services being offered. Ideally, a client designates their representative in writing well in advance of needing a representative, sometimes verbal designation is sufficient if it is well documented. If there are questions about how to proceed, case managers should staff with a supervisor and determine if escalation to HQ/AAG is appropriate. In situations where an individual is severely incapacitated and does not have the ability to choose a representative, a guardianship or conservatorship may be the only available option to ensure client choice and consent for HCS services.

When a Medicaid client lacks capacity to make their own decisions concerning their long-term care needs and no authorized representative, DPOA, or POA is in place, unless the individual has a relative or friend who is willing to pursue guardianship; the acute care hospital or another party would need to pursue guardianship or conservatorship for the individual to transition into a long-term care setting. In a small subset of clients who do not have an identified person willing to serve as a guardian or legal decision maker, resources may be available through HCS State Funded Guardianship and Conservatorship Assistance Program (GCAP). Please consult your supervisor, regional guardianship case manager, or Guardianship Program Manager.

A Court Visitor (formally known as Guardian Ad Litem- GAL) is an investigator for the court and they are responsible for vetting a proposed guardian or conservator and completing an investigative report to the court outlining recommendations as to the need and scope of a guardianship or conservatorship and who an appropriate person would be to serve as guardian or conservator in the case. In some incidents a Court Visitor or other court appointed decision maker may participate in transition planning in a case where the court has specifically ordered them to do so. Review the court order carefully with the

Guardianship Case Manager through submission of documentation to the escalation pathway inbox to establish what the Court Visitor has been authorized to do. Appendix VII

- At times, a client can still legally execute a DPOA using residual capacity even when medical records have documented the client as non-decisional for medical informed consent purposes. This is because there are different legal thresholds for execution of DPOA verses informed consent for medical procedures.
- Healthcare partners should be encouraged to assist clients in executing healthcare DPOAs with a provisional clause to allow for the consent to LTSS. Below is an example of such a provisional clause:
  - *Agent has authority to apply for LTSS benefits and /or to consent to and coordinate LTSS on behalf of principle*.
- DPOA or POA can be executed after the guardianship process has been initiated. It is a preferred less restrictive alternative arrangement to guardianship. Guardianship should be sought as a last resort option as it is the most restrictive in nature and removes a client's civil rights under court order, unless if the court intervenes to dismiss the guardianship case and orders the client capable of making their own decisions.

  For more assistance about client consent including questions on client decision-making capacity, refer to the complex case and escalation pathway Appendix VII.

What is the Role of AAA in Transitioning Clients Back to their Own Home?

AAAs are responsible for case managing clients returning to in-home services following a hospital stay.

1. For clients who were receiving in-home services prior to hospitalization, who are expected to return to this setting upon discharge, the AAA and their case management subcontractors will:
   a. Follow assessment procedures established under Chapter 3 of the Long-term Care Manual.
   b. Continue to case manage the clients who were on CFC/COPES/New Freedom/MAC/TSOA long-term care services prior to hospitalization and provide reassessments/service plan changes around the time of discharge.
   c. Be responsible for conducting a significant change assessment when appropriate.
   d. Collaborate with hospital staff on discharge planning.
   e. Coordinate with transitions of care planners at MCOs. Chapter 22a
2. For clients who were receiving in-home services prior to hospitalization and will not return to in-home services within 30 days of being hospitalized:
   a. The AAA case manager will immediately staff client's status with HCS/ Hospital supervisor to consider transferring of case to appropriate staff. This should be done promptly to avoid delays.
   b. Create a hospitalization transfer SER with the following information:
      - Hospital name
      - Admission date
      - Current hospital social worker
      - Barriers to returning home
      - Date of staffing with Hospital Supervisor

- Is the client decisional? (If not, who is the guardian/conservator or DPOA)?

c. What steps have been taken to maintain or allow the client to return to previous setting? Transfer cases to HCS hospital case managers as soon as it is known that the client will not be returning to in-home services and close all authorizations.
d. HCS hospital case manager will take over the case for all transition planning actions for clients transitioning from acute care hospitals.

3. AAA case managers determine the need to transfer vs. retain hospital referrals for transition, in addition:
    a. Provide information about long-term care services and supports to hospital staff, clients, decision makers, and families.
    b. Assist with developing multiple transition plans into LTC care settings concurrently including finding a provider.
    c. Identify and address barriers to transition as early as possible.
    d. Collaborate with hospital staff on discharge planning.
    e. Coordinate with transitions of care planners at MCOs.

- ❖ If the client cannot return to in-home services after the case has been staffed, the AAA case manager will close out authorizations and immediately transfer the case to an HCS hospital case manager.
- ❖ If the AAA staff know the client is planning to transition to a skilled nursing facility, or that an assessment is not needed prior to nursing facility admission; transfer the case immediately to the NFCM assigned to that facility once the client has been admitted to the facility.

WHAT IS THE ROLE OF RESIDENTIAL CASE MANAGERS IN TRANSITIONING CLIENTS BACK TO RESIDENTIAL SETTINGS?

RCCMs are responsible for case managing clients returning to their residential setting following a hospital stay. It is important to remember to end personal care services timely when notified a client has been admitted into the hospital. Do not wait until you know if the client is returning home or not to end personal care.

1. For hospital clients who were receiving long-term care services in residential settings (AFH, AL, or ESF) prior to hospitalization and are expected to return to this setting upon discharge:
    a. Follow established protocol for assessing and updating CARE assessments to reflect any changes to the client's care plan as outlined in Chapter 3 of the Long-term Care Manual.
    b. Continue to case manage the clients who were on CFC/COPES/New Freedom/MAC/TSOA long-term care services prior to hospitalization and provide reassessments/service plan changes around the time of discharge
    c. Be responsible for conducting a significant change assessment when appropriate.
    d. The residential case manager will authorize the service plan prior to transition.
    e. Collaborate with hospital staff on discharge planning.
    f. Coordinate with transitions of care planners at MCOs. Chapter 22a.docx
2. When clients are not expected to return to their previous residential setting, the residential unit will:
    a. Staff the case with the hospital supervisor, to discuss transferring of case to appropriate staff. This should be done promptly to avoid delays.

b. Close all authorizations and notify providers of services ending
c. Create SER documenting notification to providers of services ending
d. Create a hospitalization transfer SER with the following information and transfer the case to an HCS hospital case manager.
    - Hospital Name
    - Admission date
    - Current hospital social worker
    - Barriers to returning to residential setting.
    - Date of staffing with Hospital Supervisor
    - Is the client decisional? (If not, who is the guardian/conservator or DPOA)?
    - What steps have been taken to maintain or allow the client to return to previous setting?

3. If the HCS residential case manager knows the client is planning to transition to a skilled nursing facility from the hospital, or that an assessment is not needed prior to nursing facility admission; transfer the case immediately to the NFCM assigned to that facility once the client has been admitted to the facility.

What is the Role of Nursing Facility Case Management in Transitioning Clients Back to Skilled Nursing Facilities?

For cases managed by NFCM; when the client is not expected to return to their previous SNF setting, the NF unit will:

1. Immediately staff the case with the hospital supervisor,
2. Create a hospitalization transfer SER with the following information
    a. Hospital Name
    b. Admission date
    c. Current hospital social worker
    d. Barriers to returning to SNF setting.
    e. Date of staffing with Hospital Supervisor
    f. Is the client decisional? (If not, who is the guardian/conservator or DPOA)?
    g. What steps have been taken to maintain or allow the client to return to previous setting?
3. Transfer the case to an HCS hospital supervisor for case assignment.

What is the Role of Hospital Discharge Planners in Discharging Clients to a Community Setting?

Hospital discharge planners are responsible for sending HCS client referrals for LTC service assessment and Medicaid eligibility determination as soon as it is determined that the individual being hospitalized will need these services as part of the discharge plan.

In addition to implementing the hospital's coordination plan with the local office, discharge planners will:

1. Identify and communicate early on, barriers to discharging individual that is being referred for LTC services.

2. Prior to making a HCS referral, determine if the client is willing to accept long-term care services.
3. Submit a completed intake and referral form and financial application with valid applicant's location and contact information.
4. Pursue guardianship or conservatorship if client no longer has the ability to consent to LTC services on their own and did not consent to authorizing a representative.
5. Work with client's family or authorized representative to create discharge plan, which may include setting up medical and mental health aftercare appointments and secure medical equipment for the client to use after discharge.
6. Provide status updates, clinical info, and access to pertinent info effecting discharge planning.
7. Assist with locating long term care community options.
8. Coordinate with AAA and DSHS staff concerning referrals for long-term care services and schedule assessments.
9. Coordinate individual transitions with MCOs for services and supports. Chapter 22a.docx

❖ If an acute care hospital is unable to identify a proposed guardian or conservator for court nomination, the hospital may submit a referral for GCAP services to the Guardianship Program Manager for eligibility determination. See Appendix VIII for information on GCAP referral process.

How is Coordination with Hospital Discharge Planners Done?

HCS hospital unit supervisors or designated staff will maintain regular contact with each hospital and conduct in-service training when appropriate to disseminate updated information about long-term care services. This will also ensure that HCS' presence is complementary to hospital discharge planning activities. The goal of HCS is to nurture a positive working relationship with individuals and entities pertinent to the discharge planning process to ensure effective coordination and client outcomes. Barriers to transition individuals need to be identified and addressed early in the transition plan process. HCS designated staff will:

1. Communicate:
    a. Clearly define and explain to discharge planner the role HCS/AAA has in assessing new clients and clients returning to the community.
    b. Discuss all Medicaid long-term care services including MAC/TSOA referrals with hospital discharge staff for transition planning.
    c. Develop a written hospital transition coordination plan between the local hospital(s) and Home and Community Services office to ensure these processes and activities are understood. At a minimum, the following information shall be provided to the hospital discharge planner:
        - Contact information for the local office.
        - Contact information for specific staff including back-up staff assigned to the hospital (if available).
        - Escalation contacts for the regions or designee outlined in appendix I.

- Procedures for case staffing individual cases that may require multi-system resources and support to transition.

d. Encourage hospital discharge planners to refer individuals appropriately as soon as it becomes apparent that community-based services are needed.

2. Provide the following forms and documents:
   a. HCS intake and referral form and procedures (see appendix II)
   b. LTC application and procedures
   c. Policies for LTC assessment outlined in this chapter.
   d. A request for data needed from hospitals by HCS hospital case managers (see information under assessment data and reporting section of this chapter).
   e. Provide hospital staff with information on roles and HCS process for transitioning individuals out of acute care hospitals and share the following link where a brief training can be accessed. https://360.articulate.com/review/content/a3c57916-38cb-482e-8b32-4c5d182aa801/review

To avoid delays with discharging individuals:

- Hospital staff, patients or family must submit the HCS Intake and Referral form, and long-term care services application. The application is available online at: https://www.washingtonconnection.org/home/
- Hospital staff will follow additional instructions documented in appendix III to Expedite Acute Care Hospital Applications.
- Identify and address barriers for transitioning individuals early in the process and use the escalation path if there are concerns about HCS process or timeliness which includes escalating individual cases to HCS supervisors.

What is the Role of Medicaid Managed Care Organizations in Transitioning Clients to a Community Setting?

Managed Care Organizations (MCOs) are responsible for transitional care services which require them to work with appropriate staff at any hospital to implement safe, comprehensive transition plan(s) that assures continued access for medically necessary covered services which will support the client's recovery and prevent readmission.

MCOs also have a responsibility to work with HCS to coordinate services and assist in transition planning to help ensure coordinated efforts in Chapter 22a. They are responsible for the following activities to assist in transition planning:

1. Arranging for DME approval and delivery
2. Assigning a PCP for the client to see post discharge.
3. Assisting in finding community transition settings
4. Negotiating contracts with SNFs and paying for SNF stays that meet rehabilitative or skilled criteria.
5. A written discharge plan, including scheduled follow-up appointments, provided to the Enrollee and all treating providers; Formal or informal caregivers shall be included in this process when requested by the Enrollee.

6. Ensuring timely access to follow-up care post transition and to identify and re-engage Enrollees who do not receive post discharge care.

MCOs have the following responsibilities after discharge:

1. Organizing post-discharge services, such as rehabilitative or skilled home care services, after-treatment services, and occupational and physical therapy service
2. Telephonic reinforcement of the discharge plan and problem-solving two (2) to three (3) business days following discharge
3. For Enrollees at high risk of re-hospitalization, the MCO ensures the Enrollee has an in-person assessment by the Enrollee's PCP or Care Coordinator for post-discharge support within seven (7) calendar days of hospital discharge. The assessment must include follow-up of discharge instructions, assessment of environmental safety issues, medication reconciliation, an assessment of support network adequacy and services, and linkage to appropriate referrals;
4. Scheduling outpatient Behavioral Health and/or primary care visits within seven (7) calendar days of discharge and/or physical or mental health home health care services delivered within seven (7) calendar days of discharge.
5. Follow-up to ensure the Enrollee saw his/her provider; and
6. Planning that actively includes the patient and family caregivers and support network in assessing needs.

❖ Medicare Advantage and Dual-eligible Special Needs Plans (D-SNP) also have a requirement to participate and implement transition care activities. Refer to MB H20-029 for information about MCO contacts or on the HCS intranet site located here: Medicaid & Medicare Managed Care Coordination Contacts.

Who Else May Be Involved in Acute Care Hospital Transition Activities?

1. DDA case manager and/or DDA Nursing Care Consultant:
   - Triage referrals and determine functional eligibility by assessing the client's care needs.
   - Assist with developing transition plan into long-term care settings.
   - Provide information about long-term care services and supports to hospital staff, clients, and families.
   - Coordinate with hospital staff on discharge.
   - Collaborates with HCS case manager when needed to assist with developing client care plan.
2. DDA PASRR Team—for Pre-Admission Screening Residential Referral eligibility determination.
3. Other service providers authorized by HCS e.g., community choice guides, supportive housing provider etc.
4. Public Eligibility Specialists—Determine client's Medicaid financial eligibility.
5. Guardian or sometimes Court Visitor: Participates in transition planning and decision making.

- Coordination and/or transfer of client services between DDA and HCS may occur for several reasons. Follow instruction in Chapter 7h of the long-term care manual appendix I for details.
- If the client needs services only provided through DDA (such as SOLA or Supportive Living) consult with DDA regional management prior to determining eligibility for LTSS.

How are ETR Requests for Eligible Acute Care Hospital Clients Processed?

Personal Care Exception to Rule (ETR):

1. ETRs are reviewed and decided based upon individualized needs for assistance with personal care and how those needs differ from many clients in the same classification group.
2. ETR requests should include how additional funds requested through the ETR will be used by the provider to meet the client's individual personal care needs.
3. ETRs can be denied at the local level if the CM/SSS does not think the client's needs differ from the majority. If the request is denied locally, the client will receive documentation of this decision which includes contact information for the client to request a HQ ETR Review.
4. Personal Care ETRs will be processed within seventy-two hours (72) of receipt by the Headquarters ETR Committee.

- Follow the detailed ETR process outlined in Chapter 3 of the Long-term Care Manual. This chapter also addresses other types of ETR.

What are Some Examples of Frequent Barriers to Acute Care Hospital Client Assessment or Transition Planning?

1. Pending Guardianship: This occurs when hospital staff indicate the client does not have capacity to make their own decisions and yet the same client has not been deemed incompetent by court of law. The assessment will be completed and wait for consent from client's legal representative.
2. Client refusing to receive HCS services.
3. Lack of family or social supports
4. Physical and chemical restraints
5. Lack of readily available specialized community resources for individuals who are bariatric, need dialysis, among other medical and behavioral complexities.
6. Financial eligibility: Client is unable to provide required documents over a period, information that is needed for financial verification necessary to make financial eligibility determination.
7. Client's medical and psychological condition is not conducive for having an assessment.
8. Lack of appropriate space to conduct assessments privately.
9. Lack of adequate documentation.
10. Intermuscular (IM) medication that are "pro re nata" (PRN) or scheduled daily that cannot be replicated in a community setting.

❖ If HCS Case Managers are needing assistance with transitions resources please refer to the Transition Academy.

What is HCS Guidance About Use of Restraint in Acute Care Hospital Settings?

In 2007, the Centers for Medicare and Medicaid (CMS) published federal rules to uphold patient's rights when it came to the use of restraints or seclusion in hospital settings.

A-(0159) A restraint is— (A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.

Clarification of federal hospital regulations about appropriate use of restraints and the role of HCS/AAA staff as mandatory reporters was published via MB H24-005 Addressing Use of Restraint. Details of this guidance is outlined below.

Use of restraints in an acute care hospital setting:

Restraints are allowable in this setting; it must be for the shortest duration possible. Patients in Acute hospital settings have the right to be free from physical and mental abuse, restraints, and seclusion. Restraints may only be used to ensure immediate physical safety of the patient, staff, and others.

Additionally, please understand the following requirements when restraints are used. Please note that the section labeled Hospital Federal Regulations has additional information to support these requirements:

- Cannot be used for routine fall prevention (A-0154).
- May only be used when less restrictive interventions are ineffective (A-0164).
- Each order for restraints must be for no more than 4 hours up to a 24-hour period before a new order is needed(A-0171).
- Restraints must be discontinued at the earliest possible time regardless of the order (A-0174).
- Must be ordered only by an attending physician or licensed practitioner that is responsible for the patients care (A-0168).
- Cannot be a standing or PRN (as needed) order (A-0169).
- A licensed physician responsible for the patient's care must:
    - See a patient face to face within 1 hour after the initiation of the restraint (A-0178).
    - Assess the patient following the use of restraints (A-0172).
    - Assess the patient within 1 hour to identify the immediate situation, reaction of the patient, behavioral condition, and the identify the need to terminate the restraint or seclusion (A-0179).

Reminder: HCS/AAA cannot assess, or transition clients being restrained, Long Term Care settings cannot restrain clients.

Examples of Interventions that are Not Considered Restraints in an Acute Care Hospital setting: Please note, these examples are from CMS regulations and can be found here under A-0161.

- **Orthopedically prescribed devices**.
- **Surgical dressings** or **bandages**.
- **Protective helmets**.
- A **mechanical support** such as a neck, head, or back braces.
- A medically necessary **positioning or securing device** used to maintain the position, limit mobility, or temporarily immobilize the patient during medical, dental, diagnostic, or surgical procedures is not considered a restraint.
- Use of an **IV arm board** to stabilize an IV line is generally not considered a restraint.
    - However, if the arm board is tied down (or otherwise attached to the bed), or the entire limb is immobilized such that the patient cannot access his or her body, the use of the arm board would be considered a restraint.
- Many types of **hand mitts**.
    - However, the following can be considered a restraint:
        - Pinning or otherwise attaching those same mitts to bedding or using a wrist restraint in conjunction with the hand mitts.
        - If the mitts are applied so tightly that the patient's hand or fingers are immobilized.
        - If the mitts are so bulky that the patient's ability to use their hands is significantly reduced
- **Recovery from anesthesia** that occurs when the patient is in a critical care or post anesthesia care unit is considered part of the surgical procedure; therefore, medically necessary restraint use in this setting would not need to meet the requirements of the regulation.
    - However, if the intervention is maintained when the patient is transferred to another unit or recovers from the effects of the anesthesia (whichever occurs first), a restraint order would be necessary, and the requirements of standard (e) would apply.
- Other methods that involve the **physical holding** of a patient for the **purpose of conducting routine physical examinations or tests**.
- Siderails to **protect** the patient **from falling out of bed**.
- To permit the patient to **participate in activities without the risk of physical harm** (this does not include a physical escort).

❖ Hospitals have a responsibility to use the least restrictive alternative. As a mandatory reporter, if you are concerned that a patient is being improperly restrained you should staff with your supervisor to determine if a Department of Health report should be made.

When Would HCS Accept a Hospital Withdrawal of a Client Referred for LTC Services?

If the hospital and the client (if able to communicate their choice at the time) agree to allow HCS to withdrawal the referral due to client not being near ready for discharge (pending guardianship except when pending through GCAP services, not medically stable, etc.), the CM may will take the following actions:

1. SER mutual decision for withdrawal of referral
2. Enter outcome (withdrawal) and date in Acute hospital screen.
3. Do not send a PAN to the client; instead, the Case manager may send a courtesy letter explaining who to contact to get transition planning started again one the client has a decision maker.
4. Send a 14-443 to financial stating "the LTC request was withdrawn, please redetermine for non-LTC medical. CARE record is being inactivated."
    - Omit the 14-443 for MAGI clients.
5. Inactivate CARE record. Financial will determine Medicaid eligibility and if client qualifies, the case will be sent to the CSO.
6. As soon as a new HCS referral is received, verify with financial status of eligibility, and create a new record in the acute care hospital screen with a new referral date.

- ❖ Every referral must have a distinct referral date, even if the client was previously withdrawn and is re-referred for services. Enter the record in the acute hospital screen with a **new referral date**.
- ❖ A PAN is not required for clients for whom the hospital requests to withdrawal the referral.
- ❖ If an individual is pending appointment of a contracted guardian or conservator through GCAP services, the referral is not to be withdrawn due to pending guardianship. Instead, GCAP cases are to be reassigned in care to the Regional Guardianship case manager.

When Would a Hospital Referral for Transition Be Inactivated?

Some individuals who are referred to access LTSS may not have a transition plan in place due to reasons such as not being financially eligible for services, not being medically stable, psychiatrically stable, or guardianship is not in process, and/or among other barriers that may be identified through case staffing. The HCS hospital case manager will;

1. Offer ongoing support to the client, family and /or representative by addressing concerns regarding care in community-based settings.
2. For medically complex individuals, consult with the)HCS Nursing Care Consultant (NCC), AAA Registered Nurse case manager.
3. Offer other services such as Adult Day Health, Skilled Nursing, RN Delegation or Private Duty Nursing
4. Continue to support all efforts towards reducing or eliminating barriers to a less restrictive setting.
5. If after 4 months except in the case of GCAP eligible clients) the client has not made any progress towards transition planning:

a. Conduct a staffing with the unit supervisor to review the status of the case including what has been done, and
b. May inactivate the client in CARE using the "No Current Discharge Plan" code.
c. Advise the hospital when it would be appropriate to re-refer the individual.

6. For a client who refuses HCS services, does not apply, has been determined not to be financially eligible, HCS has lost contact, or client has been determined not to be a good fit for HCS services through the challenging/complex case protocol, the HCS hospital case manager will inactivate the case immediately, and update the acute hospital screen.

❖ Cases resulting in the termination of GCAP services for reasons including but not limited to; a client leaving hospital against medical advice, identification of less restrictive guardian/conservator, or no identified contracted guardian/conservator identified may be inactivated in CARE only by the guardianship case manager using the "No Current Discharge Plan" code.

How are Transitions from Acute Care Hospitals to a Nursing Facility Done?

1. Hospitals may discharge patients to a nursing facility without prior authorization from HCS (refer to Chapter 10 of the Long-term Care Manual for NFCM relocation.)
2. Hospital staff will facilitate the nursing facility admission from the hospital.
3. The hospital discharge planner or nursing facility must still notify the HCS hospital case manager of pending admissions to SNFs to appropriately transfer cases to NFCMs.
4. HCS staff will not have to complete initial CARE assessments for individuals (Medicaid and non-Medicaid) who have been identified as meeting the Pre-Admission Screening & Resident Review (PASRR) criteria prior to discharge from the hospital (refer to Chapter 10 of the Long-term Care manual for details.)

How are Transitions from Acute Care Hospitals to Transitional Care Units/In-Patient Rehab Long Term Acute Care Centers (LTAC) Done?

When an individual transitions to In-patient Rehabilitation (IPR) outside a hospital or to a Long-term acute care (LTAC), HCS considers that transition a hospital discharge. When the transition to IPR is located within a hospital, this is not considered a hospital discharge.

1. Conduct a CARE assessment for clients who have applied for LTC services and are ready to transition to community settings.
2. If the client is transitioned to the transitional care setting prior to assessment, conduct the assessment at the transitional care setting.

3. Individuals in transitional care beds outside a hospital are no longer considered inpatient.

- When a client transfers from an acute hospital to LTAC, this is considered a transition. The discharge outcome for this client is "Other medical facility."
- When a client is referred from LTAC e.g., Vibra Health Care to HCS for LTC services, do not add the referral to the Acute care hospital CARE screen.

How are Transfers outside the Region for Clients in Acute Care Hospitals Done?

When a client is transferring to a different region while still in the hospital, the following should be done:

1. Conduct a case staffing with supervisor to confirm need for transfer.
2. HCS hospital supervisor in charge of a transferring case must transfer the case in CARE and Barcode to the intake unit of the client's destination region while the case is still open, or
3. The supervisor at the region making the transfer may request intake at the destination region to assign the case or contact the intake supervisor to facilitate the transfer.
4. When the intended location to transition the client is outside the local HCS office, notify the receiving office and staff the case before final arrangements to transition the case are in place.
5. When a hospital discharge is imminent and a CARE assessment has been conducted, the HCS hospital case manager may keep the case and put services in place before making the transfer.

How are Hospital Assessments for Clients Referred by Acute Care Hospitals or LTAC With HCS Agreements, Near Washington State Borders Done?

HCS Hospital case managers are responsible for assessing out of state Washington residents in border acute care hospitals or LTACs:

1. When the individual has submitted a LTC application for financial eligibility and is pending Medicaid and;
2. The individual has been referred to HCS for a functional assessment for LTC services by a border acute care hospital or LTAC, and;
3. When the individual is a Washington resident and is planning to return to the state;
4. Follow procedures established in Chapter 3 of the Long-term Care Manual for CARE assessments.

ASSESSMENT DATA & REPORTING

What Information Is Needed by HCS Hospital Case Managers to Conduct an Assessment?

1. Information needed from hospitals.
    a. Submit a Complete financial application prior to the date of the assessment or at the time of sending an intake referral form.

i. PAPER: Hospitals, or clients residing in hospitals, will submit 18-005 application with an Acute Care Hospital coversheet (refer to Appendix III, Expedite Acute Hospital Applications including coversheet).
ii. WaConn: Complete an application online at: https://www.washingtonconnection.org/home/. When completing the application, the client/hospital representative are advised to indicate the name of the hospital on the address line and in the additional comment section of the application, state that the client currently resides in a hospital.

b. Client specific information needed from the hospital: To determine functional eligibility, establish the level of care, and develop a service plan for community providers, hospitals are requested to fax, email, or print and make available at the nurses' station the following information for the HCS hospital case manager on the date of the assessment. This information is not on the Medicaid application and having it promptly assures timely completion of assessment:
   i. Demographic /face sheet
   ii. Progress notes from physicians, nursing, physical therapy (PT), occupational therapy (OT), speech and other therapies
   iii. Admission notes on client's health, physical and psychiatric conditions
   iv. List of current diagnoses
   v. History & Physical (H&P)
   vi. Provide Involuntary Treatment Act (ITA) paperwork (if applicable). Also refer to the state hospital assessment Chapter 9b for details.
   vii. Current wound care notes including treatments.
   viii. Care Plan and/or Behavior Support Plan (BSP) and/or Treatment plan when applicable
   ix. Last 7-day medication administration records (MAR)
   x. Behaviors and interventions (i.e., client wanders and needs to be redirected, yelling, and screaming, assaultive behaviors)
   xi. Known sexual offender status, or related legal issues
   xii. Social work/ discharge planning notes including date of medical clearance for discharge.
   xiii. Guardianship/ DPOA copy (if applicable)
   xiv. Current Durable Medical Equipment (DME) used by client for the assessment (hospital staff to coordinate any future need for DME post discharge)
   xv. Any information critical to a successful transition plan.

c. HCS has established agreements with several acute care hospitals to access Electronic Health Records (EHR). If needing access to EHR system contact your Regional Acute Hospital Program Manager.

2. Notice of change of client condition
   a. When there is a change in the client's condition or the client transitions prior to the assessment, the hospital staff must notify the HCS hospital case manager immediately to appropriately utilize the assessment time slots.
3. Considerations for patients in restraints
   a. To speed up transitions into LTSS, hospitals are requested to transition individuals from restraints prior to assessment and maintain the individual without restraints for

prospective providers. The current HCS policy is for clients to be free of physical and chemical restraint for 3 days prior to assessment and any transition.

Use of Electronic Health Records (EHR)

The use of electronic health records is utilized for care coordination and transition planning.

Appropriate use of EHR:
Unless the document is needed to access a program or service for a specific client, you should not be printing, saving, or sending documents from the electronic health record.

1. If you have consent from a client, it may be appropriate to print the following documents:
    a. POA, guardianship or other legal documents.
    b. Medical documentation for NGMA applications.
    c. Involuntary Treatment Act (ITA) - civil commitment orders and Least Restrictive Alternative (LRA) order or the Conditional release (CR) agreement.
2. If you have printed any of the above documents send them to DMS.

❖ For acute hospital assessors who do not have access to the EHR system (or new staff), medical records need to be requested directly from the hospital. Records should be shredded after work is complete.

What Information Must Be Reported and Tracked For Hospital Referrals?

Ensuring timely access to LTC services for individuals referred by acute care hospitals is one of the key components of how ALTSA transforms lives. The ability to track hospital referrals statewide using standardized data allows ALTSA to record and tell a story of HCS transitions out of acute care hospitals and barriers to transition.

1. The Acute Care Hospital CARE Web Screen outlines required information that needs to be reported about acute care hospital referrals and transition activities.
2. HCS hospital case managers or designated staff at regional offices will follow instructions outlined in the CARE Web Help Screen for Acute Care Hospital to document client barriers, transition plan, and document updates on client progress to transition out of acute care hospitals.
3. To access the acute care hospital screen HCS hospital case managers (assessors) /staff must be granted access depending on the need for use. Access is granted by designated regional staff.

❖ The statewide reporting system for acute care hospital referrals allows HCS to track clients referred to HCS to transition out of the hospital in a coordinated way. It provides data on a statewide level that is used to respond to leadership, legislative, and constituent inquiries and identify potential policy and appropriation requests to address gaps.

MANAGEMENT OF COMPLEX HOSPITAL CLIENT TRANSITIONS

What is Length of Stay (LOS) in Acute Hospital Settings?

For HCS, Length of stay in acute care hospitals refers to the period a hospital patient continues to stay in the hospital from the date a hospital referral is made to HCS for that individual to access long-term care services.

What Additional Transition Strategies Should Be Applied to Complex Client Referrals?

This process outlines strategies to be utilized when dealing with hospital clients whose transition to community settings is hindered by significant barriers making it more likely for the individual to remain in the hospital more than 30 days past the date of referral to HCS. For such individuals:

1. The initial CARE assessment will be completed within 7 days from the date of referral or from the date the client is stable and predictable.
2. When no community option is available for a client after 60 days from the date of referral to HCS, additional contact requirements will be followed:
    a. Face to face contact at the hospital every other month and documented in a SER. Document a SER if the client has had any care plan changes or document if care plan remains the same, what transition efforts are being made etc.
    b. Document contact conversations weekly that occur with the family, collaterals, and hospital staff.
    c. The HCS hospital case manager will review the medical records and determine if the initial assessment no longer meets the client's care needs and follow assessment and care planning policy outlined in Chapter 3 of the Long-term Care Manual.
3. Complex case coordination and case staffing requirements for clients who are still hospitalized 30 days or more past referral:
    a. Conduct case staffing with local office supervisor on a weekly basis.
    b. Send at least weekly updates to local hospitals for coordination purposes per local policies and procedures.
    c. Increase communication efforts with hospital discharge planners, community partners, and community choice guides to help assist with transition efforts.
    d. Follow case staffing and escalation procedures established by the local office, Region, and HQ as outlined in this chapter to provide additional support and resources for transition options.
    e. Refer clients to specialized settings such as Community Support & Stability providers (CSS), Specialized Dementia Care Program (SDCP), Transitional Care Center of Seattle (TCCS) among others using a single referral form for Specialized settings—see appendix VI.

- ❖ Utilize the HCS Screening Tool in Appendix IV to escalate cases
- ❖ Utilize Case Staffing Referral Template Appendix V to document and submit case staffing requests.
- ❖ Utilize the Transition Academy for additional resources.

How is A Complex Client Case Escalated?

The following table outlines when and how complex cases will be escalated for Individuals in acute care hospital. Escalation of complex cases that are currently in a State Hospital, Chapter 9b. There are various staff resources available to assist with complex staffing, for details and who to contact please refer to Appendix VII

Who/ when to Escalate	What is involved and what needs to be done
Escalation from HCS to Hospitals	➢ Each hospital identifies how it would like issues to be escalated when they are not able to be resolved at the discharge planning level. ➢ HCS will be provided with discharge planning /case manager lead contacts or other designees for each hospital. ➢ When there are difficulties in utilizing the identified escalation path, the HCS local office/regional designee will contact the Acute Hospital Program Manager in HCS.
Escalation within HCS	➢ Follow local office and regional escalation procedures with designated staff. At a minimum, follow the escalation steps outlined below. ○ Supervisor will use escalation Screening Tool (see appendix IV) when staffing with the CM to determine if an individual's case needs to be escalated to further support a transition plan. This tool can be used at any point in the case management process, early use is recommended). ○ If client screens in via the escalation screening tool: ▪ staff with cross system partners ▪ Refer client to regional escalation staffing or directly to HQ if determined appropriate.
Escalation with Cross System Partners	➢ If client screens as complex, follow regional protocol and HQ guidance to staff cases with MCO, BH-ASO, DSNP or other relevant partners to create a transition team. ➢ Coordinate with the Managed Care Systems Consultants (MCSC) for your region as necessary to ensure appropriate escalation
Clients at 30 days from date of referral	➢ These cases should be staffed with a supervisor. ➢ Complex cases must be staffed with cross system partners

Who/ when to Escalate	What is involved and what needs to be done
Clients at 60 days from date of referral	➢ These cases should be staffed at regional level by designated staff. o Case staffing must be documented to include options explored and outcomes. o From the regional level, cases may be escalated to ALTSA Headquarters (HQ) if there continue to be barriers. o Use the case staffing referral form (appendix V) to document cases referred to HQ.
Clients at 100 + days from date of referral or after regional/ cross system partner staffing	➢ These cases will be staffed at HQ in collaboration with designated regional managers. In addition, HQ will staff: o Special referrals from regions and hospitals o Cases brought to the attention of the administration from external interest groups. ➢ If all recommendations have been explored and there is continuous communication with cross system partners but without a clear path to transition, such cases may be restaffed at ALTSA Headquarters (HQ).

APPENDIX I HCS REGION ESCALATION CONTACT CHART

Region 1 Area and Counties	Primary Nursing Home	Primary Acute Care Hospital	Primary *Psychiatric Hospital	Secondary Field Services Administrator	Tertiary Deputy Regional Administrator	Tertiary Regional Administrator
North: Chelan, Okanogan, Ferry, Stevens, Pend Oreille, Douglas, Grant, Spokane, Lincoln, Adams, Whitman	Marcie Lee 509-496-2816 Marcie.lee@dshs.wa.gov	Melanie Thomason 509-867-7967 Melanie.Thomason@dshs.wa.gov	Sharon Miranne 509-368-1632 Sharon.miranne@dshs.wa.gov	Valentina Karnafel 509-764-5721 Valentina.karnafel@dshs.wa.gov	Teri Bichler 509-568-3761 Teri.bichler@dshs.wa.gov	Tami Rucker 509-568-3780 Tamara.rucker@dshs.wa.gov
South: Kittitas, Yakima, Klickitat, Benton, Franklin, Walla Walla, Columbia, Garfield, Asotin	Marcie Lee 509-496-2816 Marcie.lee@dshs.wa.gov	Melanie Thomason 509-867-7967 Melanie.Thomason@dshs.wa.gov	Sharon Miranne 509-368-1632 Sharon.miranne@dshs.wa.gov	Marci Benefiel 509-585-8029 Marci.benefiel@dshs.wa.gov	Teri Bichler 509-568-3761 Teri.bichler@dshs.wa.gov	Tami Rucker 509-568-3780 Tamara.rucker@dshs.wa.gov

Region 2 Area and Counties	Primary Nursing Home	Primary Acute Care Hospital	Primary *Psychiatric Hospital	Secondary Field Services Administrator	Tertiary Deputy Regional Administrator	Tertiary Regional Administrator
North: Whatcom, Skagit, Snohomish, San Juan, Island	Amanda Drey 206-626-5707 Amanda.drey@dshs.wa.gov	Kristin Ott 425-903-6070 kristin.ott@dshs.wa.gov	Tuong Pham 206-473-7964 tuong.pham@dshs.wa.gov	Cindy Nomura 206-473-2707 Cindy.nomura@dshs.wa.gov	Joanna Blanford 425-339-4064 Joanna.blanford@dshs.wa.gov	Erin Klones 425-873-9667 Erin.Klones@dshs.wa.gov
South: King	Amanda Drey 206-626-5707 Amanda.drey@dshs.wa.gov	Kristin Ott 425-9036070 kristin.ott@dshs.wa.gov	Tuong Pham 206-473-7964 tuong.pham@dshs.wa.gov	Cindy Nomura 206-473-2707 Cindy.nomura@dshs.wa.gov	Joanna Blanford 425-339-4064 Joanna.blanford@dshs.wa.gov	Erin Klones 425-873-9667 Erin.Klones@dshs.wa.gov

Region 3 Area and Counties	Primary Nursing Home	Primary Acute Care Hospital	Primary *Psychiatric Hospital	Secondary Field Services Administrator	Tertiary Deputy Regional Administrator	Tertiary Regional Administrator
North: Clallam, Jefferson, Kitsap, Pierce	Sonya McCray 360-972-6411 Sonya.Mccray@dshs.wa.gov	Christine Romo 360-764-3888 Christine.romo@dshs.wa.gov	Christine Romo 360-764-3888 Christine.romo@dshs.wa.gov	Linda Milton 253-290-3392 Linda.milton@dshs.wa.gov	Abby Vargas 360-819-6058 Abby.Vargas@dshs.wa.gov	Kara Sells 360-664-9413 Kara.Sells@dshs.wa.gov
Central: Grays Harbor, Mason, Thurston, Pacific, Lewis	Sonya McCray 360-972-6411 Sonya.Mccray@dshs.wa.gov	Christine Romo 360-764-3888 Christine.romo@dshs.wa.gov	Christine Romo 360-764-3888 Christine.romo@dshs.wa.gov	Trisha Armenta 360-664-9414 Trisha.armenta@dshs.wa.gov	Abby Vargas 360-819-6058 Abby.Vargas@dshs.wa.gov	Kara Sells 360-664-9413 Kara.Sells@dshs.wa.gov
South: Wahkiakum, Cowlitz, Skamania, Clark	Sonya McCray 360-972-6411 Sonya.Mccray@dshs.wa.gov	Christine Romo 360-764-3888 Christine.romo@dshs.wa.gov	Christine Romo 360-764-3888 Christine.romo@dshs.wa.gov	Tami Mistretta 360-397-9596 Tamra.mistretta@dshs.wa.gov	Abby Vargas 360-819-6058 Abby.Vargas@dshs.wa.gov	Kara Sells 360-664-9413 Kara.Sells@dshs.wa.gov

APPENDIX II DSHS INTAKE AND REFERRAL FORM 10-570.PDF.

APPENDIX III EXPEDITED ACUTE HOSPITAL APPLICATION CHART AND COVERSHEET

This process should be used for Long-Term Service and Supports applications only

Region 1:

Pend Oreille, Stevens, Ferry Okanagan, Chelan, Douglas, Grant, Lincoln, Spokane, Adams, Whitman, Klickitat, Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Garfield and Asotin Counties

Submit 18-005 applications with an Acute Care Hospital coversheet (see below) or apply online at Washington Connection.

Hospitals contact Social Services intake (by calling intake at 509-568-3767 or 1-866-323-9409, or faxing the Intake and Referral form to 509-568-3772, etc.).

Region 2:

King, Snohomish, Whatcom, Skagit, Island, and San Juan Counties

Paper:
Hospitals, or clients residing in hospitals, will submit 18-005 applications with an Acute Care Hospital coversheet (see below).

WaConn:
Complete an application online at Washington Connection. When completing the application, the client/hospital representative should indicate the name of the hospital on the address line, and state that the client currently resides in a hospital in the additional comments section of the application.

Region 3:

Pierce, Kitsap, Thurston, Mason, Lewis, Grays Harbor, Pacific, Cowlitz, Clark, Clallam, Jefferson, Skamania and Wahkiakum Counties

Paper:
Hospitals, or clients residing in hospitals, will submit 18-005 applications with an Acute Care Hospital coversheet (see below).

WaConn:
Complete an application online at Washington Connection. When completing the application, the client/hospital representative should indicate the name of the hospital

on the address line, and state that the client currently resides in a hospital in the additional comments section of the application.

Hospital Application Referral Coversheet.

ATTENTION

IU staff.

This is an

Acute Care Hospital Application **for LTSS**

and contains

_____ pages.

APPENDIX IV HCS SCREENING TOOL: A GUIDE FOR ESCALATION

Revised November 2021

All cases that meet criteria should be escalated for a regional case staffing via the email icon on your desktop.

Screening Criteria for Escalation:

- **Unstable in current setting or does not have a reasonable transition plan confirmed AND**
- At least one of the criteria in section **A AND**
- At least one item from **B**

A) Mark all the Complex Client Criteria that apply:

Medically complex at D/C: ☐Wound Care; ☐ Dialysis, ☐ Vent/Trach ☐ Other	☐ Serious and Persistent Mental Illness (SPMI)(Major Depression, Bipolar Disorders, Schizophrenia and Borderline Personality Disorder)
☐ Bariatric	☐ Substance Use Disorder (SUD) – history or current
☐ Traumatic Brain Injury (TBI)	☐ Alzheimer's/dementia with behaviors
☐Criminal history: (sex offender, assaultive, arson, murder, etc.)	☐Aggressive or inappropriate behaviors: (Current or past assaultive behaviors, etc.)
☐ Homeless or cannot return to previous setting	☐ Family or client disagree with plan/complex family dynamics

B) Mark all that apply:

Medical Related	**Behavioral Health Related**
☐ Current pressure ulcer requiring ulcer care	☐ Wandering with elopement risk
☐ Unstable diabetic on insulin	☐ Uncooperative during care
☐ Requires weight-bearing or physical assistance from 2 or more people	☐ Refuses care or placements
☐ Fall risk due to balance issues	☐ Has a behavioral plan in place
☐ Pronounced cognitive impairments that impact impulsivity and judgement	☐ Unable to follow a behavioral plan
☐ Requires awake staff overnight due to frequency of care needs at night (repositioning program, toileting, wound care or other treatments, etc.)	☐ Mental Health issues (especially personality disorders); in denial or receiving MH treatment
☐ Requires suctioning (with trach)	☐ Suicidal ideation or actions
☐ Long-term central line in place; on TPN, IV antibiotics	☐ Self-harming behaviors
☐ Ostomy/colostomy care/wound care	☐ Inappropriate sexualized behaviors towards others or public displays
	☐ Up at night and requires intervention (disruptive/unsafe)
	☐ Inappropriate toileting (outside of the toilet, on floors, etc.)
	☐ Smokes; will not stop or wear patch

	☐ Reported they will continue to use substances when D/C

Medical &/or Behavioral Related	**Other Items**
☐ Requires cuing or prompting to complete tasks	☐ Non-decisional – no informal decision maker or formal DPOA, POA, or guardian in place
☐ Requires 1:1 supervision	☐ Cultural or language preferences
☐ Requires supervision for safety when going outside of home or facility	☐ Power wheelchair indoors
☐ Requires accompaniment to doctor or MH appointments, treatment centers (dialysis, methadone), or other health related appointments	☐ Complex DME or environment modifications
☐ Unaware of own safety	
☐ Refuses to take medications or other prescribed treatments	
☐ Requires secure setting (limited egress)	
☐ Requires an individual room for some specific reason	

APPENDIX V ACUTE HOSPITAL/ COMPLEX REGIONAL/HQ CASE STAFFING REFERRAL TEMPLATE

Unless your regional leadership recommends the case to be brought to the Headquarters Case Staffing, start with the regional complex staffing. Once all recommendations from the regional staffing have been completed and there is still no clear path to a transition, alert your regional contact to bring the case to HQ for staffing. Please update the regional staffing form with any new information and send to your regional lead requesting a staffing with HQ.

Complex Case staffing form - Appe

APPENDIX VI SPECIALIZED SETTINGS REFERRAL TEMPLATE

Use this form when referring individuals to the Specialized Dementia Care Program (SDCP) or Transition Care Centers of Seattle (TCCS) paying close attention to eligibility criteria and instructions outlined on the form.

Specialized Settings Referral Form.pdf

APPENDIX VII COMPLEX CASE STAFFING ESCALATION PATHWAY

The staff resources and detailed information outlined below is intended to provide support to regional staff with relevant program resources when handling complex cases.

- Complex Case Staffing: About
- How to make a referral to the Regional Complex case staffing
- How to make a referral to the Headquarters Complex Case Staffing
- Client Consent, Capacity, and Decision-Making
- How do I request assistance on a capacity or consent related concern from the Guardianship Program Manager or Guardianship Case Managers?
- Where do I send Guardianship and Conservatorship Assistance Program (GCAP) case referrals or questions?
- Managed Care Organization (MCO) and Dual Eligible Special Needs Plan (DSNP) escalation support: Including BHWS and CBHS/1915(i)
- My client is detained under an ITA with complex barriers
- Who do I contact for specialty contract referrals questions and escalations?
- Resources and Trainings
- Complex Discharge Pilot

COMPLEX CASE STAFFING

Complex case staffing is a collaborative venue where subject matter experts come together to problem-solve and generate ideas to address challenging situations. It serves as a platform for interdisciplinary teams to discuss barriers, explore various perspectives, and develop innovative strategies to propel the case forward effectively. The process involves active engagement, shared expertise, and a focus on achieving positive outcomes for the client.

There are regional and headquarters pathways available for complex cases. These venues are open to all HCS and AAA teams and occurs virtually.

How to determine which venue to staff my case?

Staff should start at the Regional Complex Case Staffing unless your regional leadership recommends the case to be brought to the Headquarters Case Staffing.

How to make a referral to the Regional Complex Case Staffing

Each region has their own process for staffing complex cases. Please contact your regions MCSC for information on how to refer your case to be staffed and/or escalated.

Region 1	Sarah Rogala, Managed Care Systems Consultant (MCSC)	sarah.rogala2@dshs.wa.gov
Region 2	Laura Botero, Managed Care Systems Consultant (MCSC)	laura.botero@dshs.wa.gov
Region 3	Genevieve Boyle, Managed Care Systems Consultant (MCSC)	genevieve.boyle@dshs.wa.gov

What are the next steps after I send an email to my regional MCSC?

The MCSC will respond to your inquiry within 2 business days and partner with you on the staffing date and time.

How to make a referral to the Headquarters (HQ) Complex Case Staffing

1) Staff with your supervisor	2) Fill out the *Complex Case Regional & HQ Case Staffing Referral**	3) Email form to the Complex Case Staffing Specialist, , Megan McCue Megan.McCue@dshs.wa.gov

* You can find the referral form in Appendix V of LTC Chapter 9a

What to expect when referring to the Headquarters Complex Case Staffing?

Referral will be added to the next HQ staffing date unless a different staffing date is requested. Staffing's occur weekly Fridays. The Complex Case Staffing specialist, the program manager or supervisor will send the assigned SSS3 an invite to the HQ Complex Case staffing which is held via teams. Each case manager, supervisor, or Program Manager will have 3 to 5 minutes to present client's case and barriers.

After completion of the case staffing, the Complex Case Staffing Specialist (CCSS) will email recommendations to the Program Manager and Supervisor for next steps, SER note staffing and follow up with hospital on collaboration and notification of case escalation. The CCSS will then track client's case until barriers have been resolved.

CLIENT CONSENT, CAPACITY, AND DECISION-MAKING

Who is the Guardianship Program Team and what do they do?

The Guardianship Program team is composed of a Guardianship Program Manager (GPM) and regional Guardianship Case Managers (GCM). GPM serves as the subject matter expert related to the processes involved with the Uniform Guardianship, Conservatorship, & Other Supportive Arrangements Act (UGA) under RCW 11.130 and the Uniform Power of Attorney Act under RCW 11.125. The GPM and regional GCMs coordinate with regional and HQ staff on cases involving clients with decisional capacity, consent, and decision-maker related concerns impacting the client's ability to access or maintain long-term care services and supports.

The Guardianship Program team members are:

Guardianship Program Manager (GMP)	*Sarah Tremblay*
Region 1 Guardianship Case Manager (GCM)	*Amy Depaolo*
Region 2 Guardianship Case Manager (GCM)	*Kendra Kruse*
Region 2 Guardianship Case Manager (GCM)	Angelique Johnson
Region 3 Guardianship Case Manager (GCM)	*Cathleen Hansen*

How do I request assistance on a capacity or consent related concern from the Guardianship Program Team?

- Document(s) Review.
- Staffing with the Office of the Attorney General (OAG) or Headquarters Guardianship team
- For any other capacity or consent related concern or question

Send an email to the ALTSA Escalation Pathway, which is monitored Monday - Friday: ALTSAAcuteHospitalGuardianshipCaseStaffing@dshs.wa.gov

Where do I send Guardianship and Conservatorship Assistance Program (GCAP) referrals or questions?

Guardianship and Conservatorship Assistance Program referrals or questions (general or case specific)
All regions may send their inquiries directly to (GPM) Sarah Tremblay Sarah.Tremblay@dshs.wa.gov
Referral form and GCAP specific information may be found at: GCAP Referral Forms & Information

What are the next steps after I send an email?

For escalation pathway emails, the GCM will respond to your inquiry within 2 business days and partner with you on recommendations, document review outcomes, and any next steps depending on the escalation request type. For GCAP case referrals or questions, the GPM will respond to your inquiry or referral within 2 business days and update referral status and eligibility determination in a SER note.

MANAGED CARE ORGANIZATION (MCO) AND DUAL ELIGIBLE SPECIAL NEEDS PLAN (DSNP) ESCALATION SUPPORT: INCLUDING BHWS, IBSS AND CBHS/1915(I)

Who are the Managed Care Systems Consultants (MCSC) and what do they do?

MCSCs are part of the HQ integration team, and each region has a MCSC assigned to assist with connecting staff to the Managed Care Organizations (MCOs) and Dual- Special Needs Plans (D-SNP). They play a key role in the coordination of Behavior Health Wraparound and Supports (BHWS), Intensive Behavioral Supportive Supervision (IBSS) and Community Behavioral Health Support (CBHS/1915i) escalation requests and assist on complex cases in the regions and with our AAA partners.

How do I request support?

- MCO and/or DSNP care coordination
- BHWS
- IBSS
- CBHS/1915i escalation or support

Send an email to your regional MCSC with your inquiry, client's name and Provider One number.

Region 1	Sarah Rogala	MCSCsupport@dshs.wa.gov
Region 2	Laura Botero	
Region 3	Genevieve Boyle	

What are the next steps after I send an email?

The MCSC will respond to your inquiry within 2 business days and partner with you on next steps depending on the escalation request.

STATE HOSPITAL DISCHARGE AND DIVERSION (SHDD) TEAM

Who is the State Hospital Discharge and Diversion Team?

The HQ State Hospital Discharge and Diversion (SHDD) Teams is composed of Transition Coordinators (TC) and a Transition Specialists (TS). Transition Coordinators (TC) support transitions from State Hospitals and Transition Specialists (TS) support diversion work from community psychiatric and acute care hospitals for clients who are involuntarily detained under the Involuntary Treatment Act (ITA). Each region has a **TC** and **TS** assigned to partner with staff. They provide clinical consultation, offer training to

support timely, quality and support a safe, person-centered transitions to client's preferred setting. In addition, they coordinate with the regional teams and the judicial system on all show cause hearings. They also serve as the primary point of contact for specialty contracted facilities (CSS, ESF, SDCP+) referrals and escalations.

My client is in the State Hospital. How do I request support?

- Transition Planning for complex barriers
- Risk Assessment Review
- Specialty contract facilities (CSS, ESF and SDCP+) referrals and escalations
- IRT Referral assistance

Send an email to your regional **TC** with your **inquiry**, **client's name and ACES ID**

Region 1	Pamela Young, Transition Coordinators	pamela.young@dshs.wa.gov
Region 2	Sarah Miller, Transition Coordinators	sarah.miller2@dshs.wa.gov
Region 3	LaTia Townsend, Transition Coordinators	latia.townsend@dshs.wa.gov

My client is in a Community Psychiatric setting or Acute Care Hospitals setting. How do I request support?

- Transition Planning for complex barriers.
- Show Cause Hearing Questions/Support
- ITA document Review
- Specialty contract facilities (CSS, ESF and SDCP+) referrals and escalations

Send an email to your regional **TS** with the **client's name, ACES ID and your inquiry.**

Region 1	Jeff Rose, Transition Specialist	jeffrey.rose@dshs.wa.gov
Region 2	Lisa Clarke, Transition Specialist	lisa.clarke@dshs.wa.gov
Region 3	Briauna Hill, Transition Specialist	briauna.hill@dshs.wa.gov

What are the next steps after I send an email?

The TS will respond to your inquiry within 2 business days and partner with you on next steps depending on the escalation request.

COMPLEX DISCHARGE PILOT

What is the Complex Discharge Pilot?

The Complex Discharge Pilot will be implemented in Spring of 2024 with the goal of decreasing length of stay, reduce admissions and strengthen care coordination between all parties working with these complex individuals.

This pilot will be specific to 5 hospital systems across the state who will have dedicated hospital staff to provide enhanced care management (ECM) to individuals identified by the hospitals as being medically stable but have barriers to discharge. These individuals, referred to as pilot participants, will be eligible for ECM services for 180 days to work through the barriers that prevent them from living within a community setting of their choice.

Pilot participants will be case managed by identified NFCM for the duration of their enrollment in the pilot.

Have questions about the Complex Discharge Pilot?

Jody Gasseling- Acute Hospital Change Manager Jody.Gasseling@dshs.wa.gov
Amanda Speck- RCL Enrollment Specialist Amanda.Speck@dshs.wa.gov

RESOURCE AND TRAININGS

Chapter 7f: Residential Support Waiver

Chapter 9a: Acute Care Hospital Assessments

Chapter 9b: State Hospital Assessment

Chapter 22a: Apple Health Managed Care and Apple Health Medicare Connect (D-SNP)

1915i SharePoint: Community Behavioral Health Support (CBHS) Services - Home (sharepoint.com)

Who to reach out for additional training or questions?

The Integration Team is here to support regional staff. If you are interested in additional trainings, please reach out to the main contact person listed below.

Complex Discharge Pilot	Jody Gasseling	Jody.Gasseling@dshs.wa.gov
Acute Hospital Assessments and Transition Policy	Jody Gasseling Erika Gustafson	Erika.Gustafson@dshs.wa.gov Jody.Gasseling@dshs.wa.gov
Community Behavioral Health Supports (CBHS)	Managed Care System Consultant (MCSC)	MCSCsupport@dshs.wa.gov
Uniform Guardianship Act DPOA, Consent, Capacity and Decision Making	Sarah Tremblay or Regional Guardianship case managers	Sarah.Tremblay@dshs.wa.gov

APPENDIX VIII GUARDIANSHIP AND CONSERVATORSHIP ASSISTANCE PROGRAM (GCAP)

The staff resources and detailed information outlined below is intended to provide support to regional staff with relevant program resources when handling GCAP cases.

- What is the Guardianship and Conservatorship Assistance Program (GCAP)
- What services does GCAP provide
- What is a GCAP Program Slot, Tier Term, or Tier Designation
- Who are GCAP Contractors
- What are the client eligibility criteria for GCAP
- How to make a GCAP referral
- When is a GCAP record created
- When and how are GCAP records finalized
- How are LTSS applications processed for GCAP clients
- How are GCAP cases assigned
- How are transfers outside the region for GCAP clients in Acute Care Hospitals done
- What is the role of the Guardianship Case Manager in assessments and transition planning
- What are the additional responsibilities of the Guardianship Case Manager

What is the Guardianship and Conservatorship Assistance Program (GCAP)

Some individuals referred to HCS for long-term care services deal with multi-faceted barriers including the lack of a decision maker for consent to services making the assessment and transition more complicated and time intensive. To reduce some of the pressure on an already strained healthcare system, DSHS, in partnership with acute care hospitals, implemented a guardianship pilot project in July 2022 aimed at targeting this small sub-group of individuals for assistance with identifying Certified Public Guardians and/or Conservators for the purposes of accessing access long-term care services and supports (LTSS) which would allow for client transitions from Acute Care Hospitals.

Effective September 1, 2024, given the successful outcomes, DSHS has transitioned the guardianship pilot project to a program. The program is called the HCS Guardianship and Conservatorship Assistance Program (GCAP).

GCAP is a state-funded program with limited slot availability for clients meeting specific criteria. GCAP is designed to assist Acute Care Hospitals (ACH) in the identification of proposed guardians and/or conservators for a small subset of eligible and presumed eligible clients needing a decision maker to access long-term care services and supports (LTSS). GCAP is designed as a collaborative process wherein DSHS HCS works in tandem with ACHs to assist them with the identification of proposed guardians and/or conservators while the hospital remains the petitioning party to a motion filed with the court under RCW 11.130. Only in limited situations does HCS serve as the petitioning party in such cases.

Additional information pertaining to GCAP and an introduction to the GCAP team may be found in Chapter 388-106-2100 WAC and on the Acute Care Hospital stakeholder site: Acute Care Hospitals | DSHS (wa.gov)

Services that GCAP Provides

GCAP provides professional guardianship and/or conservatorship services to eligible clients for the purposes of establishing a legal decision-maker required to facilitate care transitions for eligible clients no longer able to consent to their own care. GCAP offers limited financial support to certified contracted professional guardians and conservators as a way of removing barriers for Medicaid clients accessing professional decision-making services to support their long-term care needs. To support such work, service rates were mirrored from service rates for similar services offered through the Office of Public Guardians, to incentivize professional guardians and conservators to accept legal appointments for Medicaid recipient cases that would have otherwise posed financial obstacles in accessing decision-making services.

1. Each GCAP case receives:
    a. A monthly guardianship and/or conservatorship service fee at the following denominations as calculated from the date of court appointment:
        i. Months 1-3 at monthly rate of $710.00
        ii. Months 4-12 at monthly rate of $440.00
        iii. Months 13+ (Tier 2 clients only) at monthly rate of $235.00 or allowable Medicaid rate.
    b. A one-time case establishment fee in the amount of $1,500.00
        i. This fee is a one-time fee, per GCAP case, paid to contractor to assist in the offset of legal filing fees and court costs which were identified as causing significant financial barriers to professional guardians and conservators willing to accept appointment of Medicaid cases.
2. Each GCAP case filed and appointed in King County receives:
    a. A one-time King County Filing Stipend in the amount of $2,500.00
        i. This fee is a one-time fee, per GCAP case, paid to contractor to assist in the offset of legal filing fees and court costs which were identified as disproportionately higher in King County causing significant financial barriers to professional guardians and conservators willing to accept appointment of Medicaid cases in said county.
3. Each GCAP case that is terminated after contractor court appointment prior to the identified term completion date receives:
    a. A one-time case closure fee in the amount of $300.00
        i. This fee is a one-time fee, per GCAP case, paid to contractor to assist in the offset of legal filing fees and court costs associated with final notices or court reports required to close an established guardianship or conservatorship legal case under RCW 11.130.
        ii. This fee is not authorized for services completing the designated tier term.
4. Each new GCAP contractor receives:
    a. A one-time only, operational expense stipend in the amount of $4,000.00

i. This fee is paid upon the court appointment of a new contractor's first GCAP case following the execution of their initial DSHS GCAP contract.
   - This fee is not paid upon court appointment of first GCAP case following contract renewal or extension.

ii. This fee is paid to assist new contractors with offsetting the financial burden of operational expenses imposed on small businesses to meet initial contracting requirements, such as insurance requirements.
   - The contractor is responsible for maintaining ongoing compliance with contractor requirements after this one-time fee is issued.

What is a GCAP Program Slot, Tier Term, or Tier Designation

As outlined in WAC 388-106-2105, a GCAP program slot means a GCAP program vacancy based on timeframe of needed resources as designated by either a "Tier 1" and "Tier 2" designation when the following definitions are applied:

1. **Tier 1:** A program slot with a maximum service benefit of up to 12 months duration from the time of court appointment of a contractor.
2. **Tier 2:** A program slot with continuous service benefits for individuals not required to pay participation towards their cost of care based on financial thresholds per WAC 182-513-1315(1)-(3) or individuals who are not United States citizens.

A tier term is the corresponding amount of time a client will receive benefits based on the designated tier approved.

Who are GCAP Contractors

GCAP contractor eligibility criteria are outlined in chapter 388-106-2110 WAC. To become a GCAP contractor, an individual must:

1. Hold certification as a professional guardian and conservator approved by the state of Washington supreme court;
2. Be in good standing with the certified professional guardian and conservator review board (CPGCRB);
3. Have sufficient insurance coverage to meet DSHS contracting requirements;
4. Hold a program contract with DSHS; and
5. Comply with the requirements of the program as described in chapter 388-106 WAC.

What are the client eligibility criteria for GCAP

GCAP eligibility criteria are outlined in chapter 388-106-2110 WAC. To be initially determined eligible for GCAP services, an individual must:

1. Meet long-term care services and supports (LTSS) Medicaid functional eligibility requirements in chapter 388-106 WAC and financial eligibility requirements in WAC 182-513-1315(1)-(3) or be determined provisionally approved;
2. Not have financial resources to pay for guardianship services, fees, or costs from their estate;
3. Have a qualifying neuro-cognitive diagnosis as defined in WAC 388-106-2105;
4. At the time of referral and acceptance into the program, be occupying an acute care hospital bed, and not be in a restricted sub-group, including but not limited to:

a. Occupancy in a bed readiness program bed
b. Occupancy in a skilled nursing facility bed
c. Occupancy in inpatient rehabilitation bed
d. Occupancy in an inpatient mental health bed
e. Occupancy in an emergency department bed
f. Occupancy in a long-term acute care hospital (LTACH) bed
g. Occupancy in an acute care hospital bed under observation status
h. Occupancy in an acute care hospital bed under a single bed certification pursuant to chapter 71.05 RCW

5. At the time of referral and acceptance into the program, no longer require an inpatient level of care at an acute care hospital;
6. Likely require the appointment of a guardian and/or conservator to be able to access and maintain long-term services and supports; and
7. Not have a professional or lay guardian or conservator willing to accept nomination.

To remain eligible for GCAP services for the duration of the designated term, an individual must:

1. Remain functionally and financially eligible for DSHS LTSS benefits; and
2. Receive a DSHS LTSS service.

How to make a GCAP referral

When it is determined that a client no longer has the ability to consent to LTC services and did not consent to authorizing a representative, a guardianship and/or conservatorship may be needed to support the client's transition and ongoing care. A hospital, directly or through assistance of an assigned case manager or public benefits specialist, may refer such a client for consideration for GCAP services by following the practice outlined in WAC 388-106-2115 and 388-106-2120.

1. If the hospital is unable to identify a proposed guardian or conservator for court nomination, the hospital may submit a referral for GCAP services to the Guardianship Program Manager for eligibility determination. The hospital must:
   a. Submit and complete the ListServ process to meet their due diligence in attempts to identify a less restrictive guardian or conservator willing to serve the client.
   b. Submit the GCAP Referral Form which may be found on the Acute Care Hospital Stakeholder website: Acute Care Hospitals | DSHS (wa.gov)
   c. Submit all supplemental documentation and/or clinical packet as requested
   d. Submit LTSS application on behalf of client if one has not previously been submitted
      i. The Guardianship Program Manager will provide eligibility determination within 3 business days from the date referral form and complete packet are received or completion date of statewide ListServ process, whichever occurs later.
      ii. The Guardianship Program Manager will send a Notice of Department Decision (NDD) regarding program eligibility determination to the client and hospital referent.
2. If a client is determined eligible for GCAP services, the case will be transferred to the regional Guardianship Case Manager and the hospital discharge planner will work collaboratively with the Guardianship Program Manager, Guardianship Case Manager, and GCAP contractors to:

a. Confirm hospital petitioner status.
    i. When hospitals serve as petitioning party to the UGA motion, the hospital discharge planner collaborates with their legal counsel to execute petition, declaration statements, and legal pleading for filing with the court. Hospital discharge planner must supply contact information of hospital legal counsel to the Guardianship team for ongoing GCAP coordination.
    ii. When hospitals are unable to serve as petitioning party to the UGA motion, the hospital discharge planner must request for Petition Exemption ETR from the Guardianship Program Manager.
        - Petitioner Exemption ETRs will be processed within seventy-two hours (72) of receipt by the Guardianship Program Manager.
        - If approved for Petitioner Exemption ETR, HCS will serve as petitioning party through the Office of the Attorney General (OAG) and the acute care hospital discharge planner will be required to submit a supplemental declaration of support for HCS petition.

b. Schedule client visits with identified proposed contractor(s).
    i. Visits may occur in person, telephonically, or electronically based on client needs and contractor preference.

c. Assist court visitor with obtaining required clinical documentation, including a Medical Report from a hospital provider.

3. If a client is appointed a guardian and/or conservator through GCAP services, the hospital acknowledges:
    a. that transition may not occur until such time that DSHS receives copies of both orders appointing guardian and/or conservator and letters of office.
        i. Issuance timeframes of letters of office vary significantly from county to county.
        ii. Transition may be delayed if additional court authority must be sought to ensure appropriate level of care for the client.

When is a GCAP record created

Effective September 1, 2024 all GCAP referrals will generate a GCAP record in CARE Web.

1. GCAP records can only be created by a member of Guardianship Management security group.
2. GCAP records are view only for HCS staff with CARE Web access but a

When and how are GCAP records finalized

A GCAP record is finalized when either of the following occur:

1. A GCAP referral is received and eligibility determination results in denial; or
2. GCAP services are terminated.
    a. The most common reasons for GCAP service termination include but are not limited to a client leaving hospital against medical advice prior to appointment of a GCAP Contractor, identification of a less restrictive guardian/conservator, no identified GCAP Contractor, client death, completion of GCAP service term, client no longer LTSS eligible, alternative funding identified, etc.

b. When GCAP services are terminated:
   i. the GCAP record is finalized in the CARE Web screen after noting the termination reason in the GCAP notes section;
   ii. the case may be inactivated in CARE using the "No Current Discharge Plan" code or be reassigned as applicable;
   iii. A Notice of Department Decision (NDD) regarding program termination is sent to the client, hospital referent, and GCAP contractor for all termination reasons other than termination for client death or completion of original GCAP tier term.

❖ A GCAP record remains "active" or "open" for the duration of the client's designated GCAP service term, regardless of the client's residence.

How are LTSS applications processed for GCAP clients

Financial eligibility determination for GCAP approved cases are processed by the same procedures outlined in chapter 7a with the following exceptions:

1. If an individual is pending appointment of a contracted guardian or conservator through GCAP services, the referral is not to be withdrawn due to pending guardianship. Instead, GCAP cases are to be reassigned to the regional Guardianship Case Manager in active status.
2. GCAP cases are eligible to remain open or in pending status under 'good cause justification' for up to 120 days from the date of court appointment to ensure guardian/conservator receives necessary court documents sufficient to marshal pre-existing client accounts and access financial documentation required for financial eligibility determination.

How are GCAP cases assigned

A case accepted onto Guardianship and Conservatorship Assistance Program (GCAP) services is assigned to either the:

- Regional HCS guardianship case manager when the client is in an acute care hospital or
- Nursing Facility Case Manager, Residential Care Case Manager, or the AAA Case Manager when the client is residing in a setting outside of the acute care hospital setting.

1. A case accepted onto Guardianship and Conservatorship Assistance Program (GCAP) services can be assigned to the Guardianship Case Manager as either:
   a. ***Primary Case Manager***- When a case is referred by an acute care hospital and is determined by the Guardianship Program Manager as eligible for GCAP services, the case is assigned to the regional guardianship case manager for ongoing case management and transitional planning needs. The Guardianship Case Manager works in collaboration with the Guardianship Program Manager, acute care hospital legal representatives, acute care hospital discharge planners, and GCAP contractors to complete HCS care management and transitional planning duties in addition to overseeing the judicial process outlined below for the court appointment of contracted guardians and/or conservators pursuant to RCW 11.130 to meet the client's needs.

b. ***Peripheral Case Manager***- After transition of a GCAP case from Acute care hospital, the Guardianship Case Manager remains assigned to the client's team as a peripheral case manager, not primary, for purposes of providing ongoing liaison services to contracted guardians and conservators for the duration of a client's GCAP tier term. Durations can be up to 1 year from date of court appointment (for Tier 1 clients) or indefinitely (for Tier 2 clients).

2. When should a case be assigned to the Guardianship Case Manager:
   a. Hospital clients who have been referred to and initially accepted onto GCAP services will be reassigned to the Guardianship Case Manager on the HCS Acute Care Hospital unit upon initial acceptance onto GCAP services.
   b. Hospital clients active on GCAP services who were receiving long-term care services in residential settings (AFH, AL, or ESF) prior to hospitalization and are expected to return to this setting upon discharge require reassignment to the HCS hospital unit should be assigned to the Reginal HCS Guardianship Case Manager.
   c. When hospital clients active on GCAP services who were receiving in-home services prior to hospitalization and will not return to in-home services within 30 days of being hospitalized require reassignment to the HCS hospital unit, the case should be assigned to the Regional HCS Guardianship Case Manager.

How are transfers outside the region for GCAP clients in Acute Care Hospitals done

When a GCAP client is transferring to a different region while still in the hospital, the following should be done:

1. Conduct a case staffing with supervisor to confirm need for transfer.
   a. The originating regional guardianship case manager will complete staffing with the receiving regional guardianship case manager.
   b. The receiving regional guardianship case manager will set CARE Tickler to ensure assignment to client's team as a peripheral case manager, not as primary case manager. This allows for ongoing follow-up for guardianship and conservatorship related needs during the client's GCAP service term.
   c. The originating regional guardianship case manager will send the GCAP contracted guardian/conservator notification of change in guardianship case manager assignment and provide contact information for the receiving guardianship case manager.
2. HCS hospital supervisor in charge of a transferring case must transfer the case in CARE and Barcode to the intake unit of the client's destination region while the case is still open, OR
3. The supervisor at the region making the transfer may request intake at the destination region to assign the case or contact the intake supervisor to facilitate the transfer.
   a. When transferring a GCAP case, the supervisor making the transfer request should ensure that the case is also assigned to the regional guardianship case manager in the client's destination region. The guardianship case manager is added to the client's team as a peripheral case manager, not as primary case manager.
4. When the intended location to transition the client is outside the local HCS office, notify the receiving office and staff the case before final arrangements to transition the case are in place.

5. When a hospital discharge is imminent and a CARE assessment has been conducted, the guardianship case manager may keep the case and put services in place before making the transfer.

What is the role of the Guardianship Case Manager in assessments and transition planning

1. If assigned to the Guardianship Case Manager, the guardianship case manager will:
    a. Make contact with the client within two working days of receipt of referral as outlined in Chapter 3 of the Long-term Care Manual.
    b. Triage cases to determine the appropriate time for an assessment.
        i. GCAP cases may be assessed up to 2 weeks prior to final court appointment hearing but assessment cannot be released to providers until copies of both court orders and letters of office are received.
    c. Update the Acute Hospital Screen in CARE Web to start tracking the referral and keep the client record up to date. Guardianship/Decision Maker barrier should be removed when a GCAP case is appointed a contracted guardian/conservator by the court.
    d. Update the Guardianship and Conservatorship Assistance Program Screen in CARE Web to start tracking the guardianship and/or conservatorship judicial appointment process as outlined in the Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act (RCW 11.130) and corresponding GCAP services and payments for the duration of the GCAP tier term.
    e. Complete a full initial, initial/reapply or significant change assessment in CARE to determine care needs, and present appropriate service options to the client and/or contracted guardian and/or conservator and authorize personal care services within 30 days from the date of receipt of both court order appointing guardian/conservator and letters of office.
        i. When completing assessment prior to appointment hearing, assessment cannot be released until copies of both court order appointing guardian and/or conservator and letters of office have been received and scanned to DMS.
    f. When court order appointing guardian and/or conservator is received, update client mailing address to reflect the guardian's and/or conservator's mailing address to ensure that all notifications are sent to legal decision-maker.
    g. Provide information about long-term care services and supports to hospital staff, patients, and guardian/conservator.
    h. Assist with developing multiple potential transition plans into LTC care settings concurrently, including finding a provider.
    i. Identify, document, and address barriers to transition as early as possible.
        i. Remove Guardian/Decision Maker barrier upon court appointment of contracted guardian and/or conservator.
    j. Collaborate with guardian/conservator and hospital and/or transitional site of care staff on discharge planning.
    k. Coordinate with transitions of care planners at Managed Care Organizations (MCOs).

l. Submit Non-Grant Medical Assistance (NGMA) applications for those who will benefit from Waiver services and do not meet the Aged/Blind/Disabled criteria to access Waiver services.
m. Utilize FAST TRACK for community services, if appropriate
n. Submit transfer requests to HCS intake unit or direct supervisor for clients who will be receiving long-term care services in their homes for ongoing AAA case management as soon as the:
    i. Referrals for services are made.
    ii. Services are authorized.
    iii. Service plan is implemented.
    iv. Provider service contracts are arranged, if appropriate
    v. RAC are entered in CARE.
        i. GCAP RAC and Authorization are entered in CARE (See chart below).
        ii. GCAP RAC and Authorizations can only be entered by a member of the client's team who has guardianship security group designation.

RAC	SERVICE CODE	MODIFIERS
3315- GCAP	**SA111**	• **UA**: Months 1-3 at monthly rate of $710 • **UB**: Months 4-12 at monthly rate of $440 • **UC**: Months 13+ (Tier 2 clients only) at monthly rate of $235 or allowable Medicaid rate. • **U1**: Operational Expense Stipend $4,000 • **U2**: King County Filing Stipend $2,500 • **U3**: Case Establishment Fee $1,500 • **U4**: Case Closure Fee $300

    vi. ProviderOne authorization is "error free" and in CARE,
    vii. Notation entered into the Client tab in Barcode indicating GCAP approval, GCAP Tier designation, and corresponding GCAP service end date to communicate eligibility and payment approvals to PBS as outlined in Chapter 7a.
    viii. The client and/or guardian/conservator and provider have signed the service summary and returned it to the relevant HCS staff for review and signature.
o. Adds self to client's team on the CARE Web Overview Screen. After transition from Acute care hospital, the regional Guardian Case Manager for the region which client will be residing, will add themselves to the client's team but will not be listed as the primary case manager; this is because all GCAP cases remain open and followed peripherally by the regional guardianship case manager for the duration of GCAP term.

i. Guardianship case manager follows peripherally for purposes of tracking GCAP service barriers and to serve as a liaison for contracted guardians and/or conservators. Guardian case managers defer case management duties to primary case manager assigned to the case based on client's setting.

p. Likewise, follow above procedures outlined from 1(i) through (o) for transferring client cases to an HCS Residential or Nursing Facility case manager for clients who will receive services in residential or skilled nursing facility settings.

2. For hospital clients approved for GCAP services who are discharged from Acute care hospitals before an HCS hospital assessment and/or LTC service plan is in place; the guardianship case manager or supervisor will submit a transfer request for the individual to be followed up by the HCS in-home unit or HCS residential unit to expedite assessment and/or set up of services for appropriate LTC community options. When these cases are transferred it should be noted that they were discharged from the hospital before assessment or service planning could be established and that these cases need to be expedited by the receiving team once guardianship and/or conservatorship court appointment has occurred and copies of both court order appointing guardian and/or conservator and letters of office have been received.
    a. GCAP approved cases may be transferred to alternative sites of care such as Complex Pilot, bed readiness, or skilled nursing facility sites while pending completion of the legal judicial process to appoint a guardian and/or conservator.

What are the additional responsibilities of the Guardianship Case Manager

Guardianship Case Managers serve dual roles. In addition to performing the case management of GCAP eligible cases, the Guardianship Case Manager monitors the judicial process for decision making outlined in RCW 11.130 and oversee the escalation pathway inbox for inquiries related to consent, decision making, and documentation review needs.

1. Case management of GCAP eligible cases: When a case is referred by an acute care hospital and is determined by the Guardianship Program Manager as eligible for GCAP services, the case is assigned to the regional guardianship case manager for ongoing case management and transitional planning needs.
    a. The Guardianship Case Manager works in collaboration with the Guardianship Program Manager, acute care hospital legal representatives, acute care hospital discharge planners, and GCAP contractors to complete HCS care management and transitional planning duties in addition to overseeing the judicial process outlined below for the court appointment of contracted guardians and/or conservators pursuant to RCW 11.130 to meet the client's needs.
    b. The Guardianship Case Manager updates the Guardianship/Conservatorship Screen in CARE Web to reflect legal case status updates pertaining to a petition filed under RCW 11.130.
        i. Identification of contractor for court nomination
        ii. Petition Filing
            - Will serve as petitioning party for any GCAP petition filed by the Office of Attorney General when the case is approved for a Petitioner Exemption ETR.

Petitioning is initiated by completing *DSHS Form 10-162* and signature on formulated pleadings filed under RCW 11.130.

iii. Review of executed court orders and documentation
iv. Hearings
- Will attend and testify at any GCAP hearing when HCS serves as petitioner under Petitioner Exemption ETR approval or when needed based on circumstances of GCAP case.

v. Appointment Status
vi. Scanning Uniform Guardianship, Conservatorship, and Other Protective Arrangement Act (UGA) legal documents to DMS for record retention

c. The Guardianship Case Manager updates the Acute Hospital Screen in CARE Web to start tracking the referral and keep the client record up to date.
   i. Once a Court has determined that an GCAP eligible individual lacks decision-making capacity and appoints a GCAP contracted guardian and/or conservator to oversee the individual's personal and/or financial decisions through a judicial motion filed under the UGA (RCW 11.130), the Guardianship Case Manager completes needed case management and transitional planning as previously outlined in the 'What is the Role of HCS in Transitioning Clients to a Community Setting' section of this chapter.
   ii. Tracking UGA and Medicaid case status through monitoring of quarterly contractor reports.
   iii. After transition of a GCAP case from Acute care hospital, the Guardianship Case Manager remains assigned to the client's team as a peripheral case manager, not primary, for purposes of providing ongoing liaison services to contracted guardians and conservators for the duration of a client's GCAP tier term. Durations can be up to 1 year from date of court appointment (for Tier 1 clients) or indefinitely (for Tier 2 clients).

2. Oversight of the Escalation Pathway Inbox: Guardianship Case Managers oversee the escalation pathway inbox for the purposes listed below. Guardianship Case Managers will partner with regional staff to provide support by responding to regional inquires within 3 business days of receipt and documenting inquiries and outcomes on established tracking form.
   a. Case staffings involving:
      i. Guardianship
      ii. Conservatorship
      iii. Capacity
      iv. Decision-Making
      v. Power of Attorney
      vi. Other Protective Arrangements
      - Staffings occur at regional, headquarters, and OAG levels as indicated based on circumstances of the case.

- Guardianship Case Manager escalates and schedules staffings to headquarters and OAG levels as needed in collaboration with Guardianship Program Manager.

b. Reviewing documents related to decision making authorities, including:
   i. Court orders and letters of office
   ii. Power of Attorney
   iii. Trust Agreements
   iv. Supportive Decision Making Agreements
   v. Care Contracts
   vi. Any Other Protective Arrangements
      - Document reviews occur at regional, headquarters, and OAG levels as indicated based on circumstances of the case.
        - Guardianship Case Manager escalates document reviews to headquarters and OAG levels as needed in collaboration with Guardianship Program Manager.

Additional Decision Maker Resource Tools

ALTSA - How to Identify a Guardian: ALTSA - How to Identify a Guardian.	This is a resource tool designed to outline the process of identifying a person to serve as guardian and/or conservator for individuals who no longer have capacity to consent to services and have no legal decision-maker identified. A person must be identified for nomination as proposed guardian and/or conservator in order to file a legal motion with the court. This resource tool also serves to explain the process of identifying a proposed nominee utilizing alternative programs such as GCAP and Office of Public Guardians (OPG) as both are distinct and separate programs with their own eligibility criteria and governing laws.
ALTSA - Power of Attorney vs. Uniform Guardianship: ALTSA - Power of Attorney vs. Uniform	This is a resource tool designed to overview available court processes to explore identification of an alternative decision maker for individuals who no longer have capacity to consent to services themselves. This resource tool explains the differences between the Power of Attorney Act and the Uniform Guardianship, Conservatorship, and Other Protective Arrangements acts and the legal remedies that can be provided under each motion type.

GLOSSARY

Word	Definition
Complex client escalation process	Established process that requires multi-systems supports in the community to establish and sustain transitions to community settings. Such cases present significant medical, psychiatric and/ or criminal concerns that inhibit transitions to community settings.
Community settings	Long-term care service options where clients can reside such as the client's home, Adult Family Home, Assisted living facilities among others.
Conservator	A person appointed by the court to make decisions with respect to the property or financial affairs of an individual, adult or minor, subject to conservatorship.
Discharge plan	A care plan developed for a client indicating where the client will transition to including the type of support/ services the client will need. This plan is created by the client, family, hospital discharge planner, and HCS or AAA staff. The client may seek to transition in different Long-term care service options including nursing homes.
Diversion from acute care hospital	An individual who is detained through the Involuntary Treatment Act who is stabilized and transitioned into home and community long-term care settings prior to the need to petition for a 90 or 180 day commitment order (see MB H19-042).
Hospital assessment	A CARE assessment to determine functional eligibility for long-term care services in community-based settings.
Hospital discharge planners	Designated staff who work with the client to create and implement a discharge plan. Discharge functions are usually carried out by social workers and Registered Nurses in hospitals. Managed care organizations and other insurance carriers, including Medicare, participate in transition planning and play an important role.
Inpatient Rehabilitation (IPR)	Inpatient hospitalized for purposes of rehabilitation. When an individual transitions to IPR outside a hospital or Long-term acute care (LTAC), HCS considers that transition a hospital discharge.
Guardian	A person appointed by the court to make decisions with respect to the personal affairs, support, care, health, and welfare of the adult subject to guardianship to the extent necessitated by the adult's limitations.
Length of Stay	For HCS, Length of stay in acute care hospitals refers to the period from the date a hospital patient is referred to access long-term care services through the duration of their hospitalization.

Medical necessity	A determination by the attending hospital physician that the patient needs to remain in the hospital to receive medical care. A client who meets this definition is admitted under private health insurance, Medicare, or Medicaid.
Medically stable or predictable	The patient at this point does not need acute care medical intervention, is close to baseline functioning and their immediate needs, treatments, and therapies have been achieved. In most cases stage the client can transition to community settings.
Priority Cases	Cases that the hospital request to handle as priority upon referral and meet the priority criteria, outlined in this chapter. For such cases HCS staff are required to contact the client within 2 days and conduct an assessment within 7 days if conditions for conducting an assessment are met.
Provisional Approval	The process of allowing clients a conditional approval for accessing the State-Funded Guardianship and Conservatorship Assistance Program under Medicaid Long-Term Services and Supports (LTSS), without having to wait for the full functional and financial Medicaid eligibility determination.
Psychiatrically stable	The patient has been determined by a psychiatric provider usually a psychiatrist or psychiatric nurse in a hospital of psychiatric inpatient facility to on longer need in-patient hospitalization. The individual at this point is close to baseline functioning and their immediate medical psychiatric needs, treatments, and therapies have been achieved, evidenced by no use of physical or chemical restraints in the past 3 days prior to discharge.
Referral	Any request for service that is accompanied by a Medicaid application, or for a client with current Medicaid eligibility. A referral from and acute hospital generates an HCS intake.
Special Agent	The person appointed by the court for temporary authority over a specific purpose or task pursuant to RCW 11.130.375 or RCW 11.130.635. The special agent differs from court visitor, who acts as the court investigator. Special Agents are granted specific authority that are time limited, typically 60 days or up to 120 days maximum.
Swing Bed	A hospital bed that can be utilized as a skilled nurse facility bed. This is considered a discharge from an acute hospital and is transferred to an NFCM worker.

REFERENCES & PROGRAM RESOURCES

Related WACs, RCWs & Federal Regulations

WAC 388-106-0015	What long-term care services does the department provide?
RCW.70.41.310	Long-term care—Program information to be provided to hospitals—Information on options to be provided to patients.
RCW.74.39A.040	Department assessment of and assistance to hospital patients in need of long-term care.
RCW 74.34.020	Definitions

Code of Federal Regulations 482.13 (e): Condition of participation: Patient's rights—Restraint or seclusion Code of Federal Regulations

Centers for Medicare and Medicaid (CMS) State Operations Manual SOM Appendix A (cms.gov)

Transition Resources

PROGRAM/SERVICE	BRIEF DESCRIPTION
Behavioral Health Wrap Around Support, previously Behavioral Health Personal Care	Beginning July 1st, 2024, a Managed Care Organization (MCO) will only fund the following Behavioral Health Wraparound Support (BHWS) formerly, Behavioral Health Personal Care (BHPC) for additional personal care hours reflected in an increase beyond the CARE generated hours. To review eligibility see LTC Chapter 22a.
Community Behavioral Health Support (CBHS) Services/1951i	**Supportive Supervision and Oversight (WAC 182-561-0400)**. Supportive Supervision and Oversight is direct monitoring, redirection, diversion, and cueing of the client to prevent at risk behavior that may result in harm to the client or to others. These interventions are not related to the provision of personal care.
Behavioral Support Services	Services are available to in patient clients under WA Roads. Client training is available through COPES and should be accessed through that program for all COPES eligible individuals. Individuals who are not eligible for COPES should receive this service through WA Roads. See Behavior Support Services H2019
State Funded Guardianship and Conservatorship Assistance Program (GCAP)	For hospitalized individuals determined to not have decisional capacity and who lack a legal decision maker necessary to access LTSS**.** The program contracts with certified professional guardians and conservators statewide to accept court

PROGRAM/SERVICE	BRIEF DESCRIPTION
	appointment for these challenging cases in order to facilitate transitions of these individuals out of acute care hospitals. WAC 388-106-2100. Refer to Appendix VIII of this chapter.
HCS Complex Cases & MCO Coordination contacts list	HCS HQ contacts list for assistance on Complex Case Staffing provided by the SHDD team and MCSCs. Refer to Appendix VII of this chapter.
Housing Maintenance Allowance (HMA)	The HMA is income, up to 100% of the Federal Poverty Level, that the client can keep maintaining his/her residence during a NF or institutional stay. WAC 182-513-1380. For program detail see Chapter 10 of the Long-term care Manual
Individuals with Complex Behaviors	Individuals with challenging behaviors (i.e., assaultive, property destruction, self-injurious, challenging sexualized behaviors, history of arson, and/or history or criminal activity), the assigned case manager or assessor may complete DSHS 10-234a to include in the residential provider referral packet.
State Funded Community Transition or Sustainability Services (CTSS or WA Roads)	CTSS are non-recurring setup items or services necessary to assist individuals establish, resume, or stabilize a home or community-based setting. WAC 388-106-0950, WAC 388-106-0955, WAC 388-106-0960. Refer to Chapter 5 of the Long-term Care Manual for details.
Discharge Options-Desk Aid for Citizens vs. Non-citizens	This is a desk tool used by Aging and Long Term Supports Administration (ALTSA) field staff that has all the medical coverage groups/programs in Washington and what Home and Community Service can be authorized under that medical program if functionally eligible.  Discharge Options Desk Aid- Citizens vs
Diversion Services	An individual who is detained through the Involuntary Treatment Act who is stabilized and has long-term care needs, qualifies for diversion services. Refer to MB H19-042.
Specialized Behavior Support Services in Residential Settings	This is a compiled list of specialized behavior support services available in residential settings. These services are available to eligible LTC individuals with personal care and complex behavioral needs related to a mental health, neurocognitive or dementia diagnosis. The settings are not intended to replace the need for behavioral health treatment or supports accessed through the behavioral health care system.  HCS Specialized Behavior Supports 6
Supportive Housing	Service that supports individuals with complex needs secure community-based, affordable housing of their choice along

PROGRAM/SERVICE	BRIEF DESCRIPTION
	with individualized support to assist the person with stabilization and self-identified goals. For ALTSA recipients, this service is available in two ways: Foundational Community Supports (FCS), or the Governor's Opportunity for Supportive Housing (GOSH). Refer to Chapter 6 of the Long-term Care Manual for details.
The Medicaid & Long-term care services for Adults Brochure	22-619.pdf (wa.gov). This brochure is distributed to individuals interested in services. In addition, HCS hospital Supervisors and Case Managers coordinate with their local Area Agency on Aging who maintain a list of contracted service providers.
Transition Care Center of Seattle (TCCS)	A specialized Nursing Facility serving complex population of dually eligible (Medicaid-Medicare) beneficiaries transitioning out of acute care hospitals. Refer to **Admission Process Flow** and the **Specialized Referral Form** attached below for details. Transition Academy; Transitional Care Center of Seattle

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
5/12/2020	Grace Kiboneka	Version incorporates draft MB review comments from the field and subsequent responses for policy	
April, 2021	Grace Kiboneka	Version: - Incorporates clarifying language and technical corrections to several sections in the chapter and adds a new section concerning the role of HCS hospital case manager in confirming decision making capacity. Added a link where hospital staff can be referred to access a brief training on HCS process for transitioning clients out of hospitals.	
Dec, 2021 & Jan, 2022	Grace Kiboneka	Added new language under role of CM in determining capacity. Removed requirement for updating notes weekly in acute care screen. Reduced waiting period from 6 to 4 month for a case to be inactivated. Added new language for Hospital withdrawal of a referral, updated section about escalation of complex cases, Appendix IV, V, escalation of complex cases	
May 2022	Grace Kiboneka	Updated HCS Regional escalation contact chat. Appendix I	
October 2022	Grace Kiboneka	This version includes the following major modifications to:	

		• the role of Case managers in determining decision making capacity • Coordination with hospital discharge planners • Hospital withdrawals of client referred to HCS • Escalation of a complex client case • Escalation to the HCS Region Escalation Contact Chart	
August 2023	Grace Kiboneka	This version has no new policy. It clarifies policy for: • Individuals in isolation rooms, and one on precaution • Updates table for cross systems complex case contacts, managed care coordination and adds SHDD a new resource—Transition Specialists • Added SHDD and CBHC contact list as an attachment in the Resource table. • Provides a compiled list of Specialized Behavior Support Services for Residential settings. • Updated referral form for SDCP and TCCS services.	
March 2024	Grace Kiboneka	• Added detailed policy guidance on Restraint. • Clarified language for clients using IM frequently. • Updated Complex Staff resources. • Updated HCS escalation contact list. • Created appendix VII for escalation pathway resources and removed previous escalation contact matrix from the main body of the chapter and corresponding program information.	
October 2024	Jody Gasseling and Erika Gustafson	• Updated chapter title to reflect transition work • Updated contact information for chapter owners • Removed BHPC language and added CHBS, BHWS, IBSS (1915i) • Fixed grammatical errors • Updated Referral and Admission Process form for TCCS. • Updated Specialized Setting Referral Template • Updated Appendix I HCS Escalation Regional Contact Chart • Added section on Electronic Health Records • Created appendix VIII for Guardianship and Conservatorship Assistance Program (GCAP) policy	
March 2025	Jody Gasseling and Erika Gustafson	• Move and create new section for RCCM to Hospital Transfers • Updated Appendix I HCS Region Escalation Contact Chart	

		• Additional Decision Maker Resource Tools • Edited, When Would A Hospital Referral for Transition be Inactivated? • Added: legal issues, to What Info Is Needed by HCS Hospital Case Managers to Conduct an Assessment • Edited : What Conditions Must Be Met for HCS to Conduct a Hospital Assessment • Updated escalation pathway contacts and emails • Added additional SER documentation when transferring Residential, NFCM, and In Home cases • Linked Transition Academy under "What are some examples of frequent barriers to acute care hospital clients assessments or transition planning" as well as "what additional transition strategies should be applied to complex client referrals".	

State Hospital Assessments

The purpose of this chapter is to clarify state hospital assessment activities to ensure smooth transition of individuals hospitalized in a psychiatric facility back to their home, community setting or nursing facility. The goal and focus of state hospital assessment activities is to:

- Provide current information to consumers seeking long-term care services.
- Assist patients and their families to locate services of their choice to enable them to make informed choices.
- Engage individuals as soon as they anticipate being discharged from the hospital back to the community to assess long-term care needs and to expedite the authorization of services.
- Develop rapport and collegial relationships with local hospital discharge planners to accomplish this goal.
- Support transitions that increase success, stabilization, and optimal collaboration by working together with Managed Care Organizations (MCO) and Hospital Discharge planners to enable clients to fully access and utilize their medical benefits.
- Work with Forensic Navigators and Forensic Evaluators to support individuals who meet criteria for HCS services under the Civil Transitions Program (5440 bill).

Ask the Expert

For State Psychiatric Hospitals\Local Psychiatric Facilities- Each region has a State Hospital Discharge & Diversion (SHDD) Transitions Coordinator (TC) and Transition Specialist (TS). Statewide there is a Civil Transitions Program Manager who will assist with Individuals diverting from the state hospitals under the Civil Transitions Program as established by Senate Bill 5440 of 2023.

If you have questions or need clarification about the content in this chapter, please contact:

Briauna Hill Transition Specialist
253.732.3839 briauna.hill@dshs.wa.gov

If you have questions or need support in Region 1, please contact:

Pamela Young Transition Coordinator
360.742.2508 pamela.young@dshs.wa.gov

Jeffrey Rose Transition Specialist
360.742.2508 pamela.young@dshs.wa.gov

If you have questions or need support in Region 2, please contact:

Sarah Miller Transition Coordinator

360.742.1796 sarah.miller2@dshs.wa.gov

Lisa Clarke Transition Specialist
564.669.4458 lisa.clarke@dshs.wa.gov

If you have questions or need support in Region 3, please contact:

Latia Townsend Transition Coordinator
360.999.0470 latia.ray@dshs.wa.gov

Briauna Hill Transition Specialist
253.732.3839 briauna.hill@dshs.wa.gov

If you have questions or need support with Civil Transition, please contact:

Andréa Mckinney Civil Transition Program Manager
360.867.8247 andrea.mckinney@dshs.wa.gov

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BACKGROUND

The mission of the Aging and Long-Term Support Administration (ALTSA) is to transform lives by promoting choice, independence, and safety through innovative services. ALTSA works with Administrative Service Organizations (ASOs), Managed Care Organizations (MCOs), state hospitals and community providers when a state hospital identifies that an individual who is ready for discharge may have an unmet need for assistance with activities of daily living. ALTSA offers a variety of settings in which personal care services can be tailored to meet each individual's needs, goals and preferences. ALTSA also provides other services designed to support individuals to live in community-based settings, including their own homes or licensed community residential settings. Since 2004, ALTSA has worked to respond to both the functional and behavioral support needs of clients through the progressive building and expansion of specialized, contracted services and long-term care setting choices. Individuals served in ALTSA settings receive mental health services through the state's ASOs and MCOs. The Trueblood Settlement establishes a plan for providing services to individuals involved in the criminal court system and for providing treatment to people when needed so they are less likely to become involved in the criminal court system. The Civil Transitions Program (CTP) recently developed a process for connecting individuals who have been found not restorable and not competent to stand trial due to an intellectual or developmental disability, dementia, or traumatic brain injury to available wraparound services and supports in community. When a referral is screened in, HCS will offer services to individuals, even those who are not traditionally eligible based on functional and financial criteria.

PURPOSE

To support safe, person-centered transitions for individuals into their preferred setting. This is accomplished through pre-transition planning and coordination, case consultations, risk reviews, trainings, and post-transition check-ins.

ASSESSING AND DISCHARGING CLIENTS FROM THE STATE HOSPITAL

State Hospital Discharge definition: An individual discharging from a state psychiatric hospital into HCS Long-Term Services and Supports (LTSS).
Diversion definition: An individual with a 90- or 180-day commitment order for further involuntary treatment who is discharged from a local community psychiatric facility onto HCS LTSS; or an individual who is detained through the Involuntary Treatment Act who is stabilized and discharged into HCS LTSS prior to the need to petition for a 90- or 180-day commitment order. See HCS Role in Supporting a client's return to a Community Setting.

- See HCS Role in Supporting a client's return to a Community Setting
- Commitment orders must be verified and uploaded to DMS by Case Manager; court commitment paperwork, signed by a judge or commissioner, which documents that: the client is on a 90- or 180-day commitment order for further involuntary treatment or the client is on a civil commitment detainment under the Involuntary Treatment Act (this includes 120-hour, 14-day, 90-day, 180 day, or Revoked 90/180 LRA.
- For additional services that are available for individuals that meet diversion criteria Case Managers can consider the following program: GOSH

State Hospital Assessor - An HCS staff person who is assigned to assess individuals at the state hospital who have been identified ready for discharge and may have an unmet need for assistance with activities of daily living. The assessor completes a CARE assessment in collaboration with the state hospital treatment team and ASO/MCO's to assist with the individual transition planning and integration back into the community. Chapter 71.05 RCW: Mental Illness
Civil Transitions Program Criteria – The individual must be found not competent to stand trial and not restorable due to intellectual or developmental disability, dementia, or traumatic brain injury. Individuals who meet the CTP criteria will be assessed for services regardless of functional or financial eligibility criteria.
CTP Services - Clients who meet criteria, and have an immediate need for housing, a referral for housing services may be submitted without a CARE assessment or Medicaid application being submitted. Services will only be authorized for 6 months, and the 6-month timeframe will always start on the first day of the service authorization.
Civil Transition Program Assessor - An HCS staff person is assigned to assess active or inactive clients in the community or jail.

Referral Process from a State Hospital or Local Psychiatric Facility

For information regarding the referral process from a hospital setting, refer to LTC Manual 4: Social Service Intake. All CARE assessments must be initiated with seven days of referral to HCS for State Hospital Discharge and Diversion referrals received.

Referral process for Civil Transitions Program clients

- When HCS receives an **active client,** the Civil Transitions Program Manager will email the assigned case manager and supervisor requesting contact be made with the client for a significant change assessment**.** If the client agrees to continue services, the case manager will

assess for additional service needs and coordinate with current providers to determine if the client may return to the same residential facility or utilize the same in-home provider. If the client is determined to be financially and functionally eligible, the HCS Case Manager will continue with traditional services. If the client is determined not financially or functionally eligible, the HCS Case Manager will offer services from the Civil Transitions Program conditional service package.

- When HCS receives a referral for an **inactive, new client, or not meeting criteria** the Civil Transitions Program Manager will screen all referrals to determine if the client is a current recipient, meets diagnosis criteria for the state funded programs, (or active within last 30 days?). If yes, emails referred to region intake will be mark as CTP or Traditional and refer to the case manager per track (1) above to evaluate eligibility and/or referral to financial to open special medical RAC in P1. The HCS Case Manager will contact the client to offer HCS services. If the client is homeless or at risk for homelessness supportive housing can be offered prior to the CARE assessment being completed. If the client is financially and functionally eligible, the HCS Case manager will continue with traditional services. If the client is found not financially or functionally eligible, the HCS Case Manager will offer services from the conditional service package. The HCS Case Manager will connect with the Forensic Navigator to determine if the individual is eligible for any diversion, supportive housing, or case management programs as a Trueblood class member.

HCS Response Timeframes

Once a CTP referral has been received by Intake, following the regular intake process, the referral will be entered and assigned to a case manager within **two** working days. The assigned case manager will contact the client to schedule an assessment within **three** working days from the day they receive the assignment in CARE. The case manager will make two attempts to reach the client by phone within three working days of assignment. If unable to reach the client, the case manager will mail a 10-day letter to the client, to the last known address. If there is no response after 10 days, the case will be inactivated. A strong effort will be made to **start the functional assessment within seven days** from the date of referral. The HCS assessor/case manager must **complete the assessment within 30 days** of the date of receipt of the referral. If the client is at risk of becoming homeless, they may receive Supportive Housing and Transition Services immediately.

ALTSA has partnered with the following agencies to assist with the Civil Transitions Program:

1. **Behavioral Health Administration (BHA)** - Forensic Evaluators from BHA conduct an evaluation which results in an Evaluation Report that includes their opinion of competent, if not, are they restorable. The Forensic Evaluators from BHA divert forensically involved criminal defendants out of jail and inpatient treatment settings into community-based treatment settings by connecting individuals to additional supportive services in the community.
2. **Office of Forensic Mental Health Services (OFMHS)** - OFMHS assists with transforming forensic mental health throughout WA by partnering with communities and law enforcement in areas such as mental health resources in jails, competency restoration, diversion programs, and

community resources to better support people living with mental illnesses who encounter the criminal court system.

3. **Developmental Disabilities Administration (DDA) -** 5440 referrals are submitted to HCS and DDA, both agencies review the referral information. If IDD is the primary diagnosis DDA will contact the client to offer services.

Involuntary Treatment Act (ITA): Confirming ITA Status & Case Manager Process

The process identified in this section will need to be repeated at any time a new ITA or LRA is issued. Please refer to Chapter 71.05 RCW for more information regarding the legislative process.

1. **Receive Referral:** When receiving a referral from a Local Psychiatric Facility (LPF) or Acute Care Hospital (ACH), the case manager will ***inquire about the individuals ITA status*** and determine if the client is detained or at the facility voluntarily prior to discharge planning.

2. **Complete or Update CARE Assessment:** Following receipt of referral the case manager will complete a significant change assessment or new CARE assessment to determine financial and functional eligibility.

3. **Request Current ITA Documents from LPF or ACH:** The case manager will request documents from the LPF or ACH discharge planner or ITA coordinator. It is important to emphasize that the ITA documents are required to confirm program eligibility before referrals can be made to specialty contract settings.

> ***Note:*** **There is an order to the civil commitment process.**
> - Clients are usually brought in by a DCR who has authority to put them on a detainment hold for up to 120 hours or 5 days.
>
> **Please look at the paperwork the hospital sends you.**
> - Look for the word "Order" in the paperwork
> - If you don't see the word "Order", look for a DCR's signature
> - Look at the date everything was signed

4. **Send ITA documents to the Regional Point of Contact:**
   - **Region 1:** Jeff Rose at jeffrey.rose@dshs.wa.gov
   - **Region 2:** Lisa Clarke at lisa.clarke@dshs.wa.gov
   - **Region 3:** Briauna Hill at briauna.hill@dshs.wa.gov

5. **Upload ITA Documents to Data Management System (DMS):** The case manager will send ITA documents to Barcode.

6. **Update State Hospital Screen:** The case manager will complete the State Hospital Screen in the Client Details section of CARE upon the client's transition from a LPF or ACH into a community setting (see example below).

Coordinating with Hospital Discharge Planners

Home and Community Services (HCS) provides case management by working with the client, hospital staff, HCS/AAA/DDA staff, family members/informal supports, the client's physician/psychiatrist and community providers to assist clients in transitioning to and accessing services in the community. HCS state hospital assessors are stationed at state hospitals & maintain regular communication with the hospital team. HCS staff assessing individuals in local psychiatric facilities should regularly visit each hospital so that HCS presence is complementary to the hospital discharge planning activities and beneficial to clients and discharge planners. HCS should:

1. Clearly define and explain to discharge planner the role HCS/AAA has in assessing Medicaid clients and assisting with the client's return to the community.
2. At a minimum, the following information shall be provided to the hospital discharge planner:
    - Name, telephone, and fax number of the local office
    - Name, telephone number, and work schedule of assigned staff and back-up staff
    - Name and telephone number of HCS/AAA staff supervisor and Regional Administrator/Director
    - Referral (intake) procedures, including procedures for back-up staff

3. To ensure that there are no delays in discharge, case management staff should:
    - Encourage hospital discharge planners to refer individuals to HCS for and assessment as soon as it becomes apparent that community-based services are needed and consented for (i.e. before admission if the need for long-term care services is known, upon admission or during the first day of admission) and provide information regarding a patient's discharge status.

The Pre-Transition Checklist can be used to assist assessors and case managers with State Hospital Transition Planning

    - Respond to referrals by the end of the next working day, or within the time frame the hospital needs, to ensure timely coordination of transition planning.

Early Engagement

Purpose: To streamline eligibility determination and transition planning activities for patients. Early engagement efforts with the client and healthcare / hospital staff and patients aids in identifying, connecting, and authorizing appropriate community-based services and resources. Early engagement supports the Person-Centered model in transition planning.

Home and Community Services (HCS) staff (State Hospital Headquarters, Regional State Hospital Supervisor, or Program Manager Staff) will collaborate with healthcare / hospital staff to identify those patients who may request or benefit from Long-Term Services and Supports. Case Managers can support this partnership by developing an understanding of hospital referral and discharge polices to enhance early engagement with patients. HCS staff should consider the following factors: financial eligibility, clinical stability (a conversation with healthcare / hospital staff should take place where risk factors as well as medical complexities are documented in the CARE assessment), and the client's preference in care settings. As with all transition planning and case management activities, the HCS assessor will discuss the variety of long-term services and supports the Department can offer in different care settings with the client.

For medically complex discharges, and for all Triggered Nursing Referrals Case Managers can consider the following programs:

- Nursing Services (for all Nursing Triggered Referrals)
- Adult Day Health
- Registered Nurse Delegation
- Private Duty Nursing

HCS Role in Supporting a Client's Return to a Community Setting

HCS is responsible for completing assessments of referred Medicaid applicants who have indicated an interest in receiving home and community-based services.

Assessments are conducted at: Acute care or general hospitals, evaluation and treatment centers; (E&T, single certification beds, specialty care, and local community psychiatric facility) and State Hospitals.

1. Prior to hospital discharge, Home and Community Staff will:

a. Complete a full CARE Assessment, discussing care needs, and present appropriate service options to the client and/or the family.
   - Utilize FAST TRACK financial eligibility for community services, if necessary. If FAST TRACK has been used, the HCS Staff will ensure that a Medicaid application has been submitted with the necessary documentation to the local financial worker.

b. Authorize Services as outlined in the CARE Assessment

c. Follow Policy and Procedure when transferring the client case for ongoing case management.

Discharge Planning to a Community Setting (HCS/AAA Responsibilities)

For information regarding HCS/AAA case management responsibilities and Case Transfer Guidelines for Institutional (Hospital, Nursing Facility, or ICF-MR) Settings refer to LTC Manual Chapter5.

For individuals discharging or diverting from a State Hospital who wish to live independently, see LTC Manual, Chapter 5b for more information on ***Governor's Opportunity for Supportive Housing (GOSH) Services*** and other Supportive Housing resources.

For information regarding HCS case management responsibilities for 1115 LTSS Presumptive Eligibility procedures for patients deferring or discharging from a Community Psychiatric Hospital or Acute Care Hospital or who have deferred or discharged from a Community Psychiatric Hospital or Acute Care Hospital within the last 30 days and will or have returned to an in-home setting refer to Chapter 30e.

Hospital Admissions and Subsequent Transitions to a Nursing Facility:

Hospitals may discharge patients to a nursing facility without prior authorization from HCS. This includes discharges from the emergency rooms or other situations where the client is not officially admitted (e.g. observation stay). For more information on how transitions from hospitals to the nursing facility are done see LTC Manual Chapter 9a.

For Admissions into a Nursing Facility using Expanded Behavior Supports-see Chapter 10: NFCM and Relocation.

Discharges to the Transitional Care Units/Rehab Centers

For more information on discharges to transitional care units/rehab centers see LTC Manual Chapter 9a.

Special Commitment Center

The Aging and Long-Term Care Support Administration (ALTSA) facilitates community transitions for individuals being unconditionally released from total confinement at the Special Commitment Center (SCC) or from SCC's community Least Restrictive Alternative (LRA) housing. When individuals are seeking long term services and supports, referrals are submitted by the Special Commitment Center or the Office of Public Defense to the Community Support Program Manager.

Registered Sex Offenders

Per MB H21-092 Client Sex Offender Notification Process for Providers, during the assessment process continue to gather information from the client or representative about any legal or safety issues. For support and/or consultation related to registered sex offenders' contact SO.Notifications@dshs.wa.gov .

Extraordinary Medical Placement

ALTSA collaborates with the Department of Corrections (DOC) with Extraordinary Medical Placements (EMP) through an interagency agreement. EMP enables incarcerated individuals who have been determined to meet specific criteria in RCW 9.94A.728: that qualifies the individual for release from prison into a community setting to receive long-term care services provided by ALTSA.
Referrals are initiated by the DOC EMP Coordinator to the HCS Community Support Program manager. ALTSA supports prisons across the state. There are three prisons each in region 1 and 3 and 1 prison in

region 2. Staff are assigned to specific facilities and not only work EMP cases but all referrals from the prison. RCW related to EMP RCW 9.94A.728:

ASSESSMENT AND DATA REPORTING

State Hospital Discharge and Diversion State Hospital Report

One measurement of Home and Community Services work relates specifically to actively assisting ALTSA clients relocate from state hospitals to home and community-based settings. The data to track the relocation of clients is now in CARE. With this data, the report will identify clients transitioning from state hospitals or local psychiatric hospitals to the community. The legislature will be following the progress of this program. ALTSA will provide pertinent data to the legislature. The State Hospital Report can be found in ADSA Reporting. Regional Administrators, Deputy Regional Administrators, Field Service Administrators, SHDD Program Managers, and SHDD Supervisors have access to this report. CTP clients will also be tracked in CARE under the State Hospital Screen. Discharge date and discharge status will be entered by the HCS case manager, this screen will be completed despite the eligibility outcome. CTP Conditional Services are available for 6 months, a financial and functional eligibility will be completed within the first 90 days. For those at risk for homelessness, housing services will be reviewed at six months with the ability to re-authorize for up to two years. Clients receiving conditional services will be case managed by HCS and not transferred to AAA. The CTP Program Manager will send a referral to Regional Intake. Once assigned, the HCS Case Manager will contact the client to review HCS services and offer CARE assessment. Financial eligibility is concurrently determined if the client submits a Medicaid application.

State Hospital Discharge and Diversion Outcomes Tracking

Outcome tracking is used to track outcomes and identify overdue outcomes. The Data Collection and Reporting resources assigned to the project identify project performance measurements, criteria and targets. The Governor, the legislature and agency executives are closely monitoring the investment in the state's behavioral health system. Analyzing outcomes can be used to improve services and supports and identify possible gaps in services and supports. The outcomes will be used to provide recommendations to legislature on best practices related to admission, transition from long-term involuntary inpatient treatment systems, and the stability and transitions to community based behavioral health services.

Outcomes are tracked at 30 days, 6 months and 12 months after an individual's transition. Case Managers receive ticklers in CARE at 30 days, 6 months and 12 months to update outcomes. When an individual discharges from a State Hospital onto HCS services or is diverted from a Local Psychiatric Facility (LPF) onto HCS services, stability of the individual at the setting should be determined. This is done by the Case Manager contacting the Provider via phone or in-person and checking in on how things are going with the individual. Document the conversation in an SER and update the Outcome on the State Hospital screen. Ticklers for Outcomes are received in the CARE tool at 30 days, 6 months, and 12

months. Trainings on how to complete Outcomes are available to staff. You can contact the expert for your region for more information. Targeted Case Management should be a consideration by the HCS and/or AAA Case Manager. For a safe and sustainable plan of care see LTC Manual Chapter 3.

Outcomes should be updated on the Outcome tab on the State Hospital screen: 30 days after discharge or diversion, 6 months after discharge or diversion (2nd Post Discharge) and 12 months after discharge or diversion (3rd Post Discharge.) Outcomes should also be updated if there is a major change, including if the individual stops receiving HCS Services, returns to the State Hospital, or passes away.

Outcomes	When to Use
Changed HCS Settings	Client moves from one HCS setting to another HCS setting – for example moves from an AFH to an ALF
Deceased	Client passes away
Detained in Jail	Client is admitted to jail
Detained in Local Psychiatric Facility	Client is admitted to an E&T or hospital psychiatric ward/bed for a behavioral health issue
Hospital, Acute Care	Client is admitted to a hospital for a medical issue (non-behavioral health admission)
No Longer HCS	Client stops receiving HCS service – no longer wants services, moves out of state, whereabouts unknown
Returned to State Hospital	Client is admitted to a State Hospital
Stable in Setting/Interventions	Client is stable in their current HCS setting
Unstable in Setting/Interventions in Progress	Client is unstable in their current HCS setting

MANAGEMENT OF COMPLEX HOSPITAL CLIENT TRANSITIONS

Discharge Barrier Consult

The creation of Discharge Barrier Consult: Home and Community Services (HCS) and Behavioral Health Administration (BHA) determined there was a need for a cross systems staffing approach to transitioning individuals with complex needs from the state hospitals on to HCS long-term services and supports with the individual's multi-disciplinary team.

The purpose and scope of the Discharge Barrier Consult: The purpose of the Discharge Barrier Consult is to collaborate and determine appropriate statewide resources and supports for individuals transitioning from the state hospitals with an end goal of identifying barriers and risk and developing a comprehensive transition plan. The individual's case is reviewed for barriers, needs, and risks. In addition to the aforementioned, the availability of resources in the community are discussed.

The decision-making body at the Discharge Barrier Consult: The attendees of the consultation may consist of representatives from the individual's multidisciplinary transition team. The team may include

but is not limited to representatives from the Managed Care Organizations, Health Care Authority, Behavioral Health Administration HQ, the State Hospitals, and Aging and Long-term Support Administration. The Meeting is prompted by the HCS staff to include but not limited to the SHDD Assessor, SHDD Supervisor or Program Manager via email to the Transition Coordinator. The meeting is a standing meeting scheduled for every other Thursday of the month. The attendees staff cases, review barriers to transition, and work towards solutions.

There are no criteria used to determine which HCS settings are approved or disapproved for individuals: The objective of the Discharge Barrier Consult is to develop a comprehensive plan with the intent of the individual transitioning with HCS services. No decisions are made concerning approval or disapproval of HCS services for qualified individuals.

Complex Case Staffing will occur as needed in all cases when there are barriers to timely discharging a patient to the most integrated setting appropriate. The state hospital policies and procedures will have a complex case staffing protocol that will include, at a minimum: a. Regularly scheduled meetings of a complex case staffing committee with participation of appropriate staff members and administrators from:

1. State Hospitals.
2. Home and Community Services.
3. Developmental Disabilities Administration.
4. the Health Care Authority.
5. liaisons from the Managed Care Organizations, Behavioral Health Administrative Service Organizations, and other community providers, when appropriate;

- Each Hospital will conduct a complex case staffing no less than twice per month.
- The State will provide DRW with a designated staff contact who will refer for a complex case staffing particular individuals identified by DRW for review.
- With patient permission, the designated staff contact will keep DRW apprised of progress on referred cases.

Escalation Path and Process

Who/ Where to Escalate	What is involved and what needs to be done
Who to escalate?	Clients that face barriers to services related to a history of, **but not limited to**: • Arson/fire setting behavior • Murder history • Rape history or any sexual aggression towards others • Significant assaults • Significant suicidal ideation or self-harm behavior *DSHS form **10-234a *and*** DSHS 20-331 must be completed.
Escalation within Regional HCS	• Send e-mail with the client's name and reason for staffing to your supervisor, Program Manager, and Transition Coordinator.

	• A **Discharge Barrier Consult** may be warranted. To request a consultation, ask your regional SHDD Transition Coordinator or Program Manager for instructions to submit a request.
	  • **HCS Discharge Review (6358) Ask the Expert**
	  *Assessments will be initiated within 7 days of getting the referral. ALTSA determinations of financially eligibility will be initiated within 7 days of getting the application. ALTSA Referral packets will be sent within 7 business days of the client being determined financially and functionally eligible. Discharge readiness assessments conducted by professional staff, including discharge reviews conducted pursuant to RCW 71.05.232, will be initiated within 7 days of the determination that such as assessment is necessary.
	• A **jail-based restoration staffing** may be warranted. To request a staffing send an email with the client's name and reason for staffing to your supervisor and the Civil Transitions Program Manager. To request a consultation, ask your regional SHDD Transition Coordinator or Program Manager for instructions to submit a request.

Escalation within ALTSA Headquarters (HQ)	While many issues can address at the regional level by a supervisor, or Program Manager, it is necessary on occasion to escalate an issue to Headquarters. Issues are escalated if they cannot be resolved at the lowest level.
	• The Supervisor or Program Manager may also bring the issue directly to the specific work team, e.g. Supervisor, Case Manager, 5440 Program Manager, Forensic Navigator, Forensic Evaluator, for resolution if the issue can't be effectively addressed. In this case, if the issue is not resolved to the Supervisor or Program Manager's satisfaction or if there are issues beyond the Supervisor's control, the Supervisor or Program Manager will escalate the matter to the Regional Field Service Administrator or Deputy Regional Administrator and SHDD Administrator. If the SHDD Administrator cannot resolve the issue, then the issue will be escalated exclusively to the DSHS ALTSA Community Transition Office Chief.
	  • The DSHS ALTSA CLASS Office Chief, DSHS ALTSA HCS Director, and Governance will be the final level of escalation.
	  • Identified issues may need escalation beyond HCS to Health Care Authority leadership, contact HCA Nursing Consultant, Public Health.
	  • The State Hospital Discharge and Diversion Administrator, Regional Administrator, Deputy Regional Administrator, and Field Service Administrator, is responsible to elevate risks and issues to DSHS ALTSA HCS Executive Leadership and prepare documentation needed to present to them for decision.

TRANSITION RESOURCES

Community Transition Services (CTS) & Transition Support Services

Community Transition Or Sustainability Services (CTSS)

See Chapter 10 in the LTC Manual for more information regarding eligibility and services offered: CTS & CTSS

Roads to Community Living (RCL)

Roads to Community Living (RCL) is a statewide demonstration project funded by a federal "Money Follows the Person (MFP)" grant. The grant was received by Washington State from the federal Centers for Medicare and Medicaid Services (CMS). The purpose of the RCL demonstration project was to investigate what services and supports will successfully help people with complex, long-term care needs transition from an institution to a community setting.

See the Roads to community Living Chapter 29 Chapter 5a in the LTC Manual for more information regarding eligibility and services offered.

Washington Roads

Washington Roads is an additional package of services created from the lessons learned and cost savings seen through the first year of the RCL project. In 2009, Washington State legislature approved this additional funding to relocate adults from institutions. WA Roads services are available to assist with transition planning for clients who are not eligible through RCL and also as a resource for challenging or complex cases involving individuals who are currently living in the community, but who are at risk of losing their community setting.

See the WA Roads Chapter 5a in the LTC Manual for more information regarding eligibility and services offered.

Civil Transitions Program

Who is eligible for CTP?	Individual is referred to ALTSA from BHA starting December 1, 2023; Individual is found not competent to stand trial and not restorable due to intellectual or development disability, dementia, or traumatic brain injury and your competency is not restorable *Individuals meeting criteria may have an assigned Forensic Navigator through BHA, who is responsible to help the individual receive wraparound support. The HCS Case Manager will coordinate with this individual when assessing for services.

Who can provide services?	*Individual providers (IP's) who provide services to clients in their own home. *Home care agencies that provide services to clients in their own home. *Home care agencies must be licensed under RCW chapter 70.127. *Providers who are contracted with the department to provide goods and services. *Durable medical equipment vendors and adult day providers that have a core provider agreement with Health Care Authority. *Supportive Housing providers as defined in WAC 388-106-1715. Housing services: For individuals with an immediate need for housing, a referral for housing services may be submitted without a CARE assessment or Medicaid application being submitted. For more information see chapter 5b Housing Resources for ALTSA clients.
Duration of Services?	Regardless of whether a client is only functionally eligible, only financially eligible, or neither, services will only be authorized for 6 months. The 6-month timeframe will start on the first day of the service authorization. Exception: For those at risk of homelessness, housing services will be reviewed at six months with the ability to re-authorize for up to two years
CTP Resources	<table><tr><th>Functionally (NFLOC) and not Financially eligible</th><th>Functionally (MPC) and not Financially eligible</th><th>Only Financially eligible</th><th>Not Functionally or Financially eligible</th></tr><tr><td>Personal Care</td><td>Personal Care</td><td></td><td></td></tr><tr><td>Nurse Delegation</td><td></td><td></td><td></td></tr><tr><td>Assisted Technology</td><td></td><td></td><td></td></tr><tr><td>Personal Emergency Response System (PERS</td><td></td><td></td><td></td></tr><tr><td>Community Transition Service</td><td></td><td></td><td></td></tr><tr><td colspan="4">Supportive Housing</td></tr><tr><td colspan="4">WA Roads</td></tr></table>

STATE FUNDED LONG-TERM CARE FOR NON-CITIZENS

If the Public Benefit Specialist (PBS) or Social and Health Program Specialist (SHPC) 2 assigned to the case identifies that an individual who is either diverting or transitioning from the state hospital needs a Long-Term Care Non-Citizens (LTC NC) slot, a referral should be made to SHDD Public Benefit Coordinator. The Public Benefit Coordinator will make referrals to ALTSA HQ to place individuals on the LTC NC waitlist or to allocate the individual a slot. Individuals enrolled in the LTC NC program can receive personal care services in their own home or residential setting. See the HCBS Waiver LTC Chapter 7a eligibility section for financial eligibility criteria.

Medicaid manual link

EXPEDITED NON-GRANT MEDICAL ASSISTANCE (NGMA)

Once the PBS or SHPC 2 identifies an individual will require a NGMA for waiver services, they will send an email to the Civil Transitions (CTP) PBC after the NGMA referral has been submitted to request an expedited decision with the Disability Determination Services (DDS) for any individual who is diverting or transitioning from the state hospital, receiving treatment at a State Hospital-Residential Treatment Facility (SH-RTF) or who was recently transferred under court ordered civil commitment status from the state hospitals. The CTP PBC will communicate via email with a dedicated team at DDS and will coordinate efforts related to the process including, but not limited to, gathering additional medical evidence, coordinating directly with adjudicators and providing emailed NGMA decisions from DDS directly to the assigned PBS, SHPC 2 and/or the client's Barcode Electronic Client Record (ECR). The CTP PBC will review the NGMAs each month and provide averaging data and referral information to the regional partners. The CTP PBC will also provide additional data upon request from regional or Headquarters leadership.
The NGMA process should occur concurrently with social services. All social services referrals, including, but not limited to, referrals for CSS or RSW services, should proceed while an expedited NGMA is pending a decision with DDS. A NGMA is required when an individual transitions with waiver services to the community, but transition planning efforts should not be paused while waiting for the NGMA decision.
The PBS and SHPC 2s will complete NGMA referrals for all individuals identified as not having a previous disability decision on file either in the Barcode ECR or by Social Security regardless of their functional eligibility. However, an expedited referral to the CTP PBC is only needed when the individual will require waiver services upon their transition to the community.
For clients who have transferred from WSH to a BHA contracted community psychiatric facility (such as Telecare, Wellfound, or RI) to fulfill their court ordered civil commitment with an active HCS referral, the CTP PBC can coordinate with HCS assessors and the facility to obtain documents needed to complete a NGMA referral, if needed.

A monthly report is sent by the SHDD PBC to the SHDD HCS PBS & SHPC 2 teams indicating how many SHDD clients are on the waitlist for LTC NC and availability for the 10 additional slots allocated specifically for SHDD clients.

If all but one slot is filled, priority for the last slot will be reserved for an SHDD client that will be able to utilize this program first. Consideration will be made based on:

- when a client is eligible for the NC-LTC program (NGMA approval is required)
- when a client is planned for discharge; and
- where they are on the waitlist.

Determinations for Aged, Blind, Disabled Cash Assistance

For clients residing at Western State Hospital (WSH), Eastern State Hospital (ESH), State Hospital-Residential Treatment Facility (SH-RTF) or who have diverted from the state hospital require a determination for Aged, Blind, or Disabled (ABD) cash assistance, the assigned HCS Public Benefits

Specialist (PBS) or Social and Health Program Specialist (SHPC) 2 will reach out to the assigned ICMS Social Service Specialist (SSS) by 14-084/DID referral. ICMS case management can be determined below:

- If a client has no active HCS referral, ICMS case management will be assigned to CSO SSS.
- When the Public Benefits Coordinator (PBC) is notified of a new HCS referral, the PBC will set a tickle to monitor the HCS CARE assessment and eligibility for LTC services. The PBC will transfer the case to HCS/554 when functional eligibility for LTC services has been confirmed.
    - ICMS case management will remain with the CSO SSS until LTC eligibility is determined; and
    - While pending ICMS case transfer to HCS/554, the HCS PBS or SHPC 2 will process the new LTC application in a timely manner to determine financial eligibility for HCS services (including obtaining resource verification or reviewing AVS).
- If the HCS referral has been inactivated prior to case transfer to HCS/554, ICMS case management will remain with the CSO SSS.
- If the HCS referral has been inactivated after case has been transferred to HCS/554, the PBC will transfer ICMS case management back to the CSO SSS.

Refer to SH/SH-RTF ICMS Case Management process map to determine the appropriate ICMS worker (CSO SSS or HCS PBC) to contact for ABD determinations.

SSI Facilitation

SSI facilitation is not needed while clients reside at WSH, ESH, or SH-RTF because clients do not qualify for SSI while in residence.

- SSI facilitation will be provided by the local CSD SSI Facilitator if the client discharges without HCS services.
- SSI facilitation will be provided by the PBC if the client discharges with HCS services.

If a client discharges with HCS services and needs to file for SSI after discharge, the PBC will initiate the protective filing date for SSI/SSDI applications and will send letters to the client indicating the client will need to follow through with the SSA application.

If a client is active on ABD cash, the PBC will reach out to the client post-discharge to obtain an updated Interim Assistance Reimbursement Agreement (IARA) to submit with a client's pending SSI claim.

The PBC will update SSI tracking in ICMS and provide ongoing assistance to the client's SSI/SSDI application, which may include any follow-up on approval, appeal, or denial of SSI claims. The PBC will continue to provide SSI facilitation while a client remains active on ABD cash and until a final determination has been made on their SSI application.

Note on ESH clients:

ESH clients placed on discharge planning go through the ESH pre-release program where the ESH Financial Recovery Enforcement Officer (FREO) assists clients with applying for SSI/SSDI benefits prior to discharge from ESH – see *ESH Pre-Release Program.*

When an ESH client discharges with HCS services, the PBC will review SOLQ/SDX and coordinate with ESH FREO to determine if SSI/SSDI applications have been submitted prior to discharge. Then, the PBC will provide SSI facilitation moving forward.

*For information regarding ESH pre-release information please click on the link below:

ESH pre-release program

HOSPITAL TRANSITION SUPPORT UNIT

Hospital Transition Support Unit: The formulation of the HTSU Head Quarters (HQ) and regional teams were established in response to delays in state hospital transitions. ALTSA received additional funding to address the state hospital transition and diversion needs for individuals who have been determined financially and functionally eligible for Long Term Service Supports through increased staffing and service supports.	
Behavioral Support Consultation/Training Request	Each region has an assigned HTSU Behavior Support Trainer to offer a variety of supports for providers offering services to individuals who have transitioned from State Hospitals. HTSU Behavior Supports include: ❖ In-person or webinar instructor led trainings ❖ Behavior support consultation and home-visits ❖ State Hospital transition support See HTSU Provider Training Catalog HTSU Training 2024.pdf for detailed training and consultation services. To request Behavior Support Consultation and/or Training, complete and follow the instructions listed on DSHS 15-557. Completed referral forms are to be sent to the SHDD Referral inbox: SHDDRef@dshs.wa.gov.
State Hospital & Local Psychiatric Facility Transition Planning	The Pre-Discharge Checklist is a mandatory tool to assist HCS hospital assessors in discharge planning and service delivery for individuals who are hospitalized in a state hospital or local psychiatric facility and transitioning into long-term care services in a community-based setting. DSHS 20-331, assessor sends to DMS if completed as cold mail or file only.
Intensive Behavior Health Treatment (IBHTF)	Treat this facility type the same as any other facility type when ALTSA receives a request for an assessment. When a referral is received, it will be important to understand what type of personal care assistance the individual has received. For more information on this IBHTF see: IBHTF
Individuals with Complex Behaviors	For individuals with challenging behaviors (i.e., assaultive, property destruction, self-injurious, challenging sexualized behaviors, history of arson, and/or history or criminal activity), the assigned case manager or assessor will complete DSHS 10-234a to include in the residential provider referral packet.

Public Benefits Coordination	The HTSU Public Benefit Coordinator is available to provide the following pre and/or post transition assistance for an individual transitioning from a state hospital: • Establishment of a payee • All social security related matters • Coordination with the financial department • Assistance with immigration document acquisition and/or naturalization • Any other public benefit related matters For public benefits supports contact: Cherene Chiang PH: 564-233-9938 EMAIL: cherene.chiang@dshs.wa.gov

IRT PROCESS

State Hospital IRT referrals	Client can be functionally or financially eligible for MPC, CFC, CFC+Copes or RSW. Clients must be transitioning from a state hospital to an AFH or ALF (clients transitioning to GOSH and In-home settings are not eligible for IRT services). HCS assessor will: • Send referrals via email to the IRT provider in your region and include the MCO liaison. • Work with the Transition Coordinator to help coordinate in-hospital or virtual visits for the IRT team to interview clients at ESH/WSH. • Coordinate with the local MCO liaison for approval and post discharge care coordination for clients receiving RSW services and IRT supports.
Diversion IRT referrals	Client can be functionally or financially eligible for MPC, CFC, CFC+Copes or RSW. Individuals must meet diversion criteria to be eligible for IRT services and transitioning into to an AFH or ALF in Spokane County (clients transitioning to GOSH and In-home settings are not eligible for IRT) Diversion criteria, client must be under an involuntary psychiatric civil commitment (72 hr., 14-day, 90-day, 180-day) at a local psychiatric facility. HCS assessor will: • Send the referral with ITA civil commitment paperwork to the Transition Specialist. Once the client's status as a diversion is verified, HCS regional case manager can send a valid referral to the IRT provider in your region and include MCO liaison. • Help facilitate in-person or virtual interview with client at local psychiatric facility as needed. • Region 1 Heather Marshall hmarshall@passagesfs.org Region 2 N/A Region 3 - Emerald City IRT (Pierce & King County) – Michael Clarke michael@emeraldcity.health

	Healing Solutions and Integrated Medicine (HSIM)(Thurston County)(not yet providing services but looking at referrals) – Mina Liu mina@hsim.org RI International (Pierce County) - tammy.simon@riinternational.com • IRT Team Information: IRT Team Information

RULES AND POLICY

RCW 70.41.310	Long-term care -- Program information to be provided to hospitals -- Information on options to be provided to patients.
RCW 74.39A.040	Department assessment of Medicaid eligible individuals – Requirements.
WAC 388-106-0355	Eligibility requirements for nursing facility level of care.
MB 00-45	Hospital Assessments.
MB H19-042	Capturing Diversions in CARE

RESOURCES

HCS Behavior Support Consultation and/or Training Request

HCS Behavior Support Consultatic

Individuals with Complex Behavior

Individual with Complex Behaviors.c

Pre-Discharge Checklist

Pre-discharge Checklist.docx

Support for Complex Cases

SHDD vs CBHC .docx

Trueblood Overview

Trueblood Overview.pdf

PBS Financial/Social Service Communication Reference Guide

PBS FINANCIAL SOCIAL SERVICE CO

ICMS Case Management for SHDD Referrals

SHDD ICMS Case Management Process

Referrals from Office of Public Defense: Disclaimer in Care Web

OPD referrals 2025.docx

REVISION HISTORY

DATE	MADE BY	CHANGE(S)
4/4/2025	Lateisha De Lay Jeff Rose	• Added purpose statement. • Update to Civil Transitions Program • Update to NGMA process • Added information regarding Determinations for Aged, Blind, Disabled Cash Assistance when transitioning from ESH/WSH to the community. • Added information regarding transitions from the Special Commitment Center and Extraordinary Medical Program. • Added IRT Team Information • Added ICMS Case Management as an attachment. • Added HCS Discharge Review (6358) Instructions. • Added that Discharge Check List is mandatory. • Added Capturing Diversion MB as an attachment. • Removed CTS and CTSS information and added chapter link for this information. • Added information regarding Intensive Behavioral Health Treatment Facilities. • Added seven-day CARE Assessment initiation requirement
2/2/2024	Lateisha De Lay	• Add new Civil Transitions Program information
1/25/2020 4/28/2020 1/19/2021 5/3/2021	Lateisha De Lay Ashley Beckley Ashley Beckley Ashley Beckley	• Included Information related to Strategic Measures and State Hospital Report. • Added Hospital Admissions and Discharge Planning: From a Community Setting (HCS/AAA Responsibilities). • Added SHDD Resource section. • Added hyperlinks to referenced chapters. • Added State Hospital Assessor definition. • Added chart to instruct which Outcome drop-down to use. • Updated Fast Track link. • Updated Region 2 Transition Coordinator contact details. • Added Region 2 Transition Coordinator- Bret Anderson • Updated SHDD Training Catalog Hyperlink and document attachment.

10/22/2021	Ashley Beckley	• Updated Region 3 Transition Coordinator name and contact details.
1/19/2022	Ashley Beckley	• Updated hyperlinks throughout the chapter and added SHDD webpage link to state hospital resource section. • Added Public Benefits Coordination to the State Hospital & Diversion resources table. • Added link to the SHDD Website. • Updates to the escalation process.
5/5/2022	Ashley Beckley	• Added Involuntary Treatment Act (ITA): Confirming ITA Status & Case Manager Process • Added Roads to Community Living information • Updated contact information in State Funded Long-Term Care for Non-Citizens section.
7/31/2022	Ashley Beckley	• Added Escalation Process for complex cases.
10/27/2022	Ashley Beckley	• Added Civil Commitment Process & removed CARE screenshot image. • Added Support for Complex Cases document to resource section. • Update to Transition Coordinator contact information and added Transition Specialist contact details.

Nursing Facility Case Management and Relocation

The purpose of this chapter is to ensure that:

- Nursing facility residents who have the desire to move to another setting are assisted by the Nursing Facility Case Manager (NFCM) in assessing barriers to relocation. This may include:
  - Ensuring residents and their informal supports have information about community long-term care options.
  - Ensuring the desire for community transition and any barriers to relocation are identified early.
  - Working with the client, their formal decision maker, their family, NF staff, and others to remove or address any barriers to discharge (transition planning).
  - Assessing, care planning, authorizing services, and making referrals and coordinating care with other community and informal resources.
  - In coordination with the nursing facility, authorizing and arranging transition resources.
- Individuals (Medicaid and Non-Medicaid), who have an intellectual disability or related condition and/or serious mental illness, are assessed for their need for specialized services per the Pre-Admission Screening and Resident Review (PASRR) process (see *PASRR section* for more information).
- Medicaid clients are determined/ confirmed to meet nursing facility eligibility.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Julie Cope RCL/NFCM Policy Unit Manager
360.725.2529 julie.cope@dshs.wa.gov

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NURSING FACILITY CASE MANAGEMENT AND RELOCATION PURPOSE, HISTORY AND PHILOSOPHY

Philosophy of Nursing Facility Case Management

The State of Washington is among the nation's leaders in rebalancing institutional and community-based long-term care services. The Washington State legislature recognized the desire of most people to maintain as much independence as possible in lesser cost settings and as a result passed legislation directing the department to expand the options available to long-term care clients beyond nursing facility care (Chapter 74.39 RCW, Chapter 74.39A RCW, and Chapter 70.41 RCW). This legislation also directed that the department provide transition planning for individuals to assist them in moving to the least restrictive setting of their choice.

The Aging and Long-Term Support Administration (ALTSA) continues to work actively with individuals from the point of admission to a nursing facility to achieve the client's community transition goals and potential. This includes meeting face-to-face with clients early in their admission and working with families and staff at the facility to advocate that therapies, treatments and training is provided in a timely fashion. The goal is for clients to receive services in the least restrictive, most appropriate setting that meets the client's care needs while honoring client choice and preference.

ALTSA embraces the belief that individuals with very high care needs can be cared for and supported in a variety of settings through the implementation of waivers and state plan services which provide alternatives to nursing facility long term care. ALTSA's mission has been, and continues to be, to provide an array of long-term services and supports options from which clients and their families can choose.

The Role of the Nursing Facility Social Worker

The discharge planning responsibilities of nursing facility staff are governed by WAC 388-97-0080, WAC 388-97-0120, 42 Code of Federal Regulations (CFR) 483.15, and 42 CFR 483.20, and 42 CFR 483.25:

- 42 CFR 483.15 requires that when a resident's health improves sufficiently, the resident can be discharged with appropriate notice. Facilities are required to provide sufficient preparation to the resident to ensure safe and orderly transfer.
- 42 CFR 483.20 requires that the facility conduct initial and periodic comprehensive assessments (there are timeframes established in federal rule).
- 42 CFR 483.25 requires the assessment include the services needed to attain the resident's highest physical, mental and psychosocial well-being possible.

The care plan must include a summary of the resident's stay and final status, and a post discharge plan of care. The nursing facility staff should work collaboratively with the Nursing Facility Case Manager (NFCM) to provide and ensure a smooth transition from institutional long-term services and supports to community long term services and supports.

PROVIDING NURSING FACILITY CASE MANAGEMENT AND RELOCATION ACTIVITIES

NFCM Tips:

- Obtain a copy of the nursing facility census on a weekly basis to confirm the number of newly admitted/discharged Medicaid only and dual eligible (Medicaid/Medicare) clients.
- Ask the Facility Administrator for read only permissions/access to their electronic medical record.
- Bring ALTSA informational pamphlets to nursing facilities as resource materials for residents and families.
- Attend client care conferences with nursing facility staff to keep apprised of progress towards transition goals.
- Organize your schedule to ensure completion of 2-3 full CARE assessments a week.

Home and Community Services (HCS) provides nursing facility case management by working with HCS/Area Agency on Aging (AAA)/Developmental Disability Administration (DDA) staff, the client, family members/informal supports, formal decision makers, nursing facility staff, the client's physician, and community providers to assist clients in accessing services in the community.

NFCMs are responsible for transition planning and case management for:

1. Dual eligible clients (Medicare clients who also have Medicaid as a secondary payment source).
2. Medicaid applicants/recipients who need nursing facility payment to cover the cost of their care.
3. Private pay clients, when requested and as time allows.

NFCMs are **not** responsible for transition planning and case management for:

1. Program of All-Inclusive Care for the Elderly (PACE) enrolled clients. These cases should not be transferred/worked by NFCMs because the PACE organization is responsible for the transition planning and case management responsibility for these clients. HCS does not need to determine NFLOC for PACE enrolled clients as they already meet LOC, inherent to PACE enrollment and PACE organizations authorize NF admits prior to admit. These cases should remain assigned to their current HCS/AAA worker who coordinates with the PACE organization as needed. Please refer to Chapter 22c Program of All-Inclusive Care for the Elderly (PACE) for additional information.

A NFCM should not wait for communication from the nursing facility informing them that a client is ready for discharge. Instead, the NFCM should be actively involved with the resident at the earliest possible time to work with them, their formal decision maker, their family, the SNF, and community providers to remove/address barriers to a transition to a community setting.

Note: For more information on case transfer timeframes for when an in-home client enters an institutional setting, see the Case Transfer section of LTC Manual Chapter 5: Case Management.

NFCMs:

1. Are familiar with the nursing facility administrator, the Director of Nursing, the social services worker(s), and the discharge planner(s) in their assigned facilities.
2. Conduct a face-to-face visit for each newly admitted **Medicaid and dual eligible** client within 30 calendar days to begin to dialog about community options and their steps/desire for community transition. This action may be combined with the Nursing Facility Level of Care determination for the Medicaid resident.
3. Monitor and document all work and progress towards the client's transition goals in CARE.
4. Give information to nursing facility staff and residents on the services and supports provided by ALTSA. This includes meeting with residents, their formal decision maker, and families to revisit LTSS options and reconsider community transition on a regular basis.

What is the NFCM's Role with Hospital Swing Beds?

The Social Security Act allows certain small, rural hospitals and critical access hospitals to use their beds for both acute care and post-acute skilled nursing facility care with Department of Health approval. These swing bed residents' conversions require physician orders from acute care to swing bed status and ongoing progress notes in the hospital's medical record system.

Rural Hospitals with approved swing beds must comply with SNF participation requirements under 42 CFR 482.58(b)(1–7):

1. Resident rights
2. Admission, transfer, and discharge rights
3. Freedom of abuse, neglect, and exploitation
4. Social Services
5. Discharge Summary
6. Specialized rehabilitation services
7. Dental Services.

Critical Access Hospitals must comply with SNF participation requirements under 42 CFR 485.645(d)(1-8):

1. Residents' rights
2. Admission, transfer, and discharge rights
3. Freedom from abuse, neglect, and exploitation
4. Social Services
5. Comprehensive care plan and discharge planning requirements
6. Specialized rehabilitative services
7. Dental Services

8. Nutrition Services

NFCMs are assigned to swing bed residents after admission for nursing facility case management activities and to support relocation activities to community settings. Any NFCM tasks performed on behalf of a Hospital Swing Bed resident should be captured in the NFCM's performance standards.

As Hospital Swing Beds are licensed and approved by the Department of Health, mandatory reporting requirements related to quality of care or transition planning practices will be filed with the Department of Health as a complaint by email or online.
For more detailed Swing Bed information, review the CMS Fact Sheet on Swing Bed Services.

Note about the use of Restraints in the Hospital: The use of restraints for the prevention of falls should not be considered a routine part of falls prevention. The use of restraints for staff convenience is prohibited and should be reported to the Department of Health. For additional information on restraint use in Hospitals, see the Resource section in Chapter 9a: Acute Care Hospital Assessments.

What is the NFCM's role with a Hospital's Bed Readiness arrangement with their assigned Nursing Facility?

Many Hospitals have strong relationships with local nursing facilities in their communities and will invest in efficiencies with transferring patients from their acute care hospitals to these nursing facilities. The NFCM's role in these nursing facilities remains consistent with what is outlined in the Nursing Facility Case Management and Relocation activities section. The assigned NFCM to these facilities will likely see a larger volume of interdisciplinary meetings and resident care conferences to discuss transition barriers and planning progress. NFCMs should review the tips box above to maximize efficiency and meet with their supervisors to discuss workload volume when the number of care assessments required for these facilities exceeds 12 per month.

NFCM WORK PERFORMANCE & RELOCATION STANDARDS

Nursing Facility Case Managers perform a wide variety of activities relating to NF admission, Medicaid resident case management and NF transitions. One measurement of work performance standards relates specifically to actively assisting a client to relocate to a community setting. "Relocation" for this purpose is defined as a transition to a community setting in which all the following is true:

1. The individual is an HCS client.
2. There is a discharge date on the NFCM screen in CARE (and the RCL screen if utilizing RCL)
3. The case manager has completed a full face to face CARE assessment with the client, that was created after the date of admission (during the nursing facility stay) and was:
    a. Moved to Current (either before or after transition); OR
    b. Completed and moved to History (indicated by all green progress bars in CARE Web)
4. Has a program chosen in the Care Plan screen that is not Nursing Home Services (for clients that do not meet NFLOC this field may be blank).

5. Has a planned setting chosen in the Care Plan screen that is not Nursing Facility, including when the client is not functionally eligible
6. Has an address in the Contact Details Screen that is not designated as a Nursing Facility, but instead is an HCBS Setting with a start date to correlate with the discharge date on the NFCM screen.
7. Is not discharging to jail, hospital, or another institution. (see *Case Transfer Protocol for Institutional (Hospital, Nursing Facility, or ICF-MR) Settings*)
8. Has not died while in the nursing facility.

The expectation is that NFCMs will complete an average of five relocations per month which meet these criteria. The Regional Administrator or designee may identify circumstances beyond the control of an employee that could affect his or her ability to meet this minimum standard. As it is understood that not all full CARE assessments result with a community transition, NFCMs are expected to create a minimum of eight face to face full CARE assessments each month. This may be accomplished by setting up your weekly calendar as described in the appendix section of this chapter.

NFCM Tips:

- Meet with nursing facility staff and residents on a regular basis to assist with prioritizing and reprioritizing weekly scheduled CARE assessments. Weekly in person visits at the Nursing Facility is an efficient practice which ensures all NFLOC determinations are met timely and supports person-centered transition goal monitoring.
- Use the MDS Acuity Report to identify Medicaid residents with low acuity who should be approached/reapproached with community LTSS options.
- Consider using RCL or WA Roads services to authorize a Community Choice Guide &/or Client Training Services to support a resident's transition planning.
- Request a resident care conference with the nursing facility staff, the resident, formal decision makers, and family members to keep apprised of progress towards transition goals, and to discuss barriers to transition planning.
- Discuss all services or supports available to a resident which may be helpful for community living, such as affordable housing, PERS, Assistive Technology, Durable Medical Equipment, and Community Transition Goods and Services. Not all clients want personal care.

NFCMs are **not** responsible for transition planning and case management for:

- Program of All-Inclusive Care for the Elderly (PACE) enrolled clients. These cases should not be transferred/worked by NFCMs because the PACE organization is responsible for the transition planning and case management responsibility for these clients. The NFLOC determination will be completed by the PACE Case Manager. These cases should remain assigned to their current HCS/AAA worker who coordinates with the PACE organization as needed. Please refer to Chapter 22c Program of All-Inclusive Care for the Elderly (PACE) for additional information.

NURSING FACILITY ADMISSION: FROM THE COMMUNITY SETTING (HCS/AAA/DDA RESPONSIBILITIES)

***Note**: for individuals admitting from the community and whose PASRR Level I screening indicates that a Level II assessment is required, DDA PASRR Assessors will determine the client is appropriate for nursing facility care as defined in PASRR prior to admission to the nursing facility (see *PASRR Section* for more information.) DDA PASRR Assessors who identify that there is no HCS Case Manager assigned to a Medicaid Nursing Facility resident will escalate this to their DDA PASRR Program Manager for resolution.

Before a client admits to a nursing facility from a community setting the AAA/HCS/DDA case worker must:

1. Make sure the client meets nursing facility level of care (NFLOC) per the NFLOC assessment in CARE:
    a. NFLOC eligibility questions are located in the Pre-Transition & Sustainability folder on the NF Case Management screen. The questions are accessed by clicking on the "+" button when a record doesn't exist for the Nursing Facility stay or the "Edit/View" button if a record does exist for the NF stay on the Nursing Facility Case Management History table. A new window will be displayed which will enable access to the NFLOC questions. Click on the NFLOC tab at the top of the screen.
        i. All clients who are eligible for a LTC waiver or state plan, such as CFC or CFC+ COPES, are eligible for admission to a nursing facility and do not need to be re-assessed prior to completing the NFLOC questions on the NFLOC tab (a NFCM can use a DDA assessment to complete the NFLOC assessment in CARE, when needed).
        ii. Client's medical chart, nursing assistant notes, and staff interviews and other records can be used to supplement interviews with the client to assess activities of daily living, cognition, etc. to perform the NFLOC assessment for clients on state plan services such as Medicaid Personal Care (MPC), as well as for Medicaid recipients/applicants (clients who are receiving Medicaid, but not home and community program services and supports).
        iii. For clients who are case managed by DDA, the DDA Case Resource Manager (CRM) completes this NFLOC determination process based on the current DDA assessment. For cases that are co-assigned to a HCS NFCM, the DDA CRM or co-assigned NFCM completes this NFLOC determination process, in consultation with the DDA CRM.
2. Notify HCS management of admission, per local policy, and assist the client with the admission process as needed.
3. Document in the SER note:
    a. The reason for admission to the nursing facility.
    b. A discussion with the client/representative of attempts to explore other setting and support service options.

c. Notification of admission to regional HCS management, following local policy.

***Note:** If eligible, clients may choose nursing facility care regardless of the alternatives available, but the case manager must explain and offer all options and document the discussion in the SER note. Because the Nursing Facility is a medical setting, the facility will likely request support with obtaining a History & Physical, Physician Orders with Medication List and the PASRR as part of their admission consideration.

4. Assist the client in finding a Medicaid-certified nursing facility by using NF Compare or Nursing Home Locator, if necessary.
   a. Medicaid-certified nursing facilities may not discriminate against Medicaid clients per WAC 388-97-0040.
   b. A nursing facility may request a full CARE assessment and CARE Assessment Details for Admission consideration.
   c. Do not facilitate client admission to a facility that has a "Stop Placement". Residential Care Services (RCS) Division may issue a "Stop Placement" when a nursing facility is in violation of its contract. Do not admit new clients until the "Stop Placement" has been rescinded by RCS. The RCS district manager may approve readmission for clients on a case-by-case basis while a stop placement is in effect.
5. Verify that a PASRR Level I Screening Form was completed prior to admit. For more information, read the *PASRR section or visit the PASRR Program Website*.
   a. If the PASRR Level I was not performed prior to admission, the case manager should complete the form, including making referrals for a Level II if indicated.
      i. Inform the nursing facility Admission Coordinator that the admission should not have occurred without the PASRR process being followed.
      ii. Make a report to the Complaint Resolution Unit (CRU) regarding the admission without the PASRR being completed.
   b. If a Level II PASRR evaluation was indicated on the Level I PASRR form, verify the PASRR Level II was completed, and the NF has a copy of the results. Make a note in the SER note to indicate the evaluation was performed.
6. For clients with Classic Medicaid: To begin payment and document nursing facility eligibility, submit the electronic DSHS 14-443 form to the Public Benefits Specialist (PBS) in Barcode, and include the following:
   a. The date of the request for NFLOC determination or CARE assessment.
   b. If the client is functionally eligible or if the level of impairment does not meet nursing facility eligibility.
   c. Date of admission.
   d. Name of the facility.
   e. If the client is likely to meet/exceed 30 days. *(This indicates the NFCM's good faith belief that the client will be residing in the facility for less or more than 30 days based on the information they have available. The PBS uses this information to determine which program rules to apply for the facility stay and to create an award letter which allows the facility to claim and be paid.)*
   f. Date of discharge, if applicable. Complete this box if the client has already been discharged from the facility at the time that you determine NFLOC. Also include the

setting to which the client discharged, and which program was used, if services were authorized. The nursing facility also has a responsibility to submit a Notice of Action with this information, which the NFCM may retrieve or corroborate.

g. Click here for more information on how the "payment begin date" is determined.

7. For MAGI or MCS clients: Communicate the NFLOC determination directly in ProviderOne under the NFLOC Screen to include the following:
   a. The date of the request for assessment (this is the date the SNF submitted the Intake and Referral form to determine NFLOC).
   b. The date of admission.
   c. The date NFLOC was determined (this is the date of the NFLOC assessment; it should match the date on the NFLOC tab in CARE).
   d. See the section on Clients with Managed Medicaid for payment information regarding clients on an Apple Health managed care plan.

Note: Did you know there is an NFCM automated tickler in CARE that will generate 30 days after a client is determined "Yes" for NFLOC and "Yes" for Expected Discharge within 30 days?

8. Send a copy of the CARE Assessment Details to the nursing facility upon request. The service summary does not need to be signed for admission purposes.
9. End date all open authorizations effective the day prior to the admission. **Do not send a termination Planned Action Notice (PAN).** The client continues to be eligible for LTSS, they will be receiving services in another setting. Functional and Financial eligible for services remains in effect.
10. Transfer/assign the case to the NFCM per local transfer policy, when applicable (see *Case Transfer Protocol for Institutional (Hospital, Nursing Facility, or ICF-MR) Settings* for more information).
11. **Do not inactivate the client in CARE**; the NFCM will confirm NFLOC and monitor the case to facilitate transition planning.
12. The NFCM should conduct a face-to-face visit for each newly admitted **Medicaid** and dual eligible client within **30 calendar days** to begin to dialog about community options and the steps/desire to return to a community setting.

Note: For more information on case transfer timeframes for when an in-home client enters an institutional setting, see the Case Transfer section of LTC Manual Chapter 5: Case Management.

Note: The Veterans Affairs Registered Nurses (VARN) determines NFLOC eligibility for all state Veteran's home admissions.

NURSING FACILITY ADMISSION: FROM THE HOSPITAL (NFCM/ DDA CRMRESPONSIBILITIES)

Note: For individuals discharging from a hospital setting and whose PASRR Level I screening indicates that a Level II assessment is required, DDA PASRR Coordinators will determine the client is appropriate

for nursing facility care as defined in PASRR prior to admission to the nursing facility (see *PASRR Section* for more information).

In the absence of delegated authority, for home and community-based clients who are admitted from the hospital, Medicaid-funded clients, or for residents who apply for Medicaid, within the first 10 calendar days of assignment, the NFCM or DDA Case Manager, must:

1. Ensure the client meets nursing facility level of care (NFLOC) per the NFLOC assessment in CARE:
    a. NFLOC eligibility questions are located in the Pre-Transition & Sustainability folder on the NF Case Management screen. The questions are accessed by clicking on the "+" button when a record doesn't exist for the Nursing Facility stay or the "Edit/View" button if a record does exist for the NF stay on the Nursing Facility Case Management History table. A new window will be displayed which enables access to the NFLOC questions, click on the NFLOC tab at the top of the screen.
        i. All clients who are eligible for a LTC waiver such as CFC + COPES are eligible for admission to a nursing facility and do not need to be re-assessed prior to completing the NFLOC questions on the NFLOC tab (a case manager can use a DDA assessment to complete the NFLOC assessment in CARE, when needed).
        ii. A client's medical chart, nursing assistant notes, and staff interviews and other records may be used to supplement interviews with the client to assess activities of daily living, cognition, etc. to perform the NFLOC assessment for clients on state plan services such as MPC, as well as for Medicaid recipients/applicants (clients who are receiving Medicaid, but not long-term services and supports). Consider including the date of admission and name of the hospital, in the comment field of the NFCM screen in CARE.
        iii. Explain and consider authorizing Home Maintenance Allowance (HMA) for clients likely to return home within 6 months of a physician's certification.
        iv. If the NFLOC determination assessment was not completed face-to-face, conduct a face-to-face visit for each newly admitted **Medicaid** and dual eligible client within 30 calendar days to begin to dialog about community options and the steps/desire for discharge.
        v. If the client was in a SNF resident prior to the hospitalization and is returning to the same facility where they resided prior to the hospital stay, a new NFLOC determination is not required.
        vi. If the client was a SNF resident prior to the hospitalization and is returning to a different facility than the one they resided in prior to the hospital stay, **a new NFLOC must be performed and documented in the NFCM screen in CARE.**
        vii. For clients who are case managed by DDA, consider including HCS assigned NFCM for transition support or consultation on the current DDA assessment. HCS cannot enter in the NFLOC or complete the NFCM screen if the case is not assigned to an HCS RU.

2. Verify that a PASRR Level I Screening Form is completed. For more information, read the PASRR section.
    a. If the PASRR Level I was not performed prior to admission:

- Inform the nursing facility Admission Coordinator that the admission should not have occurred without the PASRR process being followed.
- Make a report to CRU regarding the admission without the PASRR being completed.

b. If a Level II PASRR evaluation was indicated on the Level I PASRR form, verify the screening for specialized services was complete and the NF has a copy of the PASRR Level II. Make a note in the SER to indicate the screening was performed.

Note: Unless other agreements have been made, if the case is being retained by the AAA, the NFLOC assessment may be completed by the AAA case manager, coordinating with the NFCM as necessary. All required steps regarding the NFLOC process must be followed, including completion of the necessary documentation.

3. For Classic Medicaid clients, complete and submit the electronic DSHS 14-443 form in Barcode to the PBS (unless already sent by Residential Care Case Manager (RCCM)/AAA/DDA) and complete the Nursing Facility Admission section by checking/filling in the appropriate boxes, including each of the following:
   a. The date of the request for assessment. This is the date the Nursing Facility requested the Intake and Referral from HCS. This is not the date of assignment in CARE.
   b. If the client is functionally eligible or whether the resident does not meet nursing facility eligibility.
   c. Date of admit.
   d. Name of the facility.
   e. If the client is likely to meet/exceed 30 days. This is the case manager's good faith belief regarding the anticipated length of time the client will be residing in the facility (indicating either less or more than 30 days). The Public Benefits Specialist uses this information to determine which program rules to apply for the facility stay and to complete the award letter which allows the facility to be paid.
      - If it was initially anticipated the client's stay would not exceed 30 days, however the client's stay ends up exceeding 30 days, the NFCM must inform the PBS using the electronic DSHS 14-443 form.
   f. Date of discharge, if applicable. Complete this box if the client has already been discharged from the facility at the time you determine NFLOC. Also, include the setting the client discharged to and which program was used if services were authorized.

4. Click here for more information on how the "payment begin date" is determined for Classic Medicaid clients.

5. For MAGI clients: Communicate the NFLOC determination directly in ProviderOne under the NFLOC Screen to include the following:
   a. The date of the request for assessment (this is the date the SNF submitted the Intake and Referral form to determine NFLOC).
   b. The date of admission.
   c. The date NFLOC was determined (this should match the date reflected on the NFLOC tab in CARE).

d. See the section on Clients with MAGI for payment information regarding clients on an Apple Health managed care plan.
e. Documenting this NFLOC determination directly in Provider One requires permissions awarded to your ProviderOne profile. For AAA/DDA and HCS Case Managers who are primarily assigned to Nursing Facilities, you can reach out to NFLOCResolution@dshs.wa.gov for support in this process.

6. Monitor and document progress with transition planning in the SERs in CARE.

7. Coordinate with nursing facility staff and other case managers. Do not rely on nursing facility staff to call when the client is ready to discharge. The work of an NFCM begins when the client is admitted to the nursing facility.

8. Attend care conferences as needed or requested. The NFCM may request a Care Conference at any time.

9. Work with the AAA, DDA and/or other HCS staff regarding clients who are returning home within 30 days.

Note: Did you know there is an NFCM automated tickler in CARE that will generate 30 days after a client is determined "Yes" for NFLOC and "Yes" for Expected Discharge within 30 days?

Note: If a client on a LTC waiver was admitted into the nursing home from the hospital, there is no need to have them sign an Acknowledgment of Services form.

NURSING FACILITY ADMISSION OR APPROVAL OF EXPANDED BEHAVIOR SUPPORT SERVICES IN A NURSING FACILITY (HCS COORDINATION OF BEHAVIOR SUPPORT CASE MANAGEMENT AND NFCM)

Before a client admits to a nursing facility with Expanded Behavior Supports (EBS) or receives approval for Expanded Behavior Support (EBS) services in this setting:

1. Ensure the client meets nursing facility level of care (NFLOC) per the NFLOC assessment in CARE:
   a. NFLOC eligibility questions are in the Pre-Transition & Sustainability folder on the NF Case Management screen. The questions are accessed by clicking on the "+" button if a record doesn't exist for the Nursing Facility stay or the "Edit/View" button if a record does exist for the NF stay on the Nursing Facility Case Management History table. A new window will be displayed which enables access to the NFLOC questions; click on the NFLOC tab at the top of the screen.
      i. All clients who are eligible for a LTC waiver such as the Residential Support Waiver are eligible for admission to a nursing facility and do not need to be re-assessed

prior to completing the NFLOC questions on the NFLOC tab (when cases are co-assigned a case manager can use a DDA assessment to complete the NFLOC assessment in CARE, when needed).

ii. Client's medical chart, nursing assistant notes, staff interviews and other records can be used *to supplement interviews with the client* to assess activities of daily living, cognition, etc. to perform the NFLOC assessment for clients on state plan services such as MPC or Chore, as well as for Medicaid recipients/applications (clients who are receiving Medicaid, but not home and community programs).

iii. For clients who are case managed by DDA, the NFCM completes this NFLOC determination process based on the current DDA assessment or in consultation with the DDA CRM.

2. For acute hospital clients seeking EBS please refer to Chapter 7f: Residential Support Waiver referral process.
3. For clients residing in a nursing facility, the assigned case manager completes the Expanded Behavior Supports in Nursing Facility referral form 15-596 and submits it to ebsreferrals@dshs.wa.gov for eligibility determination. A full CARE Assessment is not required for EBS eligibility; however, the case manager will provide a description of the current behaviors on the referral form. The EBS Referral Committee determines Expanded Behavior Support services eligibility and service level (for Example: EBS in NH; EBS Plus in NH, ECS Respite, or EBS Plus Specialized Services) and documents this decision in a SER. See the Nursing Facility Expanded Behavior Support Service Level Descriptions for detailed information.

What do I include in an EBS Referral?

Describe Behavioral Health symptoms. For each specific behavior, provide:

- Detailed description of the client's behaviors to include:
  1. When the behavior(s) last occurred
  2. Frequency of the behavior(s)
  3. Duration of the behavior(s)
  4. Alterability of the behavior(s)
- Whether there are personalized interventions that the SNF has been or will be providing.

4. When Expanded Behavior Support services in a Skilled Nursing Facility (SNF) are approved:
   a. If approved by RSW Committee, the Case Manager sends the CARE Assessment and the 130 documenting the EBS Eligibility approval to the prospective SNF for EBS admission or EBS conversion consideration. A full CARE assessment is not a requirement for admission into a SNF, however, if one is completed, include this information as part of an admission packet.
      - The Case Manager coordinates admit date/EBS Start date with the SNF and regional delegate.
      - The regional delegate will notify ALTSA HQ, NFCM Supervisor and the NFCM assigned to the facility.
        i. **This communication allows ALTSA HQ to generate a letter to the Nursing Facility outlining billing claim codes, the exceptional rate,**

and provides a start date for these specialized nursing facility services.

ii. **This communication alerts the NFCM of this new Medicaid resident's admission or start date in their assigned facility.**

iii. **Communications to HQ must occur within 60 days of approval start or end date to ensure timely claims.**

b. If approved by EBS Committee, the Committee will:

- **Document eligibility determination in SER.**
- **Notify the regional delegate, nursing facility (if contact information is known), and ALTSA HQ via email.**
- **Form 11-130 will not be completed, if approved by EBS Committee.**

5. The case manager should verify that a PASRR Level I Screening Form was completed prior to admit. For more information, read the *PASRR section*.
   a. When a Level II PASRR evaluation is indicated on the Level I PASRR form, verify the PASRR Level II was completed, and the NF has a copy of the results. Make a note in the SER to indicate the evaluation was performed.
   b. It is anticipated that most of the recipients of Expanded Services in nursing facilities will have PASRR Level II recommendations. Consider including these approaches in the client's care plan.
      - If the PASRR Level II was not performed prior to admission, the case manager should Inform the nursing facility Admission Coordinator that the admission should not have occurred without the PASRR process being followed.
      - Make a report to CRU regarding the admission without the PASRR being completed.
6. Coordinated Case Management:
   a. The assigned case manager will complete the NFLOC determination and document this in the NF Case Management Screen in CARE (if not already completed) and then transfer primary case management in CARE to the regional delegate.
      i. For clients with Classic Medicaid: To begin payment and document nursing facility eligibility, submit the electronic DSHS 14-443 form to the Public Benefits Specialist (PBS), and include the following:
         - The date of the request for assessment.
         - If the client is functionally eligible or if the level of impairment does not meet nursing facility eligibility.
         - Date of admit.
         - Name of the facility.
         - If the client is likely to meet/exceed 30 days. *(This indicates the CM's good faith belief that the client will be residing in the facility for less or more than 30 days based on the information they have available. The Public Benefits Specialist uses this information to determine which program rules to apply for the facility stay and to complete the award letter which allows the facility to be paid.)*
         - Date of discharge, if applicable. Complete this box if the client has already been discharged from the facility at the time you determine NFLOC. Also include the

setting to which the client discharged, and which program was used, if Home and Community Based Services (HCBS) were authorized.

ii. Click here for more information on how the "payment begin date" is determined.

iii. For MAGI or MCS clients: Communicate the NFLOC determination directly in ProviderOne under the NFLOC Screen, including the following:

- The date of the request for assessment (this is the date the SNF submitted the Intake and Referral form to determine NFLOC).
- The date of admission.
- The date NFLOC was determined (this is the date of the NFLOC assessment; it should match the date on the NFLOC tab in CARE)
- See the section on Clients with MAGI for payment information regarding clients on an Apple Health managed care plan.

b. The assigned case manager will provide on-going EBS case management for the client and **attend monthly (or twice monthly for EBS Plus) SNF EBS Interdisciplinary team meetings** and will SER continued eligibility in CARE.

c. The case remains active and co-assigned to the EBS CM and NFCM for the duration of EBS eligibility.

d. When the EBS participant is ready for transition planning to a lesser level of care, the EBS CM coordinates with the NFCM and transfers primary case management to the NFCM in CARE.

e. The NFCM completes the CARE assessment and works on transition planning. When intensive behavior support services are needed in the community, the CM will make an RSW referral per Chapter 7f: Residential Support Waiver.

7. SNF EBS service level changes:
   a. The primary assigned CM provides the NFCM PM, or delegate, with information on any client status changes, such as:
      - Changes in the EBS services support level (example: moving from EBS Plus to a lower level of service such as EBS);
      - Transition information such as transfers to other nursing homes or hospitals;
      - The client chooses to receive Hospice services;
      - If the client passes away and their date of death;
      - The NFCM PM, or regional delegate, notifies ALTSA HQ of any EBS in SNF status changes.

Note: Expanded Behavior Support services in a Nursing Facility is considered a Specialized Nursing Facility Program. There are other Specialized Nursing Facility Programs: Exceptional Care Needs, Community Home Project, Ventilator/Tracheotomy Weaning Program, and the Non-Citizen's Long Term Care Program. More information is available in the HCA Nursing Facility Billing Guide. There is also a Specialized Nursing Facility named the Transitional Care Center of Seattle. Information on how to make a referral for admission into Transitional Care Center of Seattle & Nursing Facilities which hold an Expanded Behavior Supports contract can be found in the Appendix.

Many of these Specialized Nursing Facility Programs will require coordination &/or a prior authorization before utilization. Please direct questions regarding this process to: TCCSAdmissionRequest@dshs.wa.gov

How is the Payment Begin Date Determined?

For Medicaid Recipients: To ensure timely hospital discharge of Medicaid-eligible individuals, Medicaid payment begins on the date of the request for a NFLOC assessment or the date of admission to the NF, whichever is later (including swing beds). The nursing facility requests a NFLOC through the intake process for clients on Classic Medicaid and MAGI. Nursing facilities must request NFLOC assessments before or on the same day of admit to be guaranteed payment (this includes weekends).

For Medicaid Applicants: NFs must request assessments for Medicare/private-pay NF residents converting to Medicaid as soon as it is determined that the resident will likely need Medicaid funding. Medicaid payment will begin on the date:

a. The financial application for NF care was received; or
b. Nursing facility admission; or
c. When the client is functionally and financially eligible.

Payment can begin no more than three months prior to the first day of the month in which the financial application is received.

NURSING FACILITY ADMITS FOR APPLE HEALTH (AH) MANAGED CARE CLIENTS (CLASSIC AND MAGI)

The Apple Health (AH) managed care program is a managed medical care program that serves over 1 million Medicaid clients statewide. This program is administered by the Health Care Authority (HCA) which contracts with managed care health plans to provide comprehensive medical care including preventative, primary, specialty and ancillary health services to all eligible clients in the state.

The AH contract with the managed care organizations (MCOs) includes a rehabilitative and skilled nursing facility benefit as part of the medical benefits covered by HCA. The MCO is responsible for paying for rehabilitative or skilled nursing days in a nursing facility if the MCO authorized the stay. The

contract requires the MCO to provide a written authorization approval or denial to the nursing facility for any stay. The facility will use this authorization to bill the MCO for services or use a denial to bill fee for service. HCA's Nursing Facility Billing Guide provides detailed instructions regarding the responsibilities of the nursing facility.

How do I know if the resident is enrolled in an AH MCO?

Staff can verify real time enrollment in an AH MCO in ACES Online. From the client summary screen select 'Medical Information' under the Details tab. You will see the ProviderOne ID for the client and AH MCO the client is enrolled in.

Client >> Medical Information

New Search: Client ID

Benefit Month: December 2021

Client

Client ID:	[redacted]	**Name:**	[redacted]
Primary Language:	English (EN)	**Extra Help Needed:**	Yes (Y) Equal Access

Client Medical Information

ProviderOne ID:	[redacted]WA	**Hospice Indicator:**	No (N)
Medicare:		**Restriction Indicator:**	No (N)
TPL Insurance:		**DDD Client Indicator:**	No (N)
Placement Code:			

Managed Care Information

Health Plan	Program	Start Date	End Date
Amerigroup Washington Inc	Fully Integrated Managed Care	10/01/2021	12/31/2999

AU Medical Information

AU ID	Coverage Group	Eligibility Start Date	Retro Medical	Delayed Certification
[redacted]	SSI Long Term Care (L01)	06/01/2020	No (N)	No (N)

Can an AH MCO enrollee transfer to another facility?

Yes, but the transfer must be coordinated with the MCO responsible for payment of the stay. The facility needs to contact the MCO to authorize and coordinate services.

When does a NFLOC need to be completed for an AH MCO enrolled resident?

1. If the client is covered by the AH MCO rehab or skilled nursing benefit, then no NFLOC is required. Always refer the nursing facility to the AH MCO if there are questions regarding the client's MCO benefit.
2. The facility must notify HCS of a need for NFLOC assessment by requesting a social service intake and the NFCM must determine NFLOC when any of the following occurs:
    a. The client is not admitting to the nursing facility under a benefit covered by the MCO;
    b. The client enrolls in an AH MCO after date of admit; or
    c. The client's rehab or skilled nursing benefit is ending (or has ended) with the AH MCO.
3. The NFCM must notify HCA whether or not the client meets NFLOC by communicating the NFLOC determination directly in ProviderOne under the NFLOC Screen. The record is available for HCA and the NF to review in the ProviderOne system. Include the following in your communication:
    a. The date of the request for assessment (this is the date the SNF submitted the Intake and Referral form to determine NFLOC);
    b. The date of admission;

c. The date NFLOC was determined (this is the date of the NFLOC assessment; it should match the date on the NFLOC screen in CARE); and
d. Whether or not the client meets NFLOC.

It is important the NFCM completes the form with accurate dates. Based on the dates provided, HCA's NH Payment Unit will determine SNF payment date discrepancies and forward these to HCS HQ. Payment dates are managed directly by HCS HQ and HCA.

If the client meets NFLOC, the payment begin date for the NF is based on the following:

For Medicaid Recipients:
To be guaranteed payment, nursing facilities must request a NFLOC assessment for a client not admitting with coverage from an MCO, enrolls in an AH MCO after date of admit or as soon as it is determined the client's skilled nursing or rehab benefit will be ending to be guaranteed payment (this includes weekends). **Medicaid payment begins on whichever is later:** the date of the request for a NFLOC assessment or the date of admission to the NF.

For Medicaid Applicants:
For applicants, the department may back date the institutional date up to three months prior to the date of application as long as the client is otherwise eligible. To determine financial and functional eligibility, NFs must request a NFLOC assessment and assist the client in applying for Medicaid on Washington HealthPlanFinder as soon as it is determined a resident will likely need Medicaid funding.

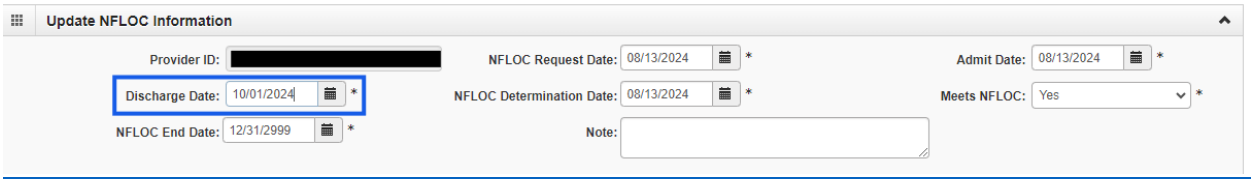
See ***Clients that Do Not Meet Nursing Facility Level of Care*** for more information regarding a client who does not meet NFLOC.

Do we need to send a 14-443 on MAGI or MCS clients?

If the client is MAGI or MCS, do not send a 14-443 to the PBS unless the client can only be served under an HCBS Waiver and not MPC or CFC upon discharge. Public Benefit Specialists will not make eligibility changes for individuals eligible for MAGI even if the client is in a NF for 30 days or more. For Managed Medicaid recipients, NFLOC is communicated to the Health Care Authority directly via ProviderOne. This ability to enter/edit the NFLOC screen in ProviderOne requires a profile update via a Non-HCA Employee Access Request form to be submitted to hcaitsecurity@hca.wa.gov.

Do we update the NFLOC Communication in ProviderOne at the time of discharge?

The NFLOC determination in ProviderOne is completed at the time of admit, application or conversion and is updated when a MAGI or MCS client discharges. Refer to ***NFLOC Communication in ProviderOne*** section for additional P1 documentation instructions for this scenario.



Will Managed Care Assist with Care Coordination and Transition Planning?

When a client enrolled in managed care needs assistance to coordinate their health care services and access to appropriate treatment, the NFCM must assist the client and their guardian, if applicable, to request "care coordination" from the client's Apple Health MCO (including clients who have managed care only for behavioral health services).

The Medicaid and Medicare Managed Care Coordination Contact information can be found on the HCS/AAA intranet website on the right side of the webpage, under Contractors.

To request care coordination, the CM may send a secure email* to the client's MCO to request care coordination and assistance to address barriers the client is experiencing to access medically necessary care covered by Apple Health.

*Emails from the DSHS URL (@dshs.wa.gov) identifies the requestor as a DSHS employee and meets HIPAA requirements to request care coordination on behalf of a HCS/AAA client.

1. When making a care coordination request include the following in your email:
   a. In the Email "Subject" line, provide the reason for care coordination request. For example:
      i. Mental health treatment
      ii. Durable medical equipment
      iii. Needs Primary Care Provider
   b. In the body of the email, provide the following information:
      i. Client Name
      ii. Client ProviderOne ID: (9-digit number ending in WA)
      iii. Date of Birth
      iv. Residence Type
      v. CM Name and Contact Information
      vi. Summary of client barrier/issue/need

2. If you do not receive a response or assistance with your request timely, the CM should discuss the case with their supervisor to determine if escalation is needed. Sent a second email to the MCO with 'escalation' in the title of the email.

3. If the CM and supervisor do not receive a response, they may determine escalation to HCS HQ is needed when issues are not resolved.

a. If the CM supervisor determines that escalation to HQ is appropriate, the CM supervisor will submit the original email communication and escalation with the MCO to Ethan.Leon@dshs.wa.gov

Once the request for escalation is received, HCS HQ will outreach with HCA to discuss the identified barrier to access. Based upon the type of request, the case manager and supervisor will be notified regarding next steps. You can find more detailed information on Managed Care in Chapter 22 of the LTC Manual.

PRE-ADMISSION SCREENING & RESIDENT REVIEW (PASRR)

What is PASRR?

Federal regulations (42 CFR §483.100 – 138) require that ***all*** individuals applying for or residing in a Medicaid-certified nursing facility be screened to determine whether they:

1. Have serious mental illness or an intellectual disability or related condition; and if so,
2. Require the level of services provided by a nursing facility; and if so
3. Require specialized services beyond what the nursing facility may provide.

The Level I Pre-Admission Screening and Resident Review Form documents the first level of screening. If serious mental illness or intellectual disability or a related condition is identified or credibly suspected, a Level II evaluation is required to confirm or exclude identification, determine whether the individual requires nursing facility level of care, and determine whether specialized services are required.

Who should be screened under PASRR?

Anyone seeking nursing facility admission to a Medicaid-certified nursing facility, whether funded by Medicaid or a non-Medicaid source, must be screened ***prior*** to admission.

Who completes the Level I pre-admission screening for people coming from a hospital?

Any professional who is referring an individual for admission to a nursing facility may complete the Level I PASRR form. The form may also be completed by designated HCS or DDA staff who are facilitating the referral.

The nursing facility is responsible for ensuring that the form is complete and accurate **before** admission. After admission, the NF must retain the Level I form (and the Level II, if applicable) as part of the resident record. In the event the resident experiences a significant change in condition, or if an inaccuracy in the current Level I is discovered, the NF must complete a new PASRR Level I and make referrals to the appropriate entities if a serious mental illness and/or intellectual disability or related condition is identified or suspected.

Who completes the Level I pre-admission screening for individuals coming from their own homes or from a residential setting?

- The referring physician or ARNP should complete the form.
- For Medicaid funded clients, the HCS, AAA, or DDA worker should verify that the screenings are complete for current clients being placed in a NF.
    - DDA may complete the Level I screening for DDA clients who are being admitted to a nursing facility directly from home.

Are there exceptions to a Level I being completed?

Level I screens are not required for individuals who are:

- Transferring from one NF to another NF; or
- Being readmitted to the same NF following hospitalization (applies only if a Level I PASRR screen had previously been completed and is still applicable to the individual's status).

What happens if someone meets the PASRR criteria for PASRR Level II?

The referral source will contact DDA and/or the Behavioral health (BH) contractor for an evaluation. (*See DDA PASRR and the BH PASRR Internet sites for a list of evaluators.*)

1. Unless the individual meets criteria for an exempted hospital discharge, a DDA assessor or MH contractor must perform a Level II evaluation to verify the diagnosis prior to admission to the nursing facility, determine whether nursing facility admission is appropriate, and determine whether the person needs specialized services. If the person has both a serious mental illness and an intellectual disability or related condition, the individual must receive a Level II evaluation from both DDA and BH.
2. It is the nursing facility's responsibility to ensure that a potential resident has a completed PASRR Level I screening and, if necessary, a Level II evaluation ***prior*** to admission into the facility.

Are there exceptions to a Level II evaluation being completed?

Per 42 CFR §483.104, a person may be admitted to a NF without a PASRR Level II when:

1. The person is readmitted to the NF directly from a hospital after receiving acute inpatient care at the hospital;
2. The NF admission is to treat the condition for which the person was hospitalized; and
3. The person's attending physician, ARNP, or physician's assistant certifies that the person requires fewer than 30 days of nursing facility services *(Level II required by Day 31 if stay unexpectedly exceeds 30 days*).

Is an NFLOC needed for a client who meets the PASRR level I screen?

Yes, NFLOC is a requirement for Medicaid recipients in nursing facility settings. For individuals who have a positive Level I screening and require a Level II evaluation, the assigned DDA or HCS CM completes the

NFLOC assessment following all regular policies. DDA PASRR Assessors will determine the client is appropriate for nursing facility care as defined in the PASRR determination process prior to admission to the nursing facility. DDA PASRR Assessors document this information within their PASRR Data System (PDS). In the event a DDA PASRR Assessor identifies that an HCS Case Manager is not assigned to the DDA Client in CARE, this will be escalated to the DDA PASRR Program Manager for resolution.

What are "specialized services"?

"Specialized services" is a term used in federal PASRR regulations (42 CFR §483.120) to describe any services or equipment that are (1) recommended in a Level II evaluation to meet the needs of individuals with serious mental illness or an intellectual disability or related condition, and (2) exceed the scope of services normally provided by the nursing facility.

What if a Nursing Facility finds that a person's condition has changed after admission?

The NF must complete a new PASRR Level I and make referrals to the appropriate entities if a serious mental illness and/or intellectual disability or related condition is identified or suspected. The NF should promptly refer residents to *DDA PASRR* or the local *BH PASRR* evaluator when either of the following occur:

- Already have a mental illness or developmental disability and show a significant change in condition (improving or declining).
- Develop a serious mental illness and may need a Level II evaluation.
- If the resident has had a significant improvement, the facility must request a new NFLOC from HCS to verify functional eligibility.

What if there is not a PASRR contracted evaluator in my area or if I have questions about a PASRR contracted evaluator?

HCA is responsible for contracting with all Level II PASRR contractors who conduct evaluations related to mental illness. For questions about HCA contracted PASRR evaluators, please contact Elizabeth Loska beth.loska@hca.wa.gov or call 360-725-1478 and review the website: PASRR Program Contacts by County.

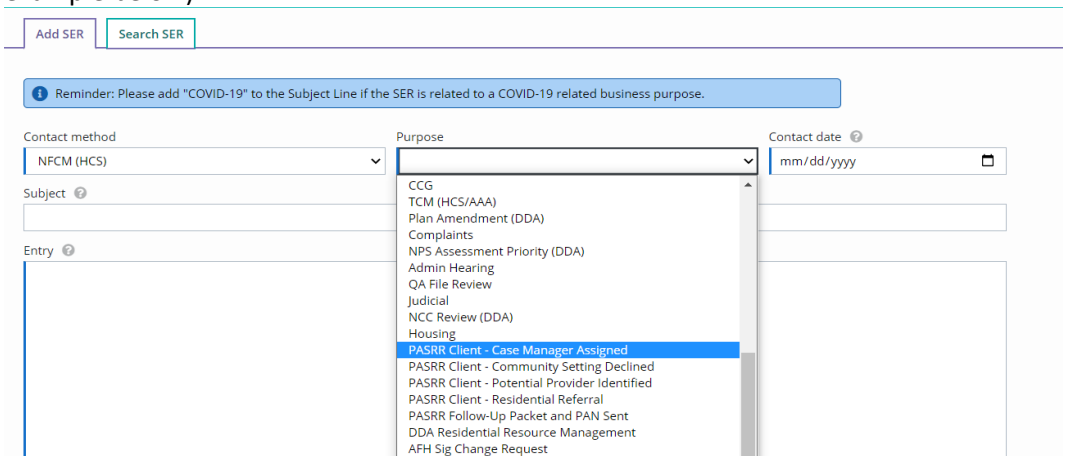
DDA is responsible for conducting Level II evaluations related to intellectual disability or related conditions. For questions about the DDA evaluators, please contact your local *DDA PASRR* Coordinator.

How should I document case activities when the client is receiving PASRR services (For DDA PASRR Assessors only)?

Complete SERs for activities related to community transition for clients in PASRR RUs using the SER subject lines in **bold type** below:

- **PASRR Client – Case Manager Assigned:** Enter a SER with this Purpose code when a current NF resident desiring community transition is assigned a DDA or HCS case manager (see

example below).



- **PASRR Client – Community Setting Declined:** Enter a SER with this Purpose code when a PASRR client is offered a viable community setting that meets their needs, but the individual or guardian does not accept the setting.
- **PASRR Client – Potential Provider Identified:** Enter a SER with this Purpose code when a potential community-based provider is identified.
- **PASRR Client – Residential Referral:** Enter a SER with this subject when referral information is shared with a potential provider for community transition (adult family home, supported living agency, assisted living, etc.).

For DDA and HCS Case Managers: Contact the DDA Regional PASRR Team prior to inactivating a case in CARE when the client is assigned to a PASRR RU. When transferring a shared PASRR case:

1. On the Transfer Form, note that the case is shared with a DDA PASRR worker; document the office and name of the worker on the form.
2. Contact the regional PASSR Team (see below) to let them know the case is being transferred.
3. In the SER documenting the transfer, the transferring worker should note that the client has a DDA PASRR case worker that should be notified once the case is assigned.
4. The assigned worker in the receiving RU should email the Regional PASRR Team to let them know the case has been transferred and is now assigned.
5. Upon notification, the Regional DDA PASRR Team can add the PASRR information back into the CARE Overview screen.

DDA PASRR distribution lists:

- DSHS DL DDA R1 PASRR Team: ddar1pasrrteam@dshs.wa.gov
- DSHS DL DDA R2 PASRR Team: ddar2pasrrteam@dshs.wa.gov
- DSHS DL DDA R3 PASRR Team: ddar3pasrrteam@dshs.wa.gov

What if I have other questions about this process?

For other questions about PASRR, please refer to your regional HCS or DDA office or your local RCS field manager.

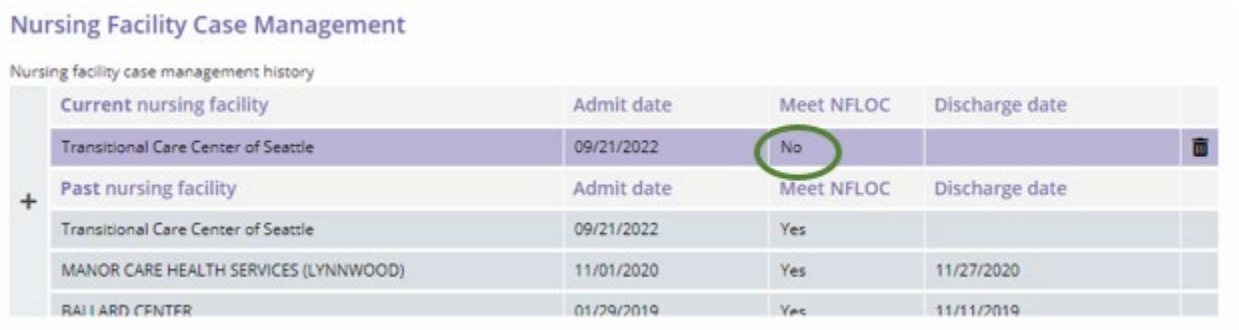
CLIENTS THAT DO NOT MEET NURSING FACILITY LEVEL OF CARE (NFLOC)

The nursing facility should submit a Intake and Referral Form (DSHS Form 15-570) when:

1. A new Medicaid client has been admitted from the hospital.
2. A current resident is converting from Medicare to Medicaid.
3. A current resident's rehab or skilled nursing benefit has ended with the AH MCO.
4. A resident is applying for Medicaid.
    - Financial eligibility may be retroactively determined for up to 3 months.
    - Functional eligibility must be requested at the time the Medicaid application is submitted.
5. A client has expressed interest in transitioning to the community.
6. There has been an improvement in the health of a current resident sufficient so the resident may no longer need nursing facility level of care.

If the client does not meet nursing facility eligibility 1) at time of admission to the nursing facility or 2) at any time during their nursing facility stay, a full CARE assessment should be completed as soon as possible to verify functional eligibility. Follow steps as outlined in the CARE Web Help file when a client does not meet functional eligibility for HCBS programs. Document any changes in NFLOC status by completing the following:

1. A new line will need to be created on the Nursing Facility Case Management Screen in the NFCM history table in CARE to document the change in determination.
    a. Create a new line on the NFCM Main screen by clicking on the "+" sign on the NF Case Management screen history table.
    b. Select the SNF where the client resides (it will likely be the same as the previous line).
    c. On the NFLOC tab, answer questions 1 through 5. If the client does not meet NFLOC (All "no" answers to questions 1-5), the system will auto-populate "Does the client meet NFLOC?" with "No".
    d. Select "Yes" from the drop-down for "Expected to discharge within 30 days?"



2. The NFCM will send written notice to the nursing facility that the client no longer meets NFLOC and that payment will end in 30 days (*see sample letter in* Resources).
   a. A copy of the letter saying payment to the facility will end must be provided to the client.
3. The facility must initiate discharge of a resident who does not require nursing facility care (WAC 388-97-0100).
   a. The facility must send a 30-day notice to the client, the client's surrogate decision maker and, if appropriate, a family member or the client's representative.
   b. Notice of a resident-initiated discharge must also be provided to the LTC Ombudsman office.
   c. The notice to the client and representative(s) must include the reason for denial and their right to a fair hearing, per RCW 74.42.450.
   d. If the client requests a fair hearing and prevails based on the NFCM re-determining NFLOC, send a letter to the client and SNF describing continuous eligibility (see sample letter in Resources).
   e. ***For Classic Medicaid only:*** When an NFCM is aware that a fair hearing has been requested, they must notify the public benefits specialist of this via a 14-443 communication.
4. ALTSA's policy is to authorize payment for up to 30 days or until the client is discharged, whichever is earlier:
   a. ***For Classic Medicaid only***: Notify Financial via a 14-443 communication that the client no longer meets NFLOC.
   b. Client must meet financial eligibility in order for the facility to be paid.
   c. Payment will be made from state funds to the nursing facility.
5. Continue to work with the client on transition planning options and document all efforts in CARE.
6. If the case manager observes that a facility has a pattern of admitting clients who do not meet NFLOC or that does not initiate determination of level of care for residents whose health has improved, notify your supervisor, and call the Complaint Resolution Unit (CRU) hotline with specific concerns.

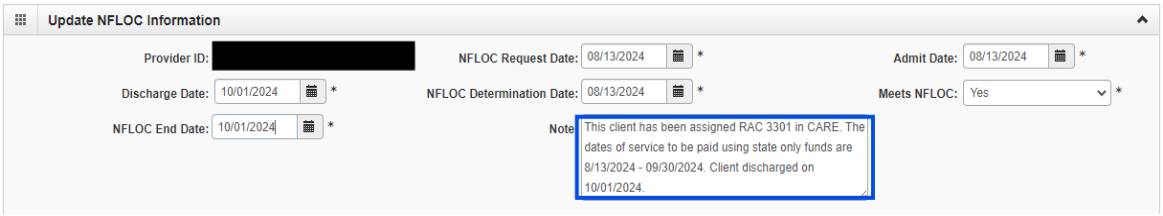
> **Note:** When a Medicaid resident declines to participate in a full CARE assessment to verify NFLOC, indicate this in the Reason for Assessment field. Keep in mind that the client should always be the primary source of information, so notify the resident that an assessment will be completed without their participation. To receive services funded by Medicaid in a nursing facility setting, the client must remain Nursing Facility Level of Care. A video tutorial on this process can be found on the NFCM Workspace.

To facilitate payment to the NF using state funds:

1. Upon completing the NFLOC assessment and determining NF level of care is not met:
   a. The case worker indicates on the NFLOC tab that the client does not meet NFLOC with the date of the determination.

b. If the client has been a resident and this is a change in status, follow the instructions above to create a new line on the NFCM history table.
c. The case worker assigns RAC 3301 in CARE, but no authorization is created.

2. ***After the client discharges from the SNF,*** the case worker completes Barcode form 14-443 (Financial/Social Services Communication) or Updates the NFLOC Communication in ProviderOne (NFLOC for MAGI or MCS) indicating that NFLOC is not met and includes the following statements in the Comment box of the 14-443 or NFLOC Screen in P1 (see sample below):
   a. The client has been assigned RAC 3301
   b. The RAC was added in CARE by the case manager and sent to P1.
   c. The dates of service to be paid using state only funds.
   d. The date of discharge (date of discharge is not paid, per the NH billing guide).



3. The SNF bills as usual:
   a. HCA's NH Payment unit will look for the 14-443 in Barcode or NFLOC Screen in P1 and process claims when NFLOC is not met, and the RAC and discharge information is provided.
   b. If NFLOC is not met per the 14-443 or NFLOC screen in P1, but RAC and discharge information is not provided, payment is "on-hold" until clarification is received (not denied, but not paid).
   c. If there is no 14-443 or NFLOC Determination in P1, the claim is denied per usual procedure and facility must contact their assigned NFCM to get it completed.

DETERMINING AND DOCUMENTING TRANSITION GOALS

The NFCM will:

1. Visit the client and inform the client and/or family/representative, as appropriate, of case management services and inquire about the resident's transition goals. Informed consent is always obtained directly from the person unless he/she/they is legally not competent to consent. In that event, State statute (RCW 7.70.065) allows the following in order of priority to give informed consent for adults: legal guardian, Durable Power of Attorney, spouse or State registered domestic partner, adult children, parents and adult siblings.
2. When appropriate, work with the client, nursing facility staff, and family to help the client relocate to a community-based setting.
3. Offer support to the client, the family and/or representative by addressing concerns regarding care in the nursing facility or other quality of life issues.
4. Monitor progress towards transition goals and encourage progress towards the highest level of functioning possible. **All cases must remain active for a minimum of 6 months to monitor progress and address transition barriers.** There is no maximum length of time a case may remain active while a Medicaid funded resident is residing in a nursing facility.
5. If it is not feasible for the client to return to their own home, talk to the client, their family/representative, and/or their case manager about other living situations such as adult family homes or assisted living facilities. In coordination with the nursing facility staff, contact AFHs and ALFs to determine if they have openings and discuss the client's care needs to learn if they would be interested in meeting the client.
6. Encourage the education of clients so that they may address their own care needs, such as self-medication programs, nutritional programs, or home evaluations.
7. Document progress towards community transition in the SER and update applicable screens in CARE.

> The client's preferences should be the primary influence regarding transition planning; family desires should be considered in transition planning but should not be the sole source. See HCS Decision Making for Transition Planning in the Appendix Section of this Chapter.

Ready for Relocation

When the client chooses to live in a less restrictive setting, the NFCM will:

1. Perform a CARE assessment (initial, significant change, or reapply) with the client.
   a. For clients on DDA services, contact the DDA CRM/PASRR Coordinator to initiate the completion of a DDA assessment and to coordinate any discharge resources that may be needed.

b. The assessment to prepare a client for community transition while they are in a SNF or hospital setting does not require the assessor to assess the community setting prior to moving the assessment to current (see Chapter 3 regarding if an assessment is in a setting other than the client's home or residence where services are being provided). The 30 day face-to-face visit required by the receiving case worker meets the requirement to identify any safety or other concerns regarding the living environment (See Chapter 5 for details).

Note: CARE assessments may be initiated or completed at any point of the client's nursing facility stay. It may be necessary to complete more than one CARE assessment to accurately reflect the client's long-term service and support needs in the community.

2. Develop an individualized plan that reflects client choice and the person's specific care needs. Document in a SER the client's informed decision regarding setting and care.
3. If appropriate, authorize Transition Resources and request care coordination with the resident's managed care organization.
4. Create an approval Planned Action Notice (PAN) for all services the client is authorized to receive as outlined in CARE (With the exception of any services provided through WA Roads.)
5. Within 7 days of discharge, update the following in CARE (whether or not the assessment is ready to move to Current or History):
   a. Discharge date on the NFCM main tab by highlighting the line in the table and clicking on the "Edit/View" button (if the client discharged on RCL after a reinstitutionalization, update the Discharge Date on both the NFCM **and** the RCL screens.)
   b. Update information in CARE on either the Residence Screen in CARE Desktop or the Contact Details screen in CARE Web.
   c. Choose the appropriate Residence Type in addition to updating other residence information. The dropdown options under Residence Type include Correctional Facility, Homeless, Medical Hospital, Psychiatric Hospital, as well as every residential and in-home setting, including if the individual is living with a relative; use "Other" only when there is no appropriate option.
   d. The residence Start Date should be the same as the Discharge Date (the Start Date field can be manually corrected on the Residence screen in CARE Desktop or the Contact Details screen in CARE Web.)
6. On the CARE Plan:
   a. Indicate Program (only choose RCL if the client has been enrolled on the RCL Enrollment Screen). If the program choices do not reflect CFC, then refer to Client does not meet NFLOC section of this chapter.
   b. Client chosen/planned living Situation.
7. For the relocation to be included on the monthly NFCM Transition report, move the assessment to Current/ History:
   a. Do not delay assisting a client to transition until the assessment is in Current but move the assessment as soon as the care plan is in place.

Note to CM: A video tutorial detailing how to make your discharges count with relocation standards can be found on the NFCM Workspace.

If the client is making an informed decision to decline personal care or other long-term services and supports, the assessment can be moved to History but must have all "Green progress bars" and Care Plan Screen completed to be included in the report.

No Current Transition Plan/Goal

Some individuals or designated decision maker may not be interested in discussing a return to the community immediately upon admission. For clients who do not have a current discharge plan or do not currently expect to return to a community setting, offer ongoing support to the client, family and/or representative by addressing concerns regarding care in the nursing facility or other quality of life issues and continue to support all efforts towards reducing or eliminating transition barriers to a less restrictive setting. If, **after a minimum of 6 months,** the client has not made any progress towards their transition goals, you *may* Inactivate the client in CARE using the "No Current Discharge Plan" code. Case inactivation *is not* required if there is no transition plan, cases may remain active if no transitions goals are identified. **For those residents receiving specialized nursing facility services, these clients must remain active with nursing facility case management.**
Follow up with clients at least annually to determine if interest/motivation to return to the community has changed, or whether the client's informal supports have changed. Document these discussions of offering alternative setting choice and sharing information on community resources and services in a SER.

Note: For DDA co-assigned clients, move the LTC assessment to history and remove yourself from the CARE team on the Overview screen. **Do not inactivate the client in CARE.** If the client is receiving PASRR services, follow all protocols in the PASRR section.

CASE TRANSFER PROTOCOL FOR INSTITUTIONAL SETTINGS (HOSPITAL, NURSING FACILITY, OR ICF-ID)

The intent of this case transfer policy is to encourage coordinated transition/treatment planning in the best interest of the client. The AAA CM, RCCM or DDA CRM/ PASRR Coordinator should collaborate with the facility's assigned NFCM to determine when a case transfer is appropriate for a client who intends to return to a community setting. For those nursing facility residents who are already on an HCS NFCM's active caseload the following also applies when a client transitions to another institutional setting:
In that regard, AAA, DDA and/or HCS staff may:

- Assess client in the NF or hospital.
- Determine NFLOC in the NFCM tab of CARE.
- Attend care conferences at the hospital, NF, or ICF-IDs
- Access transition resources for clients
- Review medical records and/or files.
- Request Housing Maintenance Allowance (HMA)

Timeline Benchmarks

The client may remain with the RCCM or AAA CM for 30 days from initial admission to Nursing Facility regardless of subsequent changes in institutional setting (hospital, SNF, ICF-ID). The client case may be kept longer than 30 days if a return to community setting is imminent. If the client does not intend to return to their previous setting, the NFCM/RCCM/CM/AAA may transfer client to the NFCM unit immediately (earlier than 30 days). DDA CRMs/PASRR Coordinators will co-carry the case with the NFCM assigned to the nursing facility where the client resides.

When a hospital stay goes beyond 30 days, the NFCM/RCCM/CM/AAA may coordinate with the Hospital unit regarding the transfer of the case. When an NFCM is unclear whether the client will return to the nursing facility, retain case management of the client until the 30-day timeline, or until the client transitions to another nursing facility. Upon admission into another nursing facility, the NFCM will transfer the case to the assigned NFCM of that center. NFCMs are required, to staff the client case with the ongoing Hospital Case Manager/RCCM/AAA/DDA case manager at transfer.
The NF case manager Supervisor will:

1. Immediately staff the case with the hospital supervisor unit,
2. Create a hospitalization transfer SER with the following information
    1. Hospital Name
    2. Admission date
    3. Current hospital social worker
    4. Barriers to returning to SNF setting.
    5. Date of staffing with Hospital Supervisor
    6. Is the client decisional? (If not, who is the guardian/conservator or DPOA)?
    7. What steps have been taken to maintain or allow the client to return to previous setting?
3. Transfer the case to an HCS hospital case manager supervisor for case assignment.

See Chapter 5 Case Management of the Long-Term Care Manual.

TRANSITION RESOURCES

Home Maintenance Allowance (HMA)

Home Maintenance Allowance: The HMA is income, up to 100% of the Federal Poverty Level, which the client can keep maintaining their community home during a NF or institutional stay. WAC 182-513-1380

Who is eligible?	A **single** client applying for HMA must be: 1. A Medicaid recipient; and 2. Certified by a physician that the client will likely be institutionalized in a NF or Medical Institution for no more than six months. A **married** client may be eligible if: 1. Both members of the couple are residing in a NF or receiving Housing Maintenance Allowance; and 2. One of them is likely to return to their place of residence within six (6) consecutive months. A married client whose spouse is not institutionalized is not eligible for the HMA.
What is covered under the HMA?	The client is allowed to keep 100% of the federal poverty level of their income to maintain their community home.
How do I authorize HMA?	1. Consult with the client or Public Benefits Specialist to determine the first month that an HMA may be authorized. 2. Request written verification from the client's physician that the client is likely to return home within six consecutive months. This may be in the physician's orders at the Nursing Facility, or you may use the HMA DSHS form 14-456. 3. Document the verification of the written Physician's Certification in a SER or place the completed HMA DSHS form 14-456 in the client's electronic client record. 4. If the physician certifies the client is likely to return home within six months: a. In Barcode, indicate the home maintenance allowance exemption on DSHS form 14-443 (HCS/AAA staff) or on DSHS Form 15-345 (DDA staff) and provide the start date. 5. If the physician will not certify the individual is likely to return home within six months: a. Indicate on DSHS form 14-443 (HCS/AAA staff) or on DSHS Form 15-345 (DDA staff) there is no HMA and leave the HMA Start Date blank. b. List details of the HMA actions in the CARE SER using Contact Code "NFCM" 6. Send the client a letter indicating the HMA Action if denied. **Note:** If the AAA CM retains case management of the case, the completion of the HMA is their responsibility. For clients shared by HCS and DDA, the DDA CRM/PASRR Coordinator completes the HMA. Additional HMA completion resources can be found on the NFCM Workspace.
When do I authorize this service and for how long?	The HMA begins on the first of the start month (as stated on the DSHS 14-456) and ends when the client is discharged from the facility or at the end of six months, whichever comes first. HMA should not be requested for a month in which the client does not have participation (i.e. the first month of admission or

	when Medicare is the primary payment source). For non-SSI clients, circumstances must be reviewed after 90 days, and the Public Benefits Specialist must be informed of the need for an extension of an additional 90 days or termination of HMA. If a client transitions to their community home and is later re-admitted, you may reauthorize the HMA with a Physician's certification indicating the client will likely return to their community home within six months. If a client has HMA approved but does not owe participation during the approved allowance benefit period (for example, the client's stay is covered by a medical benefit or is private pay for an interrupting period of time such as after an acute hospitalization), the six consecutive month limit may be adjusted by notifying the Public Benefits Specialist via DSHS form 14-443. No new verification from the physician is required if the break is covered during the original verification period.
What if it is a Temporarily Institutionalized SSI Recipient?	• SSI only income: Upon NF admission, the client's SSI income is exempted; therefore, these clients are not eligible for a HMA. • SSI/SSA (or some other income): Authorize the HMA taking into consideration the client's SSI income for the first 3 months. • SSI income would need to be subtracted from the total need, since this income is available to the client for the first 3 months. If the client continues to need NF care following the first 3 months and has additional income such as SSA, pension, retirement, etc., authorize an income exemption for 3 additional months.
Are ETRs allowed for HMA?	• If the client has only SSI income and requires NF care following the first three months of institutional care, Emergency Rental Assistance may be authorized to maintain the client's residence see LTC Manual, Chapter 6B: Interim Housing Resources (Motel Interim Stay for Transitions & Emergency Rental Assistance). • No ETRs are allowed for HMAs longer than six months in duration. • No ETRs are allowed for amounts over the federal poverty level per month.

Community Transition Services (CTS) & Transition Support Services

Community Transition Services (CTS): CTS are used to purchase one-time, set-up expenses necessary to help relocate clients discharging from an institutional setting to a less restrictive setting (see WAC 388-106-0270). The Appendix includes a Supporting Client Transitions to the Community - YouTube video which describes some of these services.

Who is eligible for Community Transition Services (CTS)?	HCS/AAA clients who are receiving Medicaid long-term services who: • Are discharging from a nursing facility, institution for mental disease (IMD) or intermediate care facility for individuals with intellectual disabilities (ICF-ID) to a home and community-based setting; and • Will be receiving Roads to Community Living (RCL), Community First Choice (CFC) or Residential Support Waiver (RSW) services upon discharge. CTS funds **must** be considered before you use CTSS state funds. For those on the Address Confidentiality Program, refer to Chapter 3: Assessment and Care Planning for additional information on service coordination.
What is covered under Community Transition Services SA297? **CTS: Goods SA296?** HCS Only: You may utilize Amazon or Kroger for purchasing Goods. Kroger Authorization Process can be found in Appendix section. See Amazon Authorization Desk Aid in Appendix section.	Services may include: 1. First month's rent, security deposits, safety deposits 2. Utility set-up fees or deposits 3. Health and safety assurances, such as pest eradication, allergen control, or non-recurring cleaning fees prior or upon return to the home. 4. Moving fees 5. Non-recurring rental insurance required for lease up. Goods may include: 1. Furniture, essential furnishings, and basic items essential for basic living outside the institution. For AFH Settings reference WAC 388-76-10685, and for Assisted Living Settings reference WAC 388-78A-3011 which outline resident unit furnishings in these settings. In the event a residential setting indicates they are unable to provide the required furnishings as outlined in WAC, notify the provider of their requirements as outlined in WAC, and also submit a referral to RCS to document the provider's inability to meet residential unit furnishings per WAC. 2. The provision of goods that increase independence or substitute for human assistance to the extent that expenditures would have been made for the human assistances, such as purchasing a microwave. CTS cannot be used to authorize environmental modifications. If a client transitioning from a congregate setting needs an environmental modification completed prior to discharge, that service must be accessed via COPES or CTSS depending on eligibility.
What is not covered under CTS?	• Federal rules require that services do not include recreational or diversional items such as television, cable or DVD players. • CTS does not pay for items or services paid for by Medicaid or other programs and resources, through the state plan or waiver such as groceries available under the Food Assistance benefit. Roads to Community Living will allow a one-time pantry stocking for enrolled participants.

	• Community Transition Services may not be used to furnish or set up living arrangements that are owned or leased by an AFH, ARC, EARC, ESF or AL facility. For eligible clients, state funded CTSS can be used in combination with federally matched CTS for items/services not covered under CTS.
How much can I spend?	The amount that can be used for CTS is $2500. **Note:** If both CTS and CTSS funds are being authorized, the "combined" costs cannot exceed $2500 without an approved ETR. CTSS ETRs are Local, CTS ETRs require a HQ approval by the CFC Program Manager.
Do I need to use a contracted provider?	If the DSHS payment system will pay directly for a service or item, a contract is required for all CTS providers. • Service providers such as pest eradicators, janitorial services and movers must be contracted with the CTSS contract and paid directly via ProviderOne. • Check to see if the provider has an existing contract for the service or goods that will be provided. • If there is not an existing contract, notify your local AAA Contracts Management team of the network capacity need. Providers must meet all other obligations associated with the contracting process such as background checks, Medicaid Provider Disclosure Statement and insurance requirements, when applicable. • For one-time payment for deposits or set up fees, the Special Considerations contract may be used. • NOTE: 1. A contract is not required if another payment mechanism is utilized. Options include: a. Using a client services P-Card (state issued credit card available to HCS HQ staff); or b. Authorizing a contracted provider to pay for rental deposits and community living set-up fees directly and be reimbursed. i. Compensation to the contracted provider for issuing payment does not count towards the CTS $2500 limit.
How do I authorize CTS?	1. Perform a CARE assessment to determine/document the need and plan of care for the CTS. CTS needs are often captured in the Treatment table as "Community Transition Goods or Items" or "Community Transition Services" Program and/or Client Safety. 2. The Sustainability Goals screen in CARE may be used as part of transition planning and as a communication tool with contracted providers. 3. For CFC and COPES, move the assessment to *Current*. The CTS provider will be assigned the "Community Transition Goods or Items" or "Community Transition Services" Program treatment on the Supports

	screen as the paid provider. For RCL enrolled recipients, services may be initially authorized without a current assessment, though will need to be included and documented in a completed assessment. 4. Document the extent of services provided and the cost in the SER; for Nursing Facility discharges use Contact Code "NFCM." 5. Assign the applicable Program RAC and authorize the items or services using the appropriate code(s). For CFC recipients, the total cannot exceed $2500 without an HQ approved ETR. For RSW clients, add RAC 3056 "RSW-CFC ancillary services." 6. Submit a DSHS form 02-615 Invoice Coversheet to DMS with all invoices, receipts, etc. Include verification that the client received the goods or services. 7. Send the client a Planned Action Notice reflecting CTS.
When do I authorize this service?	This is solely for one-time payments to help a client establish a residence (no ongoing services/items). Only if the client has needs beyond what is covered under CTS may state funded CTSS also be used. Under CFC and RSW programs, CTS funds can be accessed up to 30 days after discharge if the item/service is needed for a successful transition and no other resource is available. When Community Transition Services are furnished to individuals returning to the community from an institutional setting, the service is not considered complete and may not be billed until the participant leaves the institution and is enrolled in the CFC or RSW program. You may use CTS each time the eligible client is discharged from a Nursing Facility or State Hospital. Additional information can be found in CFC Chapter 7b.
Are ETRs allowed for CTS?	All CFC CTS funds that exceed $2500 must have an ETR approval from the Community First Choice (CFC) Program Manager. Send CFC ETR requests by choosing "Pending HQ Approval" in processing status and Victoria Nuesca as the "Worker". Send a notification email to victoria.nuesca@dshs.wa.gov with CTS ETR in the subject line.
Community Choice Guiding: SA263 **Shopping/Purchasing without client present: SA266**	1. Community Choice Guiding (when leaving a Nursing Facility or State Hospital.) to include non-medical transportation services. 2. This service includes coordinating, educating, and linking the client to resources which will establish or return an individual to their community setting, including arrangements with pharmacies, primary care physicians, financial institutions, utility companies, housing providers, social networks, local transportation options, household budgeting, and other needs identified in the care plan.

	3. Most clients receiving Community Choice Guiding services will benefit from **concurrent authorization of both** SA263 and SA266 service codes. See more information on Community Choice Guiding in Chapter 7b: COPES
Non-Medical Transportation T2003	Non-Medical Transportation can be used to support a client's non-medical transportation needs. Examples include supporting a client's reinstatement of benefits with Social Security or to visit Adult Family Homes for admission consideration. Non-Medical Transportation could also be used for other one-time transportation needs which will support a client's community living. For those AAAs which are not contracted with a local non-medical transportation provider, staff may utilize MedStar Transportation. The referral process for this Statewide contracted provider can be found in the appendix. To capture non-medical transportation in CARE, ensure that "Non-Medical Transportation" is reflected in the Treatment Screen and assigned to the paid provider in the Supports Screen. See more information on Transportation Services in Chapter 7b: COPES.

Community Transition or Sustainability Services (CTSS)

Community Transition or Sustainability Services (CTSS): CTSS are state funded non-recurring setup items or services necessary to assist individuals establish, resume or stabilize a home or community-based setting. WAC 388-106-0950; 388-106-0955; 388-106-0960.	
Who is eligible for CTSS?	A client is eligible for community transition or stabilization services if they: 1. Meet eligibility criteria to receive long-term services and supports from home and community services; 2. Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to your own home, or are living in the community and need stabilization services to remain there; and 3. Do not have other programs, services, or resources to assist you with these costs; and 4. Have needs beyond what is covered under the Community Transition Services (under CFC or RSW); or 5. Are not eligible for Community Transition Services (under CFC or RSW). 6. DDA clients who are being discharged from Nursing Facilities **only.**
What is covered under CTSS? **CTSS Goods SA290** **CTSS Services SA291**	CTSS Goods may include: 1. Furniture, essential furnishings, and basic items essential for basic living outside the institution. For AFH Settings reference WAC 388-76-10685, and for Assisted Living Settings reference WAC 388-78A-3011 which outline resident unit furnishings in these settings. In the event a residential setting indicates they are unable to provide the required furnishings as outlined in WAC, notify the provider of their requirements

HCS ONLY: Amazon and Kroger Desk Aid located in Appendix section.	as outlined in WAC, and also submit a referral to RCS to document the provider's inability to meet residential unit furnishings per WAC. 2. The provision of goods that increase independence or substitute for human assistance to the extent that expenditures would have been made for the human assistances, such as purchasing a microwave. CTSS Services may include, but are not limited to: 1. Security deposits that are required to lease an apartment or home, including first month's rent. 2. Activities to assess need, arrange for, and procure necessary household furnishings. 3. Setup fees or deposits for utilities, including telephone, electricity, heating, water, and garbage. 4. Services necessary for your health and safety such as pest eradication and nonrecurring extreme cleaning.
What is not covered under CTSS?	CTSS does not pay for items or services paid for by other state programs or Community Transition Services. CTSS does not include recreational or diversional items such as television, cable, or gaming systems.
When do I need a provider contract?	If the DSHS payment system will pay directly for a service or item, a contract is required for all CTSS providers. • Check to see if the provider has an existing contract for the service or goods that will be provided. • If there is not an existing contract, notify your local AAA Contracts Management team of the network capacity need. Providers must also meet all other obligations associated with the contracting process such as background checks, Medicaid Provider Disclosure Statement, and insurance requirements, when applicable. • For one-time only payment for deposits or set up fees, the Special Considerations contract can be used. • NOTE: 1. A contract is not required if another payment mechanism is utilized. Options include: a. Using a client services P-Card (HCS Only State issued credit card); or b. Authorizing a contracted individual transition services provider to pay for deposits and set-up fees directly and be reimbursed. i. Compensation to the contracted provider for issuing payment does not count towards the CTSS $850 limit.
How do I authorize CTSS?	You must: 1. Perform a CARE assessment to determine/document the need and plan of care for the CTSS. CTSS needs are captured in the Treatment screen in CARE as "Community Transition Goods or Items" or "Community Transition Services" with a comment indicating the nature of the service

	in the comment box. Assign the "Community Transition Goods or Items" or "Community Transition Services" Treatment to the paid provider in the Care Plan Screen. 2. If the client will not be discharging with long-term care services, document the client's need and reason for the allowance in the SER. 3. The Sustainability Goals screen in the Client Details section of CARE may be used as part of transition planning and as a communication tool with contracted providers. 4. Complete the Housing Modification Property Release Statement (DSHS Form 27-147) for all environmental modification authorizations if the client has a rental agreement or does not own the residence. 5. Document all costs in the SER under Contact Code "NFCM", for non NFCM transitions, use "Admin" Activity Code. 6. Authorize services and/or items using the appropriate code(s). The total cannot exceed $850 without local ETR. 7. Submit a DSHS form 02-615 Social Services Invoice/Receipt Packet Cover Sheet to DMS with all invoices, receipts, housing modification property release statement, etc. Include verification that the client received the goods or services. 8. Send the client a Planned Action Notice for any CTSS. **Note:** The HCS social worker must coordinate and authorize CTSS for all DDA co-assigned clients.
When do I authorize this service?	This is solely for one-time payments to help a client establish, resume, or stabilize a residence (no ongoing services/items). CTSS funds can be accessed if the item/service is needed for community living and no other resource is available. You may use the CTSS each time the eligible client transitions from an institution **or** for each occurrence of instability that threatens the loss of the client's continued living in the community.
Are ETRs allowed for the CTSS?	Yes, all CTSS requests that exceed $850 must have a local office ETR approval.

When to use Which Program: GOOD and SERVICES				
	In Current Community Setting	**To:** In-home	**To:** Residential	**To:** Institution
Stabilization **in Place**	• RCL (in demo year) • CTSS/ WA Roads			NA
Moving FROM: In-home		• RCL (in demo year) • CTSS/ WA Roads	• RCL (in demo year) • CTSS/ WA Roads	NA
Moving FROM: Residential		• RCL (in demo year) • COPES • CTSS/WA Roads[2]	• RCL (in demo year) • CTSS/WA Roads	NA
Moving FROM: Institution		• RCL • CTS (CFC or RSW)[1] • CTSS/WA Roads[3]	• RCL • CTS (CFC or RSW)[1] • CTSS/WA Roads[3]	NA

• Roads to Community Living: (RCL) Federal Match
• Community Transition Services: (CTS) [1]Available for 30 days post discharge.
  o Community First Choice: (CFC) Federal Match
  o Residential Support Waiver: (RSW) Federal Match
• COPES: Federal Match
• State-only Funds: Community Transition & Sustainability Services (CTSS) / WA Roads
[2]Use when client is not COPES eligible or there is not sufficient time to complete the COPES enrollment process in a timely manner.
[3]Use when client is not eligible through a program that receives federal match.

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Assistive Technology (AT)

Assistive Technology (AT): These services should be considered for those clients who are eligible for assistive technology through RCL, RSW (known as CFC Ancillary Services) or CFC (see chapters for additional information). Assistive Technology funds may be used to purchase adaptive/assistive items and devices. Assistive technology is designed to:

1. Increase a person's functional independence &/or substitute for caregiver assistance with an ADL, IADL or health related task;
2. Maximize a person's health and safety;
3. Increase the likelihood that adults in institutional settings will transition to their own homes and communities.

For RCL Participants only:
Smart Care Companion is an assistive technology option for in home clients on Roads to Community Living. The Smart Care Companion is a remote support service device that interacts and engages with a client to provide support through proactive suggestions, cuing and reminders for ADL &/or IADL tasks or health-related activities, and accessing their community. This service would be captured as Technology Support Services in the Treatment screen and assigned to a paid provider in the Supports Screen. See

Chapter 29: Roads to Community Living for additional details. For additional resources please see the NFCM Workspace or Transition Academy HCS SharePoint sites.

Technology Support Consultation and Technical Assistance is available. This option provides individualized AT recommendations by an assistive technology professional as well as technical assistance to ensure the client can incorporate AT into their daily life. This service would be captured as Technology Support Services in the Treatment screen and assigned to a paid provider in the Supports Screen. See Chapter 29: Roads to Community Living for additional details. For additional resources please see the NFCM Workspace or Transition Academy HCS SharePoint sites.

Please see *Chapter 7b: Community First Choice* from the LTC Manual for more information on CFC Ancillary services that are offered to CFC and RSW recipients.

Social/ Therapeutic Leave

Social/ Therapeutic Leave: The Department will pay the nursing facility for a Medicaid resident's social/ therapeutic leave up to 18 days per calendar year. See WAC 388-97-0160.	
What is covered under Social/ Therapeutic Leave?	Social/ Therapeutic leave gives NF residents an opportunity to participate in: • Social/ Therapeutic activities outside the NF and beyond the care of the NF staff. • Trial visits to less restrictive settings-more information below. Social/ Therapeutic leave **must not** be used for medical care leave in another medical institution.
How is the NF paid?	The department pays for **up to** 18 days (24 hr. periods) per calendar year for each Medicaid resident's social/ therapeutic leave. The nursing facility must track the number of days spent per year. NFs are required to notify the department of social/therapeutic leave in excess of 18 days per year through a Notice of Action (DSHS form 15-031).
How do I know if an ETR is needed?	NFs and/or the resident can request additional Social/ Therapeutic leave from the department in excess of 18 days per year.
Are ETRs allowed for Social/ Therapeutic Leave?	1. Requests for ETRs for social/ therapeutic leave exceeding 18 days per calendar year may be approved with a local ETR. ETR should be submitted via the electronic ETR process in CARE. ETRs that promote resident independence are appropriate. 2. Any requests for over 18 days of leave must be approved prior to the client taking the leave. 3. If an ETR for leave exceeding 18 days per calendar year is approved or denied you must:

	• Notify the HCS Financial Worker using a Social Service/Financial Services DSHS 14-443 form, making a note in the Comments section; • Document approval/denial in the SER; and • Send a letter notifying the client of the approval or denial **Note:** Frequent or excessive social/therapeutic leave may indicate the resident has potential for NF discharge.
Trial Visits	Many nursing facility residents may choose to consider moving to a new living arrangement or an Adult Family Home or Assisted Living Facility as their preferred community services setting and may wish to have a trial overnight period before finalizing their decision. The client may use their social/therapeutic leave for this purpose. A trial visit is often paired with CCG services to support the coordination of the visit. The CCG may pay for the trial residential services with state funded Community Transition and Sustainability Services (RAC 3105) at the daily rate as outlined in CARE. Any trial visit would be reimbursed to the CCG under SA291 or SA295 for RCL enrolled participants.

Roads to Community Living (RCL)

Roads to Community Living is a statewide, demonstration project funded by the "Money Follows the Person" grant. The purpose of the RCL demonstration project is to investigate what services and supports will successfully help people with complex, long-term care needs transition from institutional to community settings. For clients meeting eligibility criteria, additional transition services are available while the client is in the nursing facility and for one year after they have moved to the community. See the RCL chapter of the LTC Manual for more information regarding eligibility and services offered. Send any inquiries or referral requests directly to: dshsaltsarclreferrals@dshs.wa.gov.

ALTSA Housing Resources

ALTSA has resources to increase access to permanent and affordable housing for its clients and continuously strives to expand the availability and utilization of services that support tenancy in independent housing centering on the following beliefs and values:

- Affordable housing is the foundation for stability and growth.
- Housing improves health.
- Income, age, ability, lack of family and friends, or past or current conduct should not prevent anyone from having a home.
- Each tenant holds their lease or mortgage and is responsible for maintaining tenancy.

There are affordable housing vouchers and subsidies the ALTSA Housing Team can help you access, and Supportive Housing available to ALTSA clients to support their tenancy.

See the Housing Resources for ALTSA Clients, Chapters 6a and 6b, of the LTC Manual for more information regarding eligibility and services offered.

State Funded Community Transition and Sustainability Services & Washington Roads

Community Transition and Sustainability Services (RAC 3105) and Washington Roads are additional state funded service packages created from the lessons learned and cost savings seen through the first year of the RCL project. In 2009, the Washington State legislature approved this additional funding to relocate adults from institutions and are available to assist with transition planning for clients who are not eligible through RCL and also as a resource for challenging or complex cases involving individuals who are currently living in the community, but who are at risk of losing their community setting.

See the CTSS/WA Roads, Chapter 5a, of the LTC Manual for more information regarding eligibility and services offered.

RESIDENT RIGHTS

NFCMs should be familiar with resident rights and report any significant or repeated resident rights violation to the RCS Complaint Resolution unit (CRU) for review and investigation.

Single incidents, not classified as abuse, neglect, abandonment, or financial exploitation, may be handled through consultation and education with the provider or by involving the Long-Term Care Ombudsman Program. The Ombudsman program is responsible for protecting the rights of all residents and handling complaints from facility residents. The Long-Term Care Ombudsman can be contacted at 1-800-422-1384.

Residents of nursing facilities have the same civil and legal rights of all US citizens, plus additional resident rights. These rights can be found in ***Chapter 70.129 RCW***. Resident rights include, but are not limited to:

- Right to a dignified existence
- Right to self-determination
- Right to be fully informed
- Right to raise grievances
- Rights of access
- Rights regarding financial affairs
- Right to privacy
- Rights during discharge/transfer:
  - A facility cannot use the following reasons to transfer/discharge a resident*:
    - Resident is disruptive, argumentative, and/or obnoxious.
    - Resident doesn't follow facility policies or their care plan.
    - Caring for the resident is too hard or costs too much.
    - The resident refuses treatment.
    - The resident's Medicare eligibility ended.
    - The resident's savings is gone and they are now Medicaid-eligible, as described in the facility's policy for accepting Medicaid

*Unless the actions jeopardize the health and safety of themselves and/or other resident(s).

Facility Initiated Discharges

The Centers for Medicare and Medicaid Services (CMS) began an initiative to examine and mitigate nursing facility-initiated discharges in violation of federal regulations. Per CMS, a facility-initiated transfer or discharge is one that the resident objects to, did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences.

Before a long-term care facility transfers or discharges a resident, the facility must first attempt through reasonable accommodations to avoid transfer or discharge, unless agreed to by the resident.

Discharge Criteria for Nursing Facilities

There are very specific and limited criteria under which a nursing facility can initiate the discharge of a resident without the resident's consent:

- The resident no longer requires nursing facility level of care (see ***NFLOC section***)*
- The facility can no longer meet the resident's level of care needs**
- Resident poses a health or safety risk to themselves or others*
- The resident has failed to pay.
- The facility ceases to operate/closes.

*Documentation by a full CARE assessment is required.
**Documentation by a medical doctor is required.

Residents who are sent to the emergency room or hospital must be permitted to return to the facility unless the resident meets one of the above criteria. The facility may not evaluate the resident's behavior based on the behavior at the time of the transfer to the hospital.

Notification

The facility must provide written notification to the resident, resident's representative and state LTC Ombuds 30 days in advance of the date of discharge*. DSHS Form 10-237 can be used by the SNF to provide notice, but the SNF can develop and use their own notice as long as it includes the following:

- The reason for transfer or discharge;
- The effective date of transfer or discharge;
- The location to which the resident is transferred or discharged;
- A statement of the resident's appeal rights,
- LTC Ombuds information
- For residents with intellectual disability or mental health disorder, information regarding Disability Rights WA

*Exceptions: Other residents' health or safety would be in danger, the resident has urgent medical needs requiring a transfer or discharge, or the resident has not lived in the facility for 30 days.

Appeals

The resident has up to 90 days to appeal the facility-initiated notice of transfer or discharge. If the individual appeals notice, the facility cannot discharge the resident during the appeal process and by law, must assist the person in helping the resident prepare and file an appeal request.

As a case manager/social worker, you may need to intervene by having a conversation(s) with a provider to determine if a provider is trying to discharge a client in conflict with Chapter 70.129 RCW.

As an employee of DSHS, you are a mandated reporter:

Call and report any issues of abuse, neglect, exploitation, and abandonment of any nursing facility resident. This report will remain confidential within the limits provided by law. For additional information regarding abuse, neglect, self-neglect, exploitation or abandonment, see the Adult Protective Services web page. *1-800-562-6078*

OUT OF STATE NURSING FACILITY ADMISSIONS

WA State Clients Admitted in Recognized Bordering City Nursing Facilities

Medicaid clients admitted in recognized bordering city nursing facilities for stays of 30 days or less, who intend to return to Washington, may receive coverage, if eligible. WAC 182-501-0175 lists the bordering cities as:

- Idaho: Coeur d'Alene, Moscow, Sandpoint, Priest River and Lewiston
- Oregon: Portland, The Dalles, Hermiston, Hood River, Rainier, Milton-Freewater and Astoria
- Per WAC 182-502-0120, stays of greater than 30 days may be approved by ALTSA HQ when the resident's needs cannot be met within the state.

The bordering city nursing facility must be contracted with WA State to receive payment. Prior to admission, the assigned CM should:

- Ask the out of state facility if they have a nursing facility contract with Washington State; and
- Verify a fully executed contract is in the ACD.
- Notify the ALTSA's NH Payment Coordinator of out of state admission by emailing: NFRPaymentCoord@dshs.wa.gov
- Information regarding the rate for the bordering city SNF is determined by the NH Rates unit (if there are questions, the contracted SNF can contact them using the same email as above).

Follow the procedures listed in the "Nursing Facility Admission: From the Community Setting (HCS/AAA/DDA Responsibilities)" section of this chapter. If the stay extends beyond 30 days, the client must do one of the following:

1. Move to a Washington State nursing facility;
2. Apply for benefits from the bordering state; or
3. Supply the NFCM with information to demonstrate that there is a definite discharge date planned within the subsequent 30 days (e.g. a statement from the client's physician stating that the client needs an additional 20 days of rehabilitation after the first 30 days expires.)

If a Washington State client applies for Medicaid from the bordering state and is determined not to be eligible, the NFCM must assist the bordering city Nursing Facility and the client in moving back to Washington within 30 days. Continue payment authorization until the move is complete. Document your efforts in a SER and notify NFRPaymentCoord@dshs.wa.gov if the client's stay exceeds 60 days.

Clients who are placed in out-of-state nursing facilities for emergency purposes may also receive coverage for their short stay per WAC 182-502-0120. The NFCM must determine if the client meets nursing facility eligibility based on information available and notify financial.

Note: Children residing in the Providence Child Center are exempt from these requirements. Providence Child Center must comply with all PASRR requirements.

Clients Seeking Nursing Facility Care in Washington from Out of State

If a NFCM receives an inquiry regarding an individual seeking NF care in Washington and the individual is a resident of another state, encourage the individual or their representative to contact the facility to which the individual is interested in admitting. Individuals may not receive services in two states at the same time. If the individual is currently a resident of a NF in another state, staff at the discharging facility and staff at the admitting facility typically work together to arrange the transfer. If the individual is moving from another state and is not currently receiving nursing facility care out of state, the family and/or representative can work with the receiving NF to arrange the admission. If an admission date is known, the application process can be started on the Washington HealthPlanFinder website or through the local Home and Community Services office. However, the application for services cannot be finalized until the individual has made the move to the state.

ADMISSION OF DDA ENROLLED INDIVIDUALS

From home/residential settings

The Case Manager must:

1. Work with the DDA to determine if nursing facility care is the most appropriate service for the client (see Admission: From the Community Setting (HCS/AAA/DDA) Responsibilities for more information).
2. All clients entering the nursing facility must have a PASRR Level I screening completed prior to admission to the facility. If a PASRR Level II Assessment is required as a result of the PASRR Level I, verify that the Level II Assessment was performed prior to admission (see PASRR FAQs for more information). As part of the PASRR process, the DDA PASRR coordinator will determine if the client is appropriate for NF admission. This is not the functional eligibility determination. For those clients who only have a DDA PASRR RU assigned, the DDA PASRR coordinator will notify HCS for NFCM assignment. The assigned HCS NFCM will complete the NFLOC determination.
3. If a DDA assessment in CARE has been completed and moved to current, either the DDA assigned case manager or the NFCM may use this information to complete the NFLOC determination questions on the NFLOC Tab. See the section regarding NFLOC for more information). The NFCM should consult with the DDA for co-assigned cases when necessary to determine NFLOC.
4. Review and authorize the admission, if appropriate.
5. Follow all other protocols found in the section on Admission from Community settings.
6. If requested, participate in inter-disciplinary team staffing or provide consultation to the DDA or other case managers involved with the resident.
7. DDA retains case management responsibility for transition planning in coordination with the NFCM.

From the hospital

The assigned Case Manager must:

1. Determine NFLOC within the first 10 calendar days of assignment and inform the public benefits specialist per the DSHS 14-443 form.

2. Follow all other protocols found in the section on Admission from the Hospital
3. If requested, participate in inter-disciplinary team staffing or provide consultation to the DDA or other case managers involved with the client.
4. DDA retains case management responsibility for reassessment and transition planning in coordination with the NFCM.

Note: Children residing in the Providence Child Center or Bridges to Home are exempt from these requirements. Providence Child Center and Bridges to Home must comply with all PASRR requirements. DDA will coordinate with the Department of Children, Youth and Families (DCYF) case manager for these residents admitted to Nursing Facilities for children as necessary.

STATE FUNDED LONG-TERM CARE FOR NON-CITIZENS

The Aging and Long-Term Support Administration has limited state funding available for non-citizens in need of long-term care services outside of a hospital, but who are not eligible for federally matched Medicaid, Aged, Blind and Disabled (ABD) cash or Medical Care Services (MCS). New admissions into nursing facilities or residential settings under the state-funded long-term care program must be pre-approved by Emily Watts, ALTSA HQ, via email at: emily.watts1@dshs.wa.gov.

Further detail may be found at the Social Service Authorization Manual.

HOME & COMMUNITY SERVICES PRIVATE HEALTH INSURANCE AND GOOD CAUSE DETERMINATIONS

Medicaid clients are required to cooperate in the identification and use of third party liability (insurance carriers) that may be responsible for paying for nursing facility care and other long-term care services. Clients may object to the options offered by their private insurance for a variety of reasons, including the location of the facility. The Department is allowed to exempt the client from cooperation if we have determined that there is "good cause" for the exemption.

If a client has third party liability (TPL) and resides in a facility that is a non-participating/non-network/non-contracted provider of the plan, the following process will occur:

1. The nursing facility will contact the insurance carrier to determine if they will pay a non-participating/non-network/non-contracted provider, or can decide to become a participating/network/contracted provider, if possible.
2. If the TPL has denied coverage and the nursing facility believes good cause exists, the nursing home must contact the client's case manager (NFCM) through the local HCS office.
3. The local NFCM determines if a client should be exempted from using their TPL if there is no DSHS participating/network/contracted nursing facility within 25 miles or 45 minutes from the client's current residence.
4. If there is a DSHS participating/network/contracted nursing facility within 25 miles or 45 minutes of the client's current residence, the NFCM will talk with the client and/or the client's

representative about the possibility of moving to a facility that is within the insurance carrier's network.

5. The local NFCM, in coordination with their supervisor, will determine if good cause exists.

The final decision regarding good cause is made by the local HCS office:

1. To determine good cause, the local NFCM will evaluate the reasons why the client does not want to transfer to a participating network provider. Good cause can include a variety of reasons such as location, physical or emotional harm, or that a move to a different NF will cause transfer trauma.
2. The NFCM will document in the SER if good cause is approved or denied.
3. If approved, the NFCM must inform the HCA-Coordination of Benefits at 1-800-562-3022
4. If the client is deceased, no longer a resident at the facility, or no longer has the insurance, a local exception to policy to WAC 182-501-0200 may be submitted by the nursing facility directly to ALTSA headquarters to the NFCM Program Manager.

Note: The Veterans Affairs Registered Nurses (VARN) or other designee of the Washington Department of Veterans Affairs shall complete all good cause determinations for all state Veteran's home admissions.

RULES AND POLICY

RCW 74.42.055	Discrimination against Medicaid recipients prohibited.
RCW 74.42.056	Department assessment of Medicaid eligible individuals – Requirements.
RCW 74.39.041	Community residential options—Nursing facility eligible clients
RCW 7.70.065	Informed consent-Persons authorized to provide for patients who do not have capacity while the person is in a hospital or skilled nursing facility setting
WAC 388-97	Nursing Homes; Resident Rights, Care and Related Services
WAC 388-106-0355	Am I eligible for nursing facility care services?
WAC 388-106-0360	How do I pay for nursing facility care services?

REVISION HISTORY

Date	*Made By*	*Change(s)*	*MB #*
3/2025	Julie Cope Jevahly Wark Cassie Pizano	• Added clarification when a client no longer meets NFLOC, the chosen program in the Care Plan screen may remain blank. • Added additional clarification for DDA case manager's roles and responsibilities throughout the chapter. • Added clarification that HCS cannot enter an NFLOC in CARE if the case is not assigned to an HCS RU. • Removed the requirement for the case manager to complete PASRR Level I screening form. • Updated EBS referral instructions. • Added link to NFCM Workspace within Client No Longer Meets NFLOC section. • Clarified transfer protocols for cases transferring from nursing facility settings to hospital case management. • Updated treatment name for CTS from "other" to "Community Transition Goods or Items" and "Community Transition Services" • Removed Bathroom Equipment from the transition resources table as this is a covered service under the Apple Health benefit. • Update to Expanded Behavior Supports referral, approval, and notification process. • Updated TCCS Referral Flow Document in Appendix. • Added TCCS Email Template • Updated Assistive Technology to include Smart Care Companion and Technology Support Consultation and Technical Assistance service descriptions.	
10/2024	Julie Cope	• Added a Note Box with Expanded Behavioral Supports referral considerations • Provided the TCCSAdmissionRequest@dshs.wa.gov mailbox for coordination support related to Specialized Nursing Facilities.	

		• Clarified that residents receiving specialized nursing facility services must remain active with nursing facility case management. • Added MedStar statewide non-medical transportation referral process to appendix. • Included Chapter 3 hyperlink for additional information on the Address confidentiality Program.	
7/2024	Julie Cope	• Updated hyperlinks and formatting. • Provided instruction that the discharge date is to be entered in ProviderOne for MAGI and MCS participants. Previous P1 procedure only documented the discharge date when a client no longer met NFLOC.	H24-044
4/2024	Julie Cope	• Provided minor clarifications surrounding Transitional Care Center of Seattle and Expanded Behavior Supports. • ProviderOne requires a profile change to enter/edit this functional eligibility directly into the system. The date of discharge will now be communicated in ProviderOne directly for MAGI and MCS recipients. • Included additional transfer clarification for NFCMs whose clients become hospitalized. • Updated EBS Support Level Eligibility & Description and EBS/RSW Referral Flow chart in Appendix to reflect updated RSW Committee language.	H24-018
12/2023	Julie Cope	• Amended EBS in SNF HCS Coordination instructions to be consistent with MB H23-076 • Added updated EBS Service Level Description to Appendix. • Clarified PASRR level II evaluation information. • Clarified length of time a case may remain active with NFCM. • Amended the Home Maintenance Allowance client letter. • Added Non-Medical Transportation (T2003) to the Community Transition & Transition Support Services section. • Included Trial Visit information under Social/Therapeutic Leave section.	H23-090
8/2023	Amanda Speck	• Added HCS Purchasing Card Process to Appendix	H23-071

	Julie Cope	• Added Hospital Swing Bed and Hospital Bed Readiness information. • Removed APS Funded Client Intervention Services from Transition Resources Section • Revised EBS approval and notification instructions to incorporate Eligibility form 11-130 & EBS Descriptions in the Appendix. • Clarified instruction for out of state Nursing Facility admissions in neighboring cities. • Clarified case coordination instruction for those cases shared with DDA.	
6/2023	Julie Cope	• NFLOC determination exclusion for PACE participants • Updated TCCS Referral Flow Chart to include Specialty Settings referral form	H23-039
11/2022	Julie Cope	• Updated NFLOC Documentation screen • HCS Decision Making for Transitions resources • Included RCL Referral mailbox • Updated TCCS Referral Form	H22-064
5/2022	Julie Cope	Included face to face assessments into NFCM Work Performance and Relocation Standards. Updated CTS Funding Limits. Incorporated DSHS Form 11-159 into EBS Eligibility, Added ALTSA Housing Resources to the Transition Resource section, updated hyperlinks and screenshots, added Transitional Care Center of Seattle Admission Referral Flow & Supporting Client Transitions to the Community YouTube video to Chapter Appendix	H22-028
12/2021	Julie Cope	Added additional information on coordinating with MCOs. Refined Specialty Nursing Facility Program Note to include the TCCS Referral Flow hyperlink added in the Appendix.	H22-005
05/2021	Julie Cope	Amended HMA instructions, added Sample Letter for Home Maintenance Allowance replacing PAN, added Residential Furnishings WACs	H21-050
2/2020	Julie Cope	Updated HMA PAN instructions in Transition Resources	H20-056
12/2019	Julie Cope	Updated MAGI Communication procedures with HCA to include direct entry of NFLOC determination in ProviderOne Added Kroger Authorization Process to Appendix	H19-066
9/2019	Julie Cope	Added Sample Letter for Social/Therapeutic Leave to Appendix	H19-048

7/2019	Julie Cope	Added Policy Regarding Case Management of SNF residents approved for Expanded Behavior Supports	H19-039

APPENDIX

Example of NFCM Weekly Tasks Schedule

NFCM Tasks	***Monday***	***Tuesday***	***Wednesday***	***Thursd***
Facility On Site Visits-2x a week		10a-4p		10a
NFLOC Determination/Redetermination		During Visit		Durin
Weekly Transition Coordination Meetings (SNF & NFCM)		10a-12:00p		
PointClickCare Review -New Admissions/Transitions	9-10:00a		9-10:00a	
Face to Face CARE Assessment		During Visit		Durin
Supervisor on Site Visits each Quarter		10-12:00		
MCO Transition Coordination meetings *Every Other Week* (CCW, UHC, Molina, CHPW, Wellpoint, Humana)				1-3:
DME Specialist referrals for Transition Coordination		11:30-12p		
Office/Desk Day for SERs, Referrals, Authorizations, Emails, Phone calls & Paperwork to DMS for imaging, case transfers.				
MDS Acuity Report and compare to SNF Census	Monthly			

Every On-Site Visit should include:

1. Meeting with SNF staff to prioritize CARE assessment of the day, debrief after CARE Assessment is completed identifying SNF Roles and NFCM next steps, and prioritize next three scheduled CARE assessments. Share Pending CARE assessment with SSD, Obtain Plan approval with Resident, SER Actions
2. Introduce self to each new admit (Intake) where NFLOC is needed and document NFLOC in NFCM Screen, SER and enter 14-443/P1. Work with SNF staff and client to ensure HMA is requested, when eligible.

3. Complete required documentation with clients to include 14-225, Rights and Responsibilities, Release of Information, Signature on Service Summary etc.
4. Confirm that LTSS Brochures, RCL Brochures, and NFCM Brochures are available for the Social Services Department, Admissions and the Business Office.

HCS Decision Making for Transitions/Authorized Representative

ALTSA- How to Identify a Guardian
ALTSA Power of Attorney vs. Uniform Guardianship

HCS-Decision-Making-for-Transitions.pdf

Kroger Authorization Process-HCS Only

Kroger Authorization and Payment Instructi
Transition-Sustainability Checklist R1N KRO
Transition-Sustainability Checklist R1S KRO
Transition-Sustainability Checklist R2 KROG
Transition-Sustainability Checklist R3 KROG

Amazon Authorization Process (NFCM Only)

Desk Aid for Amazon Business .p

Client Services Purchasing Card Process-HCS Only

HCS Purchasing Card.docx
02-615 Invoice Packet Coversheet.p

Nursing Facility Expanded Behavior Supports Service Eligibility & Description

15-596 RSW & EBS Referral.docx
Expanded Behavior Supports in SNF-Supp

Transitional Care Center of Seattle

TCCS Admission Request Flow Chart.dc

TCCS Referral Email Template

Supporting Client Transitions to the Community - YouTube

Physician Certification for Home Maintenance Allowance

14-456 HMA Physician Certificatic

MedStar Non-Medical Transportation Referral Process

Process to consider when using Non-Me

Sample Letters:

SAMPLE LETTER
(Print on HCS letterhead)

Date:

To: <<Nursing Facility>>

Subject: Nursing Facility Level of Care Determination

This notification is to inform you that I recently performed a review of the nursing facility level of care for <<Resident's Name>>, a resident of your facility, and determined that <<he/she>> does not meet nursing facility level of care and therefore is not eligible for Medicaid payment. Nursing facility level of care criteria is determined in WAC 388-106-0355.

You are required per RCW 74.42.450 to send the client a 30 day discharge notice following all notification requirements. Medicaid payment through ProviderOne will end 30 days from the date of this letter.

If you have any questions or assistance with discharge planning, please feel free to contact me directly.

Sincerely,

<<CM Name>>
Home and Community Services

SAMPLE LETTER
(Print on HCS letterhead)

Date:

To: <<Nursing Facility>>

Subject: Nursing Facility Level of Care Re-Determination

This notification is to inform you that, based on a request for a Fair Hearing, I recently performed another assessment of the nursing facility level of care for <<Resident's Name>>, a resident of your facility, and determined that with additional information regarding care, <<he/she>> <<does>> meet nursing facility level of care and continues to be eligible for Medicaid coverage in the facility. Nursing facility level of care criteria is determined in WAC 388-106-0355. Medicaid payment through ProviderOne will continue.

All notices can be rescinded and the LTC Ombuds office should be notified of this change in determination.

If you have any questions or assistance with discharge planning, please feel free to contact me directly.

Sincerely,

<<CM Name>>
Home and Community Services

cc: <<Nursing Facility Resident>>
SAMPLE LETTER
(Print on DSHS Letterhead)

Date:

To: <<NF Resident Name>>

Subject: Social and Therapeutic Leave

We received your request for an Exception to Rule, WAC 388-97-0160. You have requested additional social and therapeutic leave days.

The exception to rule (ETR) has been <<approved/denied>> for <<amount>> of days.

If you do not agree with the ETR decision, you may call your case manager with your concern. You also have the right to present your complaint in writing to your case manager's supervisor.

- Address your written complaint to "NFCM Supervisor of (Case Manager's Name)", or
- Ask your Nursing Facility Case Manager for the name of their supervisor.

Upon receipt of your written complaint, the Supervisor will review the ETR decision on your complaint and notify you in writing within ten (10) days of their decision.

If you are not satisfied with the Supervisor's decision, you have the right to send your written complaint to the Home and Community Services Regional Administrator for your region.

The Home and Community Services Regional Administrator or designee will review your written complaint and send you a written notice of his/her decision within ten (10) working days of receipt of the complaint. <u>This notice terminates the complaint procedure.</u>

If you have any questions or would like assistance with transition planning to another setting, please feel free to contact me directly.

Sincerely,

<<CM Name>>
Home and Community Services

cc: <<Nursing Facility>>

SAMPLE LETTER
(Print on DSHS Letterhead)

Date:

To: <<NF Resident Name>>

Subject: Home Maintenance Allowance Income Exemption

This notification is to inform you that you have not been approved the Home Maintenance Allowance income exemption. Home Maintenance Allowance (HMA) eligibility criteria is outlined in WAC 182-513-1380. You are not eligible for HMA due to:

☐ The HMA income exemption is allowed for a single institutionalized client or institutionalized couple. A married client whose spouse is not institutionalized is not eligible for the HMA.

☐ HMA is limited to a maximum six-month period; and requires a physician certification that the client or couple is likely to return to their community home within the six-month period. The physician will not certify the likelihood of your return to a community home.

☐ SSI only income. Upon Nursing Facility admission, your SSI income is exempted for three months; therefore, you are not eligible for a HMA.

If you have any questions and would like assistance with transition planning to another setting, please feel free to contact me directly.

Sincerely,

<<CM Name>>
Home and Community Services

cc: <<Nursing Facility>>

Working with the Consumer Directed Employer (CDE)

The purpose of this chapter is to describe the policy and procedure for working with the CDE, Consumer Direct of Washington.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Natalie Lehl Care Management Program Manager
360.725.2330 Natalie.Lehl@dshs.wa.gov

TABLE OF CONTENTS

BACKGROUND

Consumer Direct Care Network Washington (CDWA) is the contracted the Consumer Directed Employer (CDE). CDWA serves as the administrative employer for all Individual Providers (IPs) of in-home personal care, respite services, and participants who receive personal or respite care. CDWA manages credentialing, payroll, and other administrative employer responsibilities. Clients select, schedule, supervise, and dismiss Individual Providers as their managing employer.

CDWA also manages Carina, a service that provides assistance with matching clients and caregivers

WORKING WITH CARINA THROUGH CDWA

CDWA can assist a client who needs help creating a job posting in Carina to find a provider. Carina posts are active for 60 days. If a provider is not found during the 60 days, CDWA will attempt to contact the client/AR to confirm that an IP is still needed. If so, CDWA will re-post the job in Carina. If CDWA is unable to reach the client/AR, they may contact the CM for assistance or information.

Case managers may provide the included flyer to clients requesting additional information about Carina's services and how to sign up.


Carina, English
Consumer-CM One-P


Carina,
Spanish-Espanol Cons

AUTHORIZING TO CDWA

The CDE is considered the Medicaid provider for clients who receive personal care from an IP. When a client chooses to receive care from CDWA, the Case Manager (CM) will need to do the following:

- Add CDWA to the CARE plan and move the assessment to current. CMs should not wait until the IP is fully hired to move the assessment to current.
- Assign all tasks the IP(s) will complete to Consumer Direct Care Network Washington (CDCN) P1 ID 2148685-01.
- Open an authorization to CDCN using service **code: T1019,U6**.
    - Do not authorize to the CDE using service code T1019 [no modifier].
    - For new clients, the start date of the CDWA authorization will be no earlier than the same day as the client's financial and functional eligibility start date.
- For initial service setup, complete electronic form DSHS 14-443 for HCS or DSHS 15-345 for DDA in Barcode Start date given should align with CDCN authorization start date.

- If no IP has been identified, direct the client or Authorized Representative to begin searching for an IP. If client is unable to use Carina, refer them to CDWA for additional assistance with this process.

- If an IP who is not already employed by CDWA has been identified by the client, the IP should be directed to CDWA's website to submit their online application.
- CARE notifications from CDWA will let a CM know when an IP has been hired.

SENDING AND RECEIVING ASSESSMENT DOCUMENTS TO THE CDE

Client Assessment Details and Service Summary must be sent to CDWA via CARE. For this to occur, there must be an active authorization to the Consumer Direct Care Network (CDCN) using P1 ID 214868501 and CDCN must be identified on the Support screen as a paid provider. If staff try to send documents to CDWA prior to those two steps being completed, staff will receive an error message advising why the documents cannot be sent. Staff will use CARE to select which assessment documents will be sent to the CDE. Upon receipt, the CDE will electronically sign the Service Summary/PCSP and return it electronically to DMS (Barcode) where it will be stored in the client record. Case Managers will document receipt in an SER..

For DDA, staff can send documents to the CDE through the CARE Web application by triggering the Slide Out from the Assessment History table. The necessary fields will be enabled if the assessment is in Current status.

CDE CARE NOTIFICATIONS

CARE functionality provides staff with important updates regarding client care with the CDE. CDWA has developed a Notification Matrix. The notifications are sent to the primary Case Manager assigned to the client's case in CARE and are intended to provide staff advanced notice of changes that could impact client care, such as a client's IP(s) losing eligibility to work or a client at risk of losing CDE services due to nonpayment of client responsibility. These notifications are provided to give Case Managers the information needed to address potential gaps in care for clients. Case Managers are NOT expected to address concerns with IPs or make efforts to get them back in compliance. Supervisors can view the notifications sent to their workers; the functionality of CDE notifications screen mirrors that of the existing ticklers screen.

REFERING A CLIENT/CM/IP TO CDWA

Referring a Client:

- Have the Client or their representative contact CDWA through their website at http://www.consumerdirectwa.com or using any of the following methods:
    - Email: infoCDWA@ConsumerDirectCare.com
    - Text: 877-532-8568
    - Call: 866-214-9899

Referring a Case Manager:

- Case Manager ONLY line 866-932-6468
- Email: infoCDWA@ConsumerDirectCare.com
    - Please provide: Client name, ProviderOne ID, physical address, phone number, email, date of birth (DOB), preferred language, and gender.
    - Ensure outgoing emails are encrypted according to DDA, HCS, and AAA local policy.
    - For DDA, HCS, and AAAs within the DSHS firewall, include NO personal health information (PHI) in the subject line and be sure you include [DSHS Secure] in that same line to encrypt.

Note: CDWA confirmed the infoCDWA@ConsumerDirectCare.com email address can receive encrypted [Secure] emails.

Referring an IP:

- All new IPs should visit http://www.consumerdirectwa.com and click on the Careers tab.
- If an IP needs assistance, please refer them to:
    - Email: infoCDWA@ConsumerDirectCare.com
    - Text: 877-532-8568
    - Call: 866-214-9899

NEW CLIENT AUTHORIZATION: NEW TO CDWA, NEW TO MEDICAID SERVICES

This process applies to all clients being referred to CDE services who are **new to Medicaid** services or **new to CDE** services who want to hire an IP as part of their care plan. This process should also be followed for new clients utilizing both agency-based and CDE services simultaneously. An IP match is **not** required for staff to issue an authorization and send the Client's Assessment Details and Service Summary to CDWA in these situations.

- CM will create a CDWA authorization.

- CM will send the Assessment Details and Service Summary to CDWA using the "Send Documents to CDWA" menu option in CARE web.

- ***If the Client knows who they would like to hire as an IP, they will contact CDWA with the IP's information (CM can assist the Client with notifying CDWA if the Client requests). CDWA's***

Client Support Team will then verify if the IP is new to the hiring process or if they are an existing IP. The following should be used when e-mailing this information to CDWA:

- Send **Email to:** InfoCDWA@consumerdirectcare.com
  - **Subject of email:** "CDWA new client / new to Medicaid services" *(CDWA applies email filters based on the subject and key words to direct the email internally to CDWA's Client/IP Support Team)*
  - **Include in email if known, IP's:** name, phone number, email, and mailing address.

- If an IP is **not** known, the CDWA Client/IP Support Team will use information from the client's Assessment Details and Service Summary to post the job in Carina, if the client needs assistance.
  - CM will email CDWA with the Client/Authorized Representative (AR) contact information if it is not noted in the client's Assessment Details and/or Service Summary.
    - The CDWA Client/IP Support Team will attempt to identify potential IP matches and send the IP's information to the Client/AR. If CDWA is not able to contact the client to coordinate personal care, CDWA will notify the CM via email and the CM will be expected to notify the Client/AR of potential IP matches.
    - *CDWA is unable to guarantee an IP match will be made.* The CM is responsible for working with the Client/AR to explore alternative personal care options if a match cannot be made.
- The Client/AR will be responsible for interviewing the IP(s) until an acceptable match is found based on schedule, needs, etc.
    - The Client/AR will notify the CDWA Client/IP Support Team of their IP choice and keep the CM updated throughout the process.
  - If more than one IP is chosen, CDWA will allocate hours per client's direction as the managing employer; if client/AR input is not provided, IP hours will be divided equally among the IPs until client notifies CDWA otherwise.

CLIENT/IP MATCHING PROCESS

An IP needs to be matched to a client in the CDWA system before the IP can complete the hiring process and provide services. New client/IP pairs need to be confirmed by the client, IP, or case manager before CDWA will match them in their system.

Case managers will notify CDWA of a client/IP match using the CDWA website - https://www.consumerdirectwa.com/contact/

- Under "Email Consumer Direct Care Network Washington", case managers should fill in their Name, Email, and Phone
- Choose "Case Manager" from the Select your Role drop-down
- Choose "Client/IP Match" from the Contact Reason drop-down
- Enter the IP information in the Message box

This information should be sent to CDWA as soon as a client/IP match is known. Providing this information to CDWA will result in faster client/IP pairing.

If this information is not shared by the Case Manager, the CDWA Client/IP Support Team will reach out to the Client/Authorized Representative (AR) via phone to confirm the match. CDWA will determine the number of attempts that need to be made to contact the client, based on how quickly they can make the match. If CDWA is unable to contact the Client/AR, CDWA will call the potential IP, email the CM to confirm the match, and get services started.

EMERGENT CARE NEEDS PROCESS

Sometimes a client has emergent care issues, such as:

- Left Hospital or SNF Against Medical Advice (AMA)
- APS Involvement
- Hospice
- Nursing or Wound Care involvement
- Other (with DSHS Supervisor approval)

When a client has emergent care issues and needs IP services urgently, the following steps should be taken:

- If the assessment has been completed, the CM will:
    - Create a CDWA authorization.
    - Send the Assessment Details and Service Summary to CDWA using the "Send Documents to CDWA" menu option in CARE Web.
    - Email CDWA at InfoCDWA@consumerdirectcare.com, to include the following information:
        - Subject of email: "CDWA urgent hire required" (CDWA applies email filters based on the subject and key words to direct the email internally to CDWA's Client/IP Support Team)
        - If the IP is already a CDWA employee, include the following information in the email, if known
            - IP name
            - phone number

        - email
        - mailing address
    - If the IP is a new hire, send the IP to the "Careers" tab on the CDWA website to begin the hiring process, include the following information in the email, if known
        - IP name
        - phone number
        - email
        - mailing address
- Add the Client/AR contact information if it is not noted in the client's Assessment Details and Service Summary.

- If the assessment has not been completed, the CM must:
    - Email CDWA at InfoCDWA@consumerdirectcare.com, to include the following information:
        - Subject of email: "CDWA urgent hire required" (CDWA applies email filters based on the subject and key words to direct the email internally to CDWA's Client/IP Support Team)
        - Include basic information about the client in the email:
            - name
            - phone number
            - mailing address,
            - any information that will help CDWA create a Carina ad, i.e., client is on hospice and appears to need assistance in the following areas…
        - If IP has been identified and is already a CDWA employee, include the following information in the email, if known:
            - IP name
            - phone number
            - email
            - mailing address
        - If the IP is a new hire, send the IP to the "Careers" tab on the CDWA website to begin the hiring process, include the following information in the email, if known:
            - IP name
            - phone number,
            - email
            - mailing address
        - If the IP has not yet been identified, include the following basic client information in the email:
            - name

        - phone number
        - mailing address
        - any additional information that will help CDWA create a job post in Carina, i.e. client is on hospice and needs assistance with the following ADLs…
- One the assessment is completed, the CM must:
    - Create a CDWA authorization
    - Send the AD and SS to CDWA using the "Send Documents to CDWA" menu option in CARE Web.

CDWA will:

- Follow their urgent hire protocol, which includes setting up basic client information in the system so a client/IP match can be made.
- Assist the IP with the hiring process if needed or help an existing IP who needs to be matched with the client in CDWA's system.
- Post a Carina ad, if IP is not already identified, based on information from the AD/SS, if provided, or the email from the CM.
- Email the CM when the IP has completed any necessary hiring activities, including Orientation &Safety (O&S) training if applicable, and has been issued an "OK to Provide Care" date.

FACILITY DISCHARGE PRE-AUTHORIZATION IP REFERRAL TO CDWA

This only applies to clients who require an IP match prior to facility discharge or disenrollment from the TSOA or MAC programs.

- The CM will email the client's AD and SS to CDWA. This serves as confirmation to CDWA that the client is eligible for CDE services. The following should also be included in this email:
    - **Send an Email to:** InfoCDWA@consumerdirectcare.com
        - **Subject of email:** "CDWA's new Client Pre-Authorization IP referral" *(CDWA will apply email filters based on the subject and key words to direct the email internally to CDWA's Client/IP Referral Support Team).*

- CM will add the client/AR contact information if it is not noted in the client's (AD) and (SS).

- The CDWA Client/IP Support Team will use the client's AD and SS to post the job in Carina.

- The CDWA Client/IP Support Team will attempt to identify potential IP matches and send the IPs' information to the Client/AR via phone. If CDWA is not able to contact the client by phone to coordinate personal care, CDWA will notify the CM via email and the CM will be expected to notify the Client/AR of potential IP matches.

- *CDWA is unable to guarantee an IP match will be made. The CM is responsible for working with the client/AR to explore alternative personal care options if a match cannot be made.*

- Client/AR will be responsible for interviewing the IP(s) until an acceptable match if found based on client's schedule, needs, etc.
- CM will notify the CDWA *Client/IP Support Team* of the client's IP choice by e-mail.
- The CDWA Client/IP Support Team will assist the IP with the hiring process if needed or will help an existing IP who needs to be matched with the client in CDWA's system.
- The CDWA Client/IP Support Team will email the CM when the IP has completed any necessary hiring activities, including O&S training if applicable, and has been issued an "OK to Provide Care" date.
    - *The first date the IP could potentially work is dependent on the client's discharge date in coordination with the client/AR as the Managing Employer*
- CM will create the CDWA service authorization immediately following client's discharge from the facility or TSOA/MAC program.
- CM will submit the client's Assessment Details and Service Summary to CDWA using the "Send Documents to CDWA" menu option in CARE Web

CM will confirm that IP services have started either by contacting the client or CDWA for confirmation. Once confirmation has been received, the case may be transferred if applicable.

MAC AND TSOA ENROLLED PARTICIPANTS

When a care receiver chooses to receive care from CDWA, the AAA staff will need to do the following:

Referral Process in GetCare to CDE

- Ensure the person-centered care plan reflects personal or respite care services
- Click 'Send to CDE' button in GetCare
    - For TSOA Individuals – the button is located in the Care Plan Section in the care receiver's record and will show once the updated TSOA without a Caregiver assessment is locked.
    - For Dyads – the button is located in the Care Plan Section in the Caregiver Record and will show once the updated TCARE assessment is locked and a new care plan is initiated.
- Complete an Authorization Header to CDWA under the care receiver's record

- Consumer Direct Care Network Washington (CDCN) ProviderOne ID 2148685-01
  - The care receiver will not be created in CDWA's system until this step has been completed.
- Service Authorization subservice lines do not need to be created at this time. This allows the option for care receiver's or unpaid family caregivers, to utilize their step benefit level for other items/services, identified in their person-centered care plan, while the potential IP proceeds through the hiring process with CDWA.

- After the GetCare to CDE referral process is completed; AAA staff should contact CDWA with the potential IP's information, if known. Providing this information timely to CDWA will result in a faster care receiver and IP pairing.
- If no IP has been identified, direct the care receiver or Authorized Representative to begin searching for an IP. If the care receiver is unable to use Carina, refer them to CDWA for additional assistance with this process.
- If a potential IP who is not already employed by CDWA has been identified by the care receiver, the IP should be directed to CDWA's website to submit their online application.
- GetCare CDE notifications from CDWA will let the AAA staff know when an IP has been hired and is OK to provide care.

Authorizing to CDWA

- Upon receiving notification, the IP is near completion with the CDWA hiring process, or upon the care receiver's or care receiver's authorized representatives' choice, a CDWA subservice line authorization in the GetCare system should be entered.
  - For TSOA Individuals –
    - Ensure there is a locked GetCare care plan in place with personal care services identified.
    - Use service code: T1019,U6
  - For Dyads –
    - Ensure there is a locked TCARE care plan in place with respite care services identified.
    - Use service code: T1005, No Modifier

Communication with CDWA for the MAC and TSOA Programs

Potential IP is Known:

- If the care receiver knows who they would like as an IP, they will email CDWA with the potential IP's information (AAA staff can assist the care receiver with notifying CDWA if the care receiver requests).
  - New/Potential IP: The CDWA Client Support Team will verify the new/potential IP is not in the CDWA system. IP should proceed through the CDWA hiring steps/process. As the IP progresses through the CDWA hiring process, another contact to CDWA must be

made by either the care receiver, care receiver's representative (cannot be the new/potential IP) or the AAA staff to match the new/potential IP and the care receiver together (*see Care Receiver/IP Matching Process instructions below).*

- Existing/Active IP: The CDWA Client Support Team will confirm IP is Active and in good standing then will use this initial contact to match the IP with the care receiver.
  - **Email:** InfoCDWA@consumerdirectcare.com
    - **Subject of email:** "CDWA new client / new to Medicaid services" *(CDWA will apply email filters based on the subject and key words to direct the email internally to CDWA's Client/IP Referral Support Team)*
    - **Include in email if known:** IP name, phone number, email, and mailing address

No Known Potential IP:

- If a potential IP is **not** known, the CDWA Client/IP Support Team will reach out to the care receiver.
- If care receiver indicates they need assistance finding an IP; CDWA Client/IP Support Team will use the care receiver's TSOA Individual Assessment or the TCARE Caregiver Assessment and Referral Information for Respite Care Service Providers document and internal CDWA questionnaire to post the job in Carina.
  - *CDWA is unable to guarantee an IP match will be made.* The AAA staff will work with the care receiver or authorized representative to explore alternative personal or respite care support if a match cannot be made.
- The care receiver or authorized representative will be responsible for interviewing the IP(s) to determine if the match is acceptable based on schedule, needs, etc.
- If more than one IP is chosen, CDWA will allocate hours per the care receivers' or authorized representatives' direction; if the care receiver or authorized representatives' input is not provided, authorized hours will be divided equally among the IPs until the care receiver or authorized representative notifies CDWA otherwise.

Care Receiver/IP Matching Process:

- An IP needs to be matched to a care receiver in the CDWA system before the IP can complete the hiring process and provide paid services. New care receiver/IP pairs need to be confirmed by the care receiver, authorized representative (cannot be the new/potential IP) or AAA staff before CDWA will match the IP/care receiver in their system.
- AAA staff may notify CDWA of a care receiver/IP match using the following methods:
  - Email: InfoCDWA@consumerdirectcare.com with details
  - Call: 866.214.9899, press 3 to get to the Hiring Team
  - CDWA website - https://www.consumerdirectwa.com/contact/
    - Under "Email Consumer Direct Care Network Washington", AAA staff should fill in their Name, Email, and Phone
    - Enter in the Care Receiver's ProviderOne ID
    - Choose "Client/IP Match" from the Contact Reason drop-down
    - In the Message box identify as the assigned primary case manager/AAA staff
    - Enter the IP information in the Message box
- IP matching information should be sent to CDWA as soon as a care receiver and IP match is known. Providing this information to CDWA will result in faster care receiver and IP pairing.

- If this information is not shared to CDWA, the CDWA Client/IP Support Team will reach out to the care receiver or authorized representative via phone to confirm a match. If CDWA is unable to contact the care receiver or authorized representative, CDWA will call the potential IP and email the AAA staff to confirm the match.

CDE to GetCare Notifications:
Functionality in GetCare system will provide AAA staff with important updates regarding care receivers personal or respite care services with the CDE. CDE to GetCare notifications are:

- Sent to AAA staff and Supervisors GetCare dashboards for the particular AAA with MAC/TSOA role/permissions.
- Notification type on the GetCare dashboard is CDE Notification. The status filter can be utilized to view All, Complete, or Incomplete notifications. The delete function on CDE Notifications has been disabled in GetCare.
- Intended to provide AAA staff advanced warning of changes that could impact care receiver care, such as a care receiver's IP(s) losing eligibility to work
- To give notice to AAA staff so they can work with care receivers to address any potential gaps in care.
- Not sent for AAA staff to work with IPs to get them back in compliance.

Emergent Care Needs Process:
Sometimes a care receiver has emergent care issues, such as:

- Left Hospital or SNF Against Medical Advice (AMA)
- APS Involvement
- Hospice
- Nursing or Wound Care involvement
- Other (with DSHS Supervisor approval)

When a care receiver has emergent care issues and needs IP services urgently, the following steps should be taken:

- If the TSOA without a Caregiver or TCARE assessment has been completed, the AAA staff will:
  - Complete the Referral process to CDE in GetCare steps outlined above.
  - Email CDWA at InfoCDWA@consumerdirectcare.com, to include the following information:
    - Subject of email: "CDWA urgent hire required" (CDWA applies email filters based on the subject and key words to direct the email internally to CDWA's Client/IPSupport Team)
    - If the IP is already a CDWA employee, include the following information in the email, if known
      - ✓ IP name
      - ✓ phone number
      - ✓ email
      - ✓ mailing address
    - If the IP is a new hire, send the IP to the "Careers" tab on the CDWA website to begin the hiring process, include the following information in the email, if known

- ✓ IP name
- ✓ phone number
- ✓ email
- ✓ mailing address

- Ensure the Care Receiver and/or Designated Representative information is noted in the Contacts ribbon in GetCare so it populates on the TSOA without a Caregiver Assessment or the TCARE® Caregiver Assessment and Referral Information for Respite Care Service Providers document.

- If the TSOA without a Caregiver or TCARE assessment has not been completed, the AAA staff must:

  - Email CDWA at InfoCDWA@consumerdirectcare.com, to include the following information:
    - Subject of email: "CDWA urgent hire required" (CDWA applies email filters based on the subject and key words to direct the email internally to CDWA's Client/IP Support Team)
    - Include basic information about the care receiver in the email:
      - ✓ name
      - ✓ phone number
      - ✓ mailing address,
      - ✓ any information that will help CDWA create a Carina ad, i.e., care receiver is on hospice and appears to need assistance in the following areas…
    - If IP has been identified and is already a CDWA employee, include the following information in the email, if known:
      - ✓ IP name
      - ✓ phone number
      - ✓ email
      - ✓ mailing address
    - If the IP is a new hire, send the IP to the "Careers" tab on the CDWA website to begin the hiring process, include the following information in the email, if known:
      - ✓ IP name
      - ✓ phone number,
      - ✓ email
      - ✓ mailing address
    - If the IP has not yet been identified, include the following basic care receiver information in the email:
      - ✓ name
      - ✓ phone number
      - ✓ mailing address
      - ✓ any additional information that will help CDWA create a job post in Carina, i.e. care receiver is on hospice and needs assistance with the following ADLs…

Once the TSOA without a Caregiver or TCARE assessment has been completed, the AAA staff must:

- Complete the 'Referral Process in GetCare to CDE' steps outlined above.

CDWA will:

- Follow their urgent hire protocol, which includes setting up basic care receiver information in the system so a care receiver/IP match can be made.
- Assist the IP with the hiring process if needed or help an existing IP who needs to be matched with the care receiver in CDWA's system.
- Post a Carina ad, if IP is not already identified, based on information from the TSOA without a Caregiver Assessment or the TCARE® Caregiver Assessment and Referral Information for Respite Care Service Providers document, if provided, or the email from the AAA staff.
- Email the AAA staff when the IP has completed any necessary hiring activities, including Orientation &Safety (O&S) training if applicable, and has been issued an "OK to Provide Care" date.

Facility Discharge Pre-Authorization IP Referral to CDWA

- The AAA staff will email the TSOA without a Caregiver Assessment or the TCARE® Caregiver Assessment and Referral Information for Respite Care Service Providers document to CDWA. This serves as confirmation to CDWA that the client is eligible for CDE services. The following should also be included in this email:
  - **Send an Email to:** InfoCDWA@consumerdirectcare.com
    - **Subject of email:** "CDWA's new Client Pre-Authorization IP referral" *(CDWA will apply email filters based on the subject and key words to direct the email internally to CDWA's Client/IP Referral Support Team).*
  - The CDWA Client/IP Support Team will use the TSOA without a Caregiver Assessment or the TCARE® Caregiver Assessment and Referral Information for Respite Care Service Providers document to post the job in Carina.
  - The CDWA Client/IP Support Team will attempt to identify potential IP matches and send the IPs' information to the care receiver/care receiver's representative via phone. If CDWA is not able to contact the care receiver by phone to coordinate personal care, CDWA will notify the AAA staff via email and the AAA staff will be expected to notify the care receiver/care receiver's representative of potential IP matches.

    CDWA is unable to guarantee an IP match will be made. The AAA staff is responsible for working with the care receiver/care receiver's representative *to explore alternative personal care options if a match cannot be made.*

  - Care receiver/AR will be responsible for interviewing the IP(s) until an acceptable match if found based on care receiver's schedule, needs, etc.

- AAA Staff will notify the CDWA *Client/IP Support Team* of the care receiver's IP choice by e-mail.
- The CDWA Client/IP Support Team will assist the IP with the hiring process if needed or will help an existing IP who needs to be matched with the care receiver in CDWA's system.
- The CDWA Client/IP Support Team will email the AAA staff when the IP has completed any necessary hiring activities, including O&S training if applicable, and has been issued an "OK to Provide Care" date.

The first date the IP could potentially work is dependent on the care receivers' discharge date in coordination with the care receiver/AR as the Managing Employer.

- AAA staff will create the CDWA service authorization immediately following care receiver's discharge from the facility.

PACE ENROLLED CLIENTS

PACE organizations (PO) are responsible for providing and paying for the IP services for their PACE enrolled participants. PACE organizations contract with Accentcare, a subcontractor that does IP functions for them and works closely with CDWA.

PACE Organization Responsibilities:

The PACE organizations manage the following functions for PACE participants receiving IP services:

- Complete Authorizations in the ProviderOne System for IP services.
  - Authorizations with the user ID GutheBA in CARE are authorizations inputted in P1 by Beverly Guthery/Accentcare.
- Communication with the participant about the IP and the IP services they are receiving.
  - The PO works closely with the PACE participant to get an IP set up for them either via CDWA or a contracted home care agency.
- Perform home visits that include the IP and participant and observe their living situations.
- Send copy of the care plan summary to CDWA.
  - Accentcare uploads the care plan created by the PO into a PACE specific email address created by CDWA for this purpose.
- Assignment of IP hours and ongoing communication with CDWA about the IP hours.
- Communicate with HCS/AAA if care plan changes to include an IP when an IP was not previously assisting the client.

HCS/AAA Staff Responsibilities:

- Confirm assessment is set up for in-home services and a PACE In-Home RAC is added to CARE.

- Ensure that tasks are assigned to the appropriate provider type and if informal support is being provided that it will not be impacted by the addition of the IP.
- On the CARE Provider screen, add CDWA (P1# 214868501) as a provider in addition to PACE provider.
- On the CARE Support screen, assign CDWA to any task that the IP will be expected to complete.
- If updates to CARE occurred, resend the Assessment Detail and MCO Service Summary to PACE org.

Note for HCS/AAA Staff with a PACE client:

•HCS/AAA staff should not change the status of authorizations created by user ID GutheBA as it disrupts IPs payments and creates rework for Accentcare to get the authorization back in place.
•HCS/AAA are not involved in setting up an IP for a client who has enrolled in PACE.
•HCS/AAA do not need to send a care plan summary to CDWA via CARE.

IP MILEAGE WHEN A CLIENT TRANSFERS TO AN ADULT FAMILY HOME

IPs can assist a client with moving into an Adult Family Home (AFH) and can claim mileage on the day that a client transitions. If the assessment for residential is moved to current prior to the transition, mileage is removed from the CARE plan.

When an assessment for residential is moved to current prior to the transition, CDWA can allow the IP to claim mileage.

The CM will take the following steps:

- Email the DSHS CDE mailbox (CDE@dshs.wa.gov) with the client's name, the IP's name, and the date that mileage needs to be paid. Include a note that the mileage is needed due to an AFH transition.
- The DSHS CDE team will notify CDWA.
- CDWA will work within their system to allow the IP to claim mileage.
- CDWA will notify the IP that the IP can claim mileage for that day.

IP/CLIENT MATCH CONCERNS

CMs are required to notify CDWA when there are concerns about the care being provided to the client. Specifically, as per RCW 74.39A(4)(a)(b), the CM must notify CDWA when:

- There is reason to believe an IP or prospective IP is not delivering or will not deliver the services identified in the plan of care; or
- The IP's performance is jeopardizing the health, safety, or well-being of the client.

CDWA will take appropriate action, including completing a new CC&S review as needed.

NOTIFYING CDWA OF CHANGES TO HOUR ALLOCATION

CMs will use the authorization to communicate how many hours a client may allocate to their IP(s). CDWA receives this as updated information on a nightly batch and internally adjusts the available hours. CDWA has a portal for clients and IPs to use called Direct My Care. Clients can allocate hours in the portal. IPs who live with the clients can claim their time in the portal. CDWA will use the following logic for allocation:

- For a 1:1 (one IP, one client), the entire authorization is allocated to the IP (up to the Work Week Limit (WWL) of the IP).
- A 1:1 allocation does not need to be confirmed in the portal. However, if the client wants to allocate less than the full number of hours, they can call CDWA, make the change in the portal, or have their CM contact CDWA.
- For a 2+:1 (more than one IP, one client), CDWA will attempt to confirm allocations with the client. If unable, they will prorate/split the hours evenly. This is not preferred, because if the allocation is not sufficient, it may cause care to be interrupted until allocation is confirmed.
- CDWA cannot "schedule" hours and cannot shift hours without the directions of the client/AR or CM on behalf of the client. Allocation of hours when there are multiple IPs requires active engagement by the client/AR.

UTILIZING CCG SERVICES IN CONJUNCTION WITH CDWA

Due to contract and policy rules, the role of a Community Choice Guide (CCG) is limited in terms of the type of assistance that may be provided in the IP hiring process. A CCG may assist a client in the following ways:

- Contacting CDWA when a specific IP is requested by the client. The CCG may call or email CDWA on the client's behalf and can include their (the CCG's) contact information.
- A CM may include the CCG's contact information in the care plan as a contact for the results of a Carina job posting. This would give CDWA another point of contact instead of reaching out to the CM when a match list has been generated.
- Setting up interviews with potential providers to determine if the match is acceptable according to the client's preferences.
- Assisting the client during the interview.
- Notifying CDWA that an IP has been selected.

COMMUNICATION WHEN CDWA CANNOT FILL AUTHORIZED HOURS

If authorized hours are not being utilized, CDWA will have a conversation with the client about any ongoing need for assistance to locate and hire another IP.

HOW DO I KNOW IF AN IP IS READY TO WORK?

Case Managers will receive an "OK to provide care" notification in CARE on the CDE Notifications screen. This notification will be sent when an IP is newly hired or there is a new match between a client and an existing IP.

WHAT IF CDWA CANNOT OPEN MY ENCRYPTED EMAIL?

If there is an issue with accessing secure emails to the InfoCDWA@consumerdirectcare.com address, CDWA staff will reach out directly to the CM and request that the CM email the CDWA staff directly at their CDWA email address. This allows CDWA staff to obtain a password and open the email.

WHAT IF A CLIENT IS HOSPITALIZED?

Contact CDWA to determine the number of hours the IP worked from the first of the current month to the date of the client's admission to the hospital. End date the authorization based on current policy.

HOW DO I REACH THE ASSIGNED SERVICE COORDINATOR (ASC) FOR A CLIENT, CARE RECEIVER OR ASSOCIATED IP

Call the main number, 866-214-9899. Select Option 2 and enter the Client or IP's ProviderOne ID. The system will route you directly to the client's ASC if they are available at the time of your call. If the ASC is unavailable, you can leave a voicemail, and the ASC will call you back as soon as possible.

WHEN SHOULD I CALL THE CDWA CASE MANAGER LINE?

You can contact CDWA on the dedicated CM line (866-932-6468) for escalations of issues or questions. This is a non-published number *for CMs only* and not for distribution to the public. It should not be used to inquire about new client and IP matches.

HOW IS MILEAGE ASSIGNED TO CDWA?

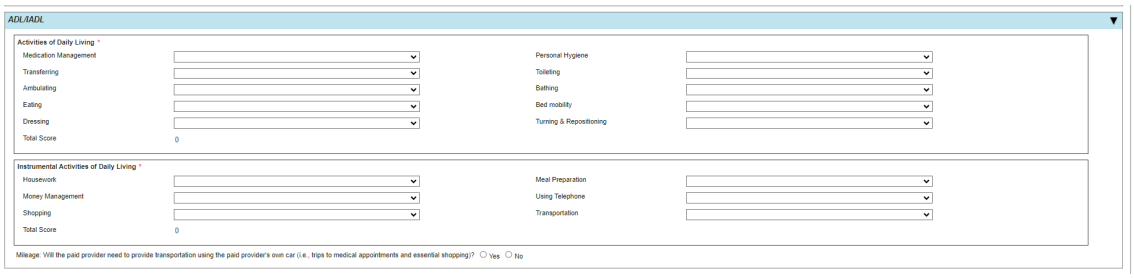
The CDE is "assigned" mileage by a status coding of 'unmet' or 'partially met' on the Medical Transportation and/or Essential Shopping screens within the assessment. If CDWA contacts staff

requesting an authorization for mileage, check the Pending/Current assessment to make sure the assessment reflects this need.

For MAC and TSOA care receiver's, the CDE is 'assigned' mileage by the 'Yes' selection on the TSOA without a Caregiver or TCARE assessment.

If CDWA contacts the AAA staff requesting an authorization for mileage, check the locked TSOA without a Caregiver or TCARE assessment Addendum for MAC/TSOA Dyads to ensure the assessment reflects Yes on "Will the paid provider need to provide transportation using the paid provider's own care (i.e.. Trips to medical appointments and essential shopping?"

- TSOA without a Caregiver Assessment



- TCARE Assessment Addendum for MAC/TSOA Dyads

WHAT IF AN ASC OR CDWA REPRESENTATIVE CANNOT SEE TASKS FOR YOUR CLIENT?

Review the Supports screen to ensure tasks have been appropriately assigned to CDWA as a paid provider. If not, correct and re-submit AD/SS to CDWA. If tasks are assigned correctly, tell the Service Coordinator to refer the issue to their "data management team" at CDWA.

For MAC and TSOA Care Recievers check the CDE Transaction log in GetCare to ensure the assessment and client tasks were sent. If the CDE transaction log shows the successful send; tell the Service Coordinator to refer the issue to their "data management team" at CDWA.

HOW DO I ESCALATE UNRESOLVED ISSUES?

Most issues and complaints can only be addressed and answered by CDWA.

If HCS or AAA staff receive a complaint or have questions regarding a specific IP hiring issue the following actions should be taken:

1. Field staff will refer IPs to CDWA (InfoCDWA@consumerdirectcare.com or 866-214-9899) for assistance or to file a formal complaint.

2. If field staff have an issue, they should contact CDWA on the Case Manager phone line or email at InfoCDWA@consumerdirectcare.com.
3. If field staff are having trouble getting their questions answered they should reach out to their regional CDWA contact. A CDWA contact list is available on the ALTSA Intranet site.
4. If field staff have already sent it to the regional CDWA contact and have not gotten resolution, then they should send the issue to the State Director, De'Shanel Childs,at De'ShanelC@consumerdirectcare.com and provide all the necessary background information including lack of response from previous attempts.
5. If the issue is still not addressed, contact the CDE Team at cde@dshs.wa.gov.

If DDA staff receive a complaint or have questions regarding a specific IP issue the following actions shall be taken:

1. Field staff will ask IPs to contact CDWA either by phone, email, or text. Refer them to CDWA (InfoCDWA@consumerdirectcare.com or 866-214-9899) to get assistance or file a formal complaint.
2. If it's a payment issue that we previously addressed through our payment specialist in the old system, we will still address through our regional payment specialists.
3. For other issues, field staff should contact CDWA at 866-214-9899 (enter the client's P1 ID to be directed to the Service Coordinator) or email at InfoCDWA@consumerdirectcare.com.
4. If there is no resolution or issues remain confusing, CRM notifies supervisor.
5. Supervisor will reach out to their regional CDWA Program Manager. A CDWA contact list is available on the ALTSA Intranet site.
6. If there is no resolution or issues remain confusing, supervisor notifies FSA (or designee)
7. FSA (or designee) will reach out to the CDWA area director;
8. If no response is received within 2 business days (or sooner if more urgent), FSA (or designee) escalates to the state director, De'Shanel Childs,at De'ShanelC@consumerdirectcare.com and provides all necessary background information including lack of response from previous attempts.
9. If still unresolved, FSA (or designee) will contact the CDE Team at cde@dshs.wa.gov.

*If the issue involves questions about DDA/ALTSA processes, FSA (or designee) will contact the CDE Team at cde@dshs.wa.gov.

CLIENT RESPONSIBILITY

Client Responsibility

Clients will pay any applicable client responsibility (participation) directly to CDWA, not to their IP. Clients will receive a monthly service statement from CDWA informing them of their client responsibility amount owed for that month. If clients don't pay their client responsibility, they will receive a 30-day termination letter warning them that their services provided by CDWA will be terminated unless the past due balance is paid within 30 days. CMs will receive notification in CARE when a client is at risk of losing their CDE services due to non-payment.

Unpaid Client Responsibility Process

Clients may be terminated from CDE services if their responsibility is not paid. Clients are notified via mail and telephone prior to CDE services being terminated. IPs are notified via email and text messages. Notifications are issued 30 days, 15 days, 10 days, 5 days, and 1 day prior to service termination.

CMs will be notified, via the CARE CDE Notifications, when a client's CDWA services are at risk of termination.

CMs receive a notification via CARE at 30 days, 15 days, 10 days, and 1 day prior to the date of termination. During this time, CMs must work with clients to discuss alternative service options if all outstanding client responsibility is not paid in full. Prior to the 1-day notification, CMs should have a backup plan in place with the client. At no later than the 1-day notification, the CM will:

1. Reach out to the client and confirm that services through CDWA are terminated effective the date on the notification.
   a. In this situation the client is still eligible for personal care services from another provider; do not send a PAN.)
2. End date the CDWA authorization using the date identified on the notification.

Once the client meets their client responsibility payment requirements, CDWA will reactivate the client's account in their system, and will notify the CM that the client responsibility account is paid.
The CM will use this information to open a new CDWA authorization with the start date being the date identified in the notification.

If the client pays participation before the end date identified on the notification and there is no break in service, the CM will not adjust the authorization.

NOTE: Care receivers in the MAC and TSOA programs are not subject to client responsibility.

WORKING WITH APS

APS information is confidential under RCW 74.34.095. This includes some communications with the CDE. APS will notify the CDE of a Substantiated finding (a finding to represent the action/inaction did impact the health, safety, or well-being of the client, or the plan of care was not delivered). An Unsubstantiated or inconclusive finding means the IP's action/inaction did not jeopardize or cannot be confirmed that the client's health, safety, or well-being was jeopardized. APS does **not** provide a notification to the CDE of every allegation against an IP. APS will communicate concerns to the **Case Manager.** The CM must share information that is relevant to the care planning with CDWA, but significant caution should be used on whether the investigation itself is relevant for care planning with CDWA.

It is appropriate for the CM to contact CDWA regarding concerns about the care plan, the client's safety, or other concerns, but the APS investigation should not be the sole concern.

MEDICAID FRAUD REFERRALS

CDWA will report allegations of fraud to the Fraud In-Box at HCBSProviderFraud@dshs.wa.gov.
DSHS HQ staff will:

1. Review the allegation.
2. Determine if good cause should be granted based on feedback from CDWA and local office staff or if payment suspension is necessary.
3. Notify CDWA of the decision via email to CDWACompliance@consumerdirectcare.com.
4. Make the referral to the Medicaid Fraud Complaint Unit and provide updates as appropriate.

CDWA will send notice to the employee within 5 days of the payment suspension.

ADMINSTRATIVE FUNCTIONS

Character Competence and Suitability (CC&S)
The CDE is responsible for completing the CC&S when needed. They may contact the CM to provide input. CMs may also reach out to the CDE to provide additional information, or report concerns about a client/IP match.

IP-Related PANs/Administrative Hearings
CMs staff no longer issue IP specific Planned Action Notices (PANs), nor do clients or IPs have hearing rights related to IP employment decisions as of full implementation of the CDE. Clients may use CDWA's dispute resolution process and IPs may use CDWA's grievance and dispute resolution process to exercise due process.

Mileage and Training Authorizations
Mileage and training costs are included in the CDE rate. CM no longer create separate authorization lines for mileage or IP training seat time.

IPs claim mileage through CDWA's DirectMyCare portal, the Interactive Voice Response (IVR) system, or by calling CDWA. CDWA will be made aware of a client's eligibility for mileage through the assessment. IPs will need to provide verification of driver's license and insurance to CDWA to be eligible for mileage reimbursement.

Travel Time:
Requests for IP travel time may be submitted by the client or IP Directly to CDWA. CDWA will approve or deny all requests for IP travel time.

IP Overtime/Work Week Limits (WWL)
Washington State statute limits the number of hours the Consumer Direct Employer (CDE) may pay any single provider in a work week (RCW 74.39A.525).

A work week limit (WWL) is defined as the total number of service hours an IP can provide in a work week. Service hours are defined as the time IPs are paid by the CDE to provide personal care, relief care, skills acquisition training, or respite services under Medicaid state plan and 1915(c) waiver programs, 1115 waiver programs, Roads to Community Living (RCL), the Veteran Directed Care (VDC)program and programs funded solely by the state. The WWL and service hours do not include hours paid for required training, approved travel time, administrative time, or paid time off. All hours worked over 40 hours (including required training and approved travel time) will be paid as overtime.

Every IP is assigned a permanent WWL. Most IPs have a permanent WWL of 40 hours. A relatively small number of IPs who worked in January of 2016 have a permanent WWL that is more than 40. An IP's permanent WWL is greater than 40 hours if the average number of weekly service hours worked in January of 2016 was greater than 40. Permanent WWLs over 40 hours range individually from 40.25 to 65 hours per week.

The CDE tracks and manages the WWLs of all IPs.

The client or their representative should contact the CDE if the IP needs their WWL temporarily increased. The CDE will follow the statutory guidelines to make a determination about temporary WWL increases. The CDE may contact the Case Manager to obtain additional information to make their decision.

IP Employment Verifications

CDWA uses The Work Number services from Equifax to help provide automated income and employment verifications.

Those wishing to verify an IP's employment with CDWA can visit: www.theworknumber.com/verifiers or, call The Work Number Client Service Center at 1-800-367-5690. The CDWA employer code is 29876.

CDWA's Electronic Visit Verification (EVV) Application

IPs who do not live with the client they serve will utilize CDWA's EVV application, CareAttend. IPs will also have the option to use CDWA's IVR system, or fob to claim time if they don't live with their client. A fob is a small device that is kept in the Client's home that displays a code at the start and end of their shift. IPs would use the code as part of the clock in/clock out process. CDWA will provide training to IPs on how to submit time.

Nurse Delegation

The CM will open an authorization to Registered Nurse Delegator (RND) and send them the Nurse Delegation referral form. If the RND approves nurse delegation with an IP, the CM will notify CDWA. CDWA will verify the IP's credentials/training and will notify the RND if all requirements are satisfied. If IP lacks training, CDWA will initiate the training process and notify the RND once the IP is fully trained.

Please refer to LTC Manual Chapter 13 for further guidance on when and how to make ND referrals.

Public Disclosure

Staff receiving a public records request for records relating to an IP should forward the request to: HCSPublicRecords@dshs.wa.gov.

The Public Records Coordinator (PRC) will review the request to determine what records are being requested, and who the owner of record is for the date range of the records requested.

- DSHS is the owner of IP records prior to the IP's first day of employment with the CDE.
- CDE is the owner of IP records that were created on or after their first day of employment with the CDE.

If the PRC determines the owner of record is the CDE, the requester will be referred to the CDWA: jeffh@consumerdirectcare.com. DSHS, will process records owned, maintained, or used by DSHS as usual.

In April 2022, the transition of IPs to the CDE was concluded. The transition took place in phases and at the beginning of each phase, the PRCs received communication from the lead PRCs indicating which IPs were employed by the CDE and no longer contracted with DSHS.

Collective Bargaining

The CDE will negotiate with the collective bargaining agent. A Rate Setting Board (RSB) has been established. Starting in 2022, this board will determine the labor and administrative rates that will be proposed to the legislature.

CDWA E-mail Correspondence

Email Address	Subject Line	Reason
InfoCDWA@consumerdirectcare.com	"CDWA new client / new to Medicaid services"	Used when the client is new to IP services or new to Medicaid. CDWA email system will filter email to the Client/IP Referral Support team
InfoCDWA@consumerdirectcare.com	"CDWA's new Client Pre-Authorization IP referral"	Used when a client is leaving a facility or MAC/TSOA program and the hiring process needs to start prior to discharge. CDWA email system will filter email to the Client/IP Referral Support team

InfoCDWA@consumerdirectcare.com	"CDWA urgent hire required"	Used when a client has an emergent care need, such as 1. Left Hospital or SNF Against Medical Advice (AMA) 2. APS Involvement 3. Hospice 4. Nursing or Wound Care involvement 5. Other (with Supervisor approval) CDWA email system will filter email to the Client/IP Referral Support team
CDWABackgroundCheck@consumerdirectcare.com	N/A	Used related to IP background checks

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
10/2023	Natalie Lehl	Clarity and modifications in case management policy	
12/2023	Natalie	• Policy language updates to: • Working with Carina • Notifying CDWA of changes • New client authorizations Communication when an IP is ready to work	
07/2024	Natalie Lehl	• Updated Veteran Direct Care program name	
10/2024	Natalie Lehl	• Carina information flyers • Clarification on New to CDWA, New to Medicaid Authorizations • Add MAC/TSOA Policy • Fixed broken links	
03/2025	Natalie Lehl	• DDA Escalation Process updated • Corrected CDWA escalation contact • Clarified process for sending/receiving documents to CDE and authorizing to CDWA • Updated Template	

Adult Day Services

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Susan Worthington Adult Day Services Program Manager
360.725.2638 susan.worthington@dshs.wa.gov
Adultdayservices@dshs.wa.gov

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BACKGROUND

Adult Day Services (ADS) provide opportunities for adults with functional limitations to regularly attend a center where a variety of health, social, and related support services are provided. Services are individualized to meet the unique needs of each participant. For a quick overview of the programs, download the brochure here (DSHS 22-1731). This brochure can be used as a marketing tool and an informative brochure to leave with the client.

ADS goals are to:

- Provide clinical and non-clinical services to address unmet needs.
- Assist participants with their activities of daily living (ADLs).
- Support participants to live in their community/resident of choice.

Each client has a Negotiated Care Plan (NCP) and their progress with program-component interventions is measured over time.

Table 12.1 Program Components

	ADULT DAY CARE (ADC)	ADULT DAY HEALTH (ADH)
Core services (e.g. help with ADLs, social services, health education, meals) are provided	Yes	Yes
Skilled nursing, therapy (e.g. PT), psychological/ counseling services, and other services that requiring physician (or other prescriber) orders	No	Yes
Provide transportation to/from program	Assist client with resources	Yes

Visit WAC-388-71-0702 for more detail.

REMOTE/HYBRID PROGRAM	ADULT DAY CARE (ADC)	ADULT DAY HEALTH (ADH)
Core services (e.g. social services, health education,) are provided	Yes	Yes
Skilled nursing, therapy (e.g. PT), psychological/ counseling services, and other services that requiring physician (or other prescriber) orders	No	Yes

Note: Much of this chapter is laid out in a series of side-by-side comparisons between ADC and ADH. Where there are significant differences between the three programs, that content is detailed in the sub-sections Adult Day Care, Adult Day Health and Remote/Hybrid.

FUNDING & ELIGIBILITY

Adult Day Services are available to clients that are eligible under Community Options Program Entry System (COPES), Roads to Community Living (RCL), New Freedom Waiver, MAC/TSOA, or other approved funding sources.

Other funding sources include:

- Medicaid Alternative Care (MAC) via the AAA.
- Tailored Support for Older Adults (TSOA) via the AAA.
- Respite funds at ADCs that have the appropriate respite contract.
- Senior Citizens Services Act (SCSA) funds for eligible clients age 60+ (check with the ADC).
- Unique grant or other fund sources (check with the ADC).
- Private pay.

Case Managers use CARE to determine eligibility for Adult Day Services (ADS). Clients are eligible if they are age 18 or older and assessed as needing one or more core services, plus the additional services offered by ADH (if eligible for ADH).

Remote/Hybrid clients (either ADC or ADH) must meet certain requirements to qualify for this program, some examples are:

- Client must live in a remote area that would make transportation very difficult.
- The client cannot be transported due to a medical condition but is still able to participate in the program.
- The goal is to have all clients come to the ADS facility. But there are certain circumstances that remote client participation would be in the best interest of the client and the other participants and staff:
    - Any client that is contagious- such as being diagnosed with COVID etc.
    - Onset of mobility or medical issues preventing transportation.
    - Provider needs to contact case manager for evaluation/eligibility of specific situations on a case-by-case basis.
- It is possible (but should be rare) that in-facility and remote clients can change between programs. Additional authorizations will be needed.

ADC Eligibility	ADH Eligibility
Core Services: • Personal care • Routine health monitoring, overseen by a Registered Nurse. • Therapeutic activities • Supervised/protective environment as needed for client safety. WAC 388-106-0805	ADC eligibility PLUS: • Assessed as having an unmet need for skilled nursing or skilled rehabilitative therapy. • There is a reasonable expectation these services will improve, restore, or maintain the client's health. WAC 388-106-0300

Clients are **not eligible** if they:

- Can independently perform services provided at the ADC or ADH (depending on client's program type).
- Are not capable of safely participating in a group setting for each program type.
- For Remote/Hybrid can commute to the ADS facility.

Ineligibility Criteria - ADC	Ineligibility Criteria - ADH
• Have unmet needs that can be met in a more cost-effective manner. • Live in a nursing facility (NF), assisted living facility (ALF), adult family home (AFH), or other licensed residential or institutional facility. • Have care needs that: – Exceed the scope of authorized services the ADC can provide. – Can be met in a less structured setting. – Are being met by paid or unpaid caregivers.	• Live in a nursing home or other institutional facility (clients can live in an AFH or ALF) • Have care needs that: – Exceed the scope of authorized services the ADH can provide. – Do not need to be provided or supervised by a nurse or therapist. – Can be met in a less structured setting. – Skilled care needs are being met by paid or unpaid caregivers.

REFERRALS

	ADC	ADH
1	Determine functional and financial eligibility.	
2	Based on CARE assessment result, discuss ADC/ADH/Remote option with client and/or their representative.	
3	If interested, provide client and/or their representative with the contact information for contracted ADC providers in their area so they can schedule a tour.	
4	After client has toured and agreed to attend, contact the client's chosen ADC provider. Complete the Adult Day Services Referral Form (DSHS Form 10-580) and fax or email the ADC provider the referral form along with the client's assessment details, service summary, and consent.	
5	**Within 2 business days**, the ADC provider must accept or deny the referral.	

	ADC	ADH
6	If it is accepted, use CARE to conduct an interim, annual, or significant change assessment and add ADC in the treatment screen section. • Add ADC to the treatment screen. • Change status to "partially met" for all ADLs the client will receive help with at the ADC.	If not already completed, conduct an Initial, Significant Change or Interim assessment in CARE to complete the ADH screen, • Add ADH to the treatment screen. • Change status to "partially met" for all ADLs the client will receive help with at the ADH.
7	Authorize in-person ADC services in ProviderOne (P1), using: • ** One-time intake code: **S5102-UA** • Full day (4 hours) code: **S5102-HQ.** • Partial day (less than 4 hours) code: **S5100** in 15-minute units scheduled to attend	Authorize in-person ADH services in P1 using: • **One-time intake code: **S5102-CG** • 10-day trial period code: **S5102-U9.** • Send PAN to client for approval of ADH intake and 10-day trial period, • 10-day trial period **RCL** client, use code **S5102-U9** • Full day (4+ hours) code: **S5102-TG**
7A	Authorize ADC services in P1, for **Remote/hybrid** clients using: • ** One-time intake: code **S5102-UA** • Authorize in 15-minute units using code**: S5100 U1. Full day in considered 4 hours billed at 16 units.** • **Providers can bill for a minimum of one (1) hour (4 units) per visit.**	Authorize ADH services in P1 for **Remote/hybrid** clients using: • **One-time intake: code **S5102-CG** • **Authorize visits in 15-minute units using code: S5100-U2. Full Day is considered four hours which would be billed as 16 units.** • 10-day trial period: code **S5102-U9.** • Send PAN to client for approval of ADH intake and 10-day trial period, • 10-day trial period for **RCL** client, use code **S5102-U9** • **Providers can bill for a minimum of one (1) hour (4 units) per visit.**
8	ADC Timeframes (from first day of attendance): • **10 paid service days:** *a)* Complete intake evaluation in person *b)* Determine if and how it can/will meet the client's needs *c)* Develop preliminary service plan to-determine is client will be **in-person** or **remote/hybrid.** d) Give to client and/or their representative and to the case manager.	ADH Timeframes (from first day of attendance): **10 paid service days:** *a*) Complete intake evaluation in person *b)* Develop preliminary service plan to determine is client will be **in-person** or **remote/hybrid** *c)* Obtain orders from client's health care provider for skilled services, and *d)* send preliminary service plan to case manager if client meets eligibility criteria.

	ADC	ADH
	• If not accepted, the preliminary service plan must include the reason(s) as to *why.* • **30 days:** Develop and complete a Negotiated Care Plan (NCP) and send to the case manager *(from accepting client to the ADC)*	• **30 days:** Develop and complete an NCP and send to the case manager *(from date of acceptance into ADH)*
9	Case manager will: • Provide the client's department service plan to the ADC center **within five working days** after the client or client's representative has signed it. • Send PAN to client for approval of ADC and Community First Choice (CFC) care plan hours. • Review NCP • Document in a SER the NCP was received. • Send copy to the Hub Imaging Unit (HIU).	Case manager will: • Send another PAN for approval of on-going attendance. • Review preliminary service plan. – Document a SER it was received. – Send copy to HIU. • Review NCP (same steps as preliminary).

****NEW: CASE MANAGERS NEED TO AUTHORIZE THE INTAKE FOR ALL PROGRAMS, ADC, ADH AND REMOTE/HYBRID. AUTHORIZATIONS FOR CLIENT INTAKE IS A ONETIME APPROVAL PER ATTENDANCE CYCLE. IF THE CLIENT DISCHARGES FROM SERVICES AND AT A LATER DATE IS REAUTHORIZED, THE AUTHORIZATION MAY BE FORCED PER HQ ADS PROGRAM MANAGER.**

ADULT DAY CARE (ADC)

Services

ADC is a supervised, non-residential program providing the following services:

- Assistance with ADLs.
- Social services including referrals for services not within the scope of COPES waiver or RCL.
- Routine health monitoring by a Registered Nurse (e.g., baseline and routine monitoring of vital signs, weight, and dietary needs).
- Therapeutic activities (e.g., recreational, relaxation, group exercises) that an unlicensed individual can provide or a licensed individual without physician orders.
- Health education (e.g., nutrition, disease management skills) that an unlicensed individual can provide or a licensed individual without physician orders.
- Nutritional meals and snacks.
- Assistance with arranging for transportation to and from the center.
- First aid, and providing or obtaining care, in an emergency.

Services are for adults with health conditions that do not require the intervention of a registered nurse or licensed rehabilitative specialist (e.g. Physical Therapist). See WAC 388-71-0704 for more detail.

ADC Remote/Hybrid

The percentage of time for the remote visit will be the delivery method for ADC services will vary on the participants' needs and goals. Each client will be evaluated on their ability to attend in-facility visits.

- Participants will have an in-person initial intake and comprehensive assessment by a nurse or trained qualified staff in the participant's place of residence or in the Adult Day Care center. Participants will be required to be seen in-person a minimum of once per quarter to update their assessment, after the initial intake and comprehensive assessment.
- Adult Day Care providers offering services through telehealth are required to have IT policies to meet HIPAA requirements, as well as a business associate agreement with either Zoom or Microsoft Teams. These delivery methods have been approved by the WA HIPPA Compliance officer (Contact the ADS PM for contact information).
- Participant's privacy will be protected by the Adult Day Care provider. The host of the telehealth meeting (ADC staff) will also have the ability to turn off the participant's camera to ensure there is no video camera/monitor in the bedroom or bathroom. The participant will have the ability to turn on or off the video camera/monitoring equipment at will.
- Participants will be offered group sessions for nutritional training, presentations from local libraries, other community activities, etc. through Zoom or Microsoft Teams, in addition to their one-on-one time for medical treatment.
- The initial intake and comprehensive assessment will evaluate tasks the participant is able to do without assistance. If the participant cannot follow instructions or cannot physically do what is asked without help and no help is available, then they would not be a candidate for telehealth services.
- The initial intake and comprehensive assessment will evaluate the participant's and/or caregiver's ability to use the required technology, and provide any training needed. The participant may also receive assistance learning the technology required for the telehealth delivery of this service through a Client Training contracted provider.
- Adult Day Care providers are required to have emergency protocols in place if staff are unable to reach a participant, as well as have staff trained on emergency situations that may occur during the telehealth session.

Negotiated Care Plan (NCP) Review

When the ADC provider receives the DSHS plan of care, they will conduct their own intake/evaluation to assess their ability to meet the client's needs. The ADC has to determine if it can meet the client's needs within **10 paid service days** of the client's first attendance date.

The ADC provider must develop an NCP within **30 days** of acceptance to the program which needs to be signed by the client or their representative. Care/case managers then review the NCP documentation for:

- Consistency with the client's DSHS authorized service plan.
- ADS services assigned to the ADC provider are being provided.
- How services and interventions provided by the ADC provider meet the client's identified needs along with the schedule of when and by whom they are or will be provided.
- Whether identified potential behavioral issues are documented and how they will be managed; ***and***
- Contingency plan(s) for responding to emergent care needs or other crises.

After review:

- Enter a SER note via the initial, annual, or significant change assessment in CARE documenting receipt and review of the NCP.
- Send the client either the initial PAN or one specifically for ongoing ADC approval.

Continued authorization of services indicates approval of the NCP. ADC clients must be assessed for continued need and eligibility on, at minimum, an annual basis.

The ADC provider must report any changes in the client's condition or unanticipated absences of **more than 3 consecutive scheduled days. Report** to the client's case manager within 1 week. The case manager will determine if any updates to the assessment, service plan, or authorization are needed.

Authorizing Services

Authorize P1 payment for the intake evaluation for both ADC and ADC Remote/Hybrid.

Table 12.2 P1 Codes

ADC		CODE-COPES/RCL
ADC Intake *	One unit	S5102-UA
4 hours or more	Daily	S5102-HQ
Up to 4 hours	15-minute	S5100
REMOTE/HYBRID		**CODES-COPES/RCL**
ADC Intake *	One unit	S5102-UA
Up to 4 hours	15-minute	S5100-U1

*Authorization for client intake is a onetime approval **per attendance** cycle. If the client discharges from services for 6 months or longer then returns or has a significant change in their assessment the intake code authorization will need to be forced by the HQ ADS Program Manager.

Current ADC rates are here. On July 1, 2024, there will be a 20% increase in Adult Day Services, please check for a new rate sheet at that time. Transportation ***is not*** paid for within the ADC daily rate. The ADC provider should help with suggestions for transportation, but they are not required to provide it. Refer to the P1 manual for further information.

Authorize ADC services in P1 for up to 1 year. Terminate authorization if the:

- ADC does not meet the NCP requirements,
- Client does not meet the ADC eligibility, or
- Client chooses to stop attending the ADC program.

ADULT DAY HEALTH (ADH)

Services

In addition to the Core services listed under the ADC section, ADH offers routine *clinical* services including skilled nursing and skilled therapy. Psychological services provided by an ADH include assessing psychosocial needs, presence of dementia, abuse or neglect, and alcohol and/or drug misuse. Intermittent supportive counseling is also available. WAC 388-71-0706

ADH staff can make referrals for other needed services. The dollars for transportation are included in the ADH rate, therefore the ADH providers are required to provide transportation.

Physician Orders

Physician orders are not needed to start the referral process but are needed before skilled services start. Having orders from a health care provider does not establish ADH eligibility but are helpful in evaluating the client's need for skilled nursing or rehabilitative therapy.

The ADH center needs to obtain physician orders for care that will be provided (or supervised) by licensed nurses and/or licensed therapists, per applicable state practice laws. These orders must also indicate how often the client needs to see the prescribing health care provider. Orders are needed for services to start and then updated for skilled services to continue, per WAC 388-71-0712 and WAC 388-71-0714.

Skilled Nursing Services

Skilled nursing services and care exceeds the level of routine health monitoring, general health education, and general therapeutic activities. They are provided with the reasonable expectation that the service will improve, maintain, or slow the progression of a client's disease or functional ability.

Skilled nursing services are medically necessary and are provided by an RN as authorized by a physician or by an LPN under physician or RN supervision, within the confines of the Nurse Practice Act (See Resources). Orders by the health care provider must be obtained:

- When required by applicable state practice laws for licensed nurses.
- Upon initial service; or
- Updated when a significant change occurs, nursing interventions change, or, at minimum, annually.

Table 12.3 Skilled Nursing Services

INCLUDES	DOES NOT INCLUDE
• Skilled care and assessment of an unstable or unpredictable acute or chronic medical condition. • Skilled nursing tasks (e.g. medication administration, wound care, inserting or irrigating a catheter). • Time-limited training to teach the client and/or their caregiver self-care for newly diagnosed, acute. or episodic medical conditions (e.g. self-administration of an injection, colostomy care, disease self-management). • Evaluating and managing a plan of care when skilled nursing oversight is needed to ensure that complex, non-skilled care is achieving its purpose.	• Coaching or reminding the client. • Medication assistance when client is capable of self-administration *or* is having this need met by paid or unpaid caregivers. • Continued teaching/training when it is apparent the training should have achieved its purpose, or the client is unwilling or unable to be trained (excluding language barriers in the absence of a trained interpreter/translator). • Group teaching/training or therapy where 3 or more clients are simultaneously being treated or trained by the nurse. • Routine monitoring of a medical condition that does not require frequent skilled nursing intervention.

See WAC 388-71-0712 for more detail.

Skilled Rehabilitative Services

ADH centers must offer one or more of the following therapeutic services:

- Physical Therapy
- Occupational Therapy
- Speech-Language Pathology
- Audiology

Skilled rehabilitative therapy services are medically necessary and are provided or supervised by a licensed physical, occupational, speech-language pathology, or audiology therapist (within each provider type's scope of practice).

Orders must be obtained from the client's health care provider initially and then updated when a significant change occurs or, at a minimum, annually.

Table 12.4 Skilled Rehabilitation Therapy

INCLUDES	DOES NOT INCLUDE
• Assessing baseline mobility, strength, ROM, endurance, balance, and ability to transfer • Assess speech, swallowing, auditory, and communication disorders. • Providing 1:1 and group treatment to develop, restore, or maintain functioning, slow decline, or relieve pain. • Creating an individualized exercise, strength, mobility, or endurance plan) • Training clients and/or their caregivers in use of supportive or adaptive equipment • Providing other medically necessary services that can only be provided or supervised by a therapist. • Training/teaching clients and/or their caregivers in managing care needs. • Evaluating and managing a plan of care when skilled therapist oversight is needed to ensure complex, non-skilled care is effective.	• Reminding/coaching the client in tasks that are not essential to the skilled therapy or intervention per the client's service plan. • Monitoring a medical condition that doesn't require frequent skilled therapy interventions. • Massage therapy. • Teaching/training when it is apparent the training should have achieved its purpose, or the client is unwilling or unable to be trained (excluding language barriers in the absence of a trained interpreter/translator). • Group therapy/training where ratio of licensed therapists and staff assistants to clients is inadequate to ensure that for each client the group activity: – contributes to their planned therapy goal(s). – meets their complexity of individual needs.

See WAC 388-71-0714 for more detail.

ADH Remote/Hybrid

The percentage of time telehealth will be the delivery method of ADH services will vary on the participants' needs and goals.

- Participants will have an in-person initial intake and comprehensive assessment by a nurse and PT/OT (if part of the care plan) either in the participant's place of residence or in the Adult Day Health center. Participants will be required to be seen in-person a minimum of once per quarter after the initial intake and comprehensive assessment.
- Adult Day Health providers offering services through telehealth are required to have IT policies to meet HIPAA requirements, as well as a business associate agreement with either Zoom or Microsoft Teams. These delivery methods have been approved by the WA HIPAA Compliance officer.
- Participant's privacy will be protected by the Adult Day Health provider. The host of the telehealth meeting (ADH staff) will also have the ability to turn off the participant's camera to ensure there is no video camera/monitor in the bedroom or bathroom. The participant will have the ability to turn on or off the video camera/monitoring equipment at will.
- Participants will be offered group sessions for nutritional training, presentations from local libraries, other community activities, etc. through Zoom or Microsoft Teams, in addition to their one-on-one time for medical treatment.

- The initial intake and comprehensive assessment will evaluate tasks the participant is able to do without assistance. If the participant cannot follow instructions or cannot physically do what is asked without help and no help is available, then they would not be a candidate for telehealth services.
- The initial intake and comprehensive assessment will evaluate the participant's and/or caregiver's ability to use the required technology, and provide any training needed. The participant may also receive assistance learning the technology required for the telehealth delivery of this service through a Client Training contracted provider.
- Adult Day Health providers are required to have emergency protocols in place if staff are unable to reach a participant, as well as have staff trained on emergency situations that may occur during the telehealth session.

Negotiated Care Plan (NCP) Review

Rather than develop a preliminary service plan within the first 10 paid service days, the ADH center might choose to develop a negotiated care plan during this timeframe. Otherwise, they have 30 calendar days to develop the NCP.

Every 90 days, the ADH provider must review each service and goal in the NCP to determine if skilled services are still required or sooner if the client's condition changes.

Care/case managers then review the NCP documentation for:

- Consistency with the client's DSHS authorized service plan.
- ADS services assigned to the ADH are being provided.
- Physician or other health care provider orders (obtained by the ADH provider) for skilled nursing services and/or rehabilitative therapy.
- Client consented to following-up with the prescribing physician/health care provider for skilled services.
- Goals must not exceed 90 days from the date of signature and be:
  - Time Specific
  - Measurable
  - Individualized
- Client's choices and preferences regarding care and services received and how these preferences will be accommodated.
- How services and interventions provided by the ADH program meet the client's identified needs along with the schedule of when and by whom they are or will be provided.
- Whether identified potential behavioral issues are documented and how they will be managed.
- Contingency plan(s) for responding to emergent care needs or other crises; ***and***
- Discharge or transfer plan.

The ADH must report any changes in the client's condition or unanticipated absences of **more than 3 consecutive visits.** Report to the case manager and they will determine if any updates to the assessment, service plan, or authorization are needed.

After review:

- Enter a SER note via the initial, annual, or significant change assessment in CARE documenting receipt and review of the NCP.
- Send the client either the initial PAN or one specifically for ongoing ADH approval.

Continued authorization of services indicates approval of the NCP.

ADH Service Authorization

Authorize P1 payment for the intake evaluation plus 10 units of service for the trial period. This 10-day trial allows the ADH center to determine their ability to meet the client's needs and develop a preliminary service plan.

After receiving, reviewing, and approving the NCP and the client is eligible for ADH, approve P1 payment for a 12-month period. The Service Authorization must include:

- Name of the Center.
- Number of attendance days/week.
- Nursing services and/or rehabilitative therapies to be provided.
- Authorization timeframe (start and end date).

Table 12.5 P1 Codes

ADH	COPES/RCL	MODIFIER
Intake Evaluation*	S5102	CG
10-Day Trial Visit	S5102	TG
10-Day Trial Visit RCL	S5102	U9
Daily Rate (4 hour day)	S5102	TG

Current ADH rates are here. On July 1, 2024, there will be a 20% increase in Adult Day Services, please check for a new rate sheet at that time. Transportation ***is*** paid for within the daily rate for ADH. Refer to the P1 manual for further information. Continue to use P1 to enter, authorize, change, and terminate payments.

*Authorization for client intake is a onetime approval **per attendance** cycle. If the client discharges from services for 6 months or longer then returns or has a significant change in their assessment the intake code authorization will need to be forced by the HQ Program Manager.

When terminating authorization for an Adult Family Home (AFH) client, send a notification to both the ADH and AFH provider. When terminating ADH based on ineligibility, list the effective date on the PAN 10 days later than the mailing. Clients should be given the opportunity to reduce the current number of attendance days to 1-2 days/week to ensure a successful and effective transition.

Assigning Needs to ADS Provider

The ADS provider is considered an informal support and needs to be listed in CARE as providing the respective ADL tasks per the NCP.

Because the ADH provider is considered an unpaid caregiver, they need to be listed in collateral contacts on the CARE "Supports Screen". ADH is listed on the "Treatment Screen" with the provider type as ADH.

Transferring Client from HCS to the AAA

For new in-home or ADH-only clients: HCS will transfer the case to the AAA when it receives an acceptable preliminary NCP. Complete the ongoing PAN and P1 authorization then complete the transfer. See Chapter 3 on how to complete transfers.

RESOURCES

Related WACs, RCWs and CMS Waivers

WAC-388-71-0702	Adult Day Services
WAC 388-71-0704	Adult Day Care
WAC 388-71-0706	Adult Day Health
WAC 388-71-0712	Skilled Nursing
WAC 388-71-0714	Skilled Rehabilitative Therapy
WAC 388-106-0805	Adult Day Care Eligibility
WAC 388-106-0300	COPES Services

Standards of Nursing Conduct / Nurse Practice

Each individual, upon entering the practice of nursing, assumes a measure of responsibility and trust and the corresponding obligation to adhere to standards of nursing practice. You are individually responsible and accountable for the quality of nursing service you provide to clients.

18.79 RCW	Nurse Practice Act
18.130 RCW	Uniform Disciplinary Act
WAC 246-840-700	Standards of nursing conduct or practice
WAC 246-840-710	Violations of standards of nursing conduct or practice

ACRONYMS

AAA	Area Agency on Aging
ADC	Adult Day Care
ADH	Adult Day Health
ADL	Activities of Daily Living
ADS	Adult Day Services

AFH	Adult Family Home
ALF	Assisted Living Facility
CARE	Comprehensive Assessment and Reporting Evaluation
CFC	Community First Choice
COPES	Community Options Program Entry System
DSHS	Department of Social and Health Services
HCS	Home and Community Services
HIU	Hub Imaging Unit
NCP	Negotiated Care Plan
P1	ProviderOne
PAN	Planned Action Notice
RCL	Roads to Community Living
ROM	Range of Motion
SER	Service Episode Record

FAQS

1. **What CARE screens do I complete to authorize ADC?**

Treatment	Select ADC from the treatment list. This must be selected in order to assign treatments to the provider.
Supports	Assign the provider to treatment(s) needed.
P1 Screen	Authorize ADC using a daily code (4 hours) or use the 15-minute unit code (for under 4 hours).

2. **What CARE screens do I complete to authorize ADH?**

Treatment	Document the need to assign treatment.
ADH	Assist in determining eligibility (Medical > Treatments > ADH).
Care Plan	ADH only: Select COPES in "Client is Eligible" dropdown. Select "ADH" for Recommended/Planned settings. COPES/RCL + ADH: Select COPES or RCL in "Client is Eligible" dropdown. Select "Home" or "Residential" for care setting.
Supports	Assign ADH treatment to the provider. *** Remember** to complete the Provider Schedule section.

3. **What do I do when there is a change in the number of weekly service days needed?**

If the client's needs are already identified in the assessment and only the number of days needs to be changed, document in CARE by completing an Interim Assessment, send a new PAN for the client and update P1 authorization. Frequency change is documented on the Treatment and Supports screens. This will create a new Service Summary for the client's review and signature (or by their authorized representative).

An updated authorization is needed for any change in service level or number of service days, regardless of whether a new assessment/ reassessment is completed.

If the client's needs are not identified or the current care plan no longer meets their needs, complete a new assessment.

4. **What if a client wants to exchange in-home hours for ADC services?**

   A provider change can be done without completing a new assessment. Document change in CARE and update P1 authorizations to the new provider. Follow the same process to change the ADC provider.

5. **What if a client requests ADS between assessments?**

   A new assessment is not needed if the care needs that qualified the client for ADC or ADH are already identified in the current assessment. Instead, reassign the need in CARE and update the authorization.

   If the client has a new need that is not identified in the assessment, complete a "Significant Change" reassessment.

6. **What do I do if a client changes from ADC to ADH?**

   New need (e.g. ADC client newly diagnosed with diabetes): Do a reassessment.

   Not a new need (e.g. ADC client receiving outpatient OT has been discontinued): Reassign need for OT to a new provider in CARE, send updated PAN, and adjust P1 authorizations.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #

Nurse Delegation

Chapter 13 describes Department of Social and Health Services (DSHS) Nurse Delegation (ND) Program, how to determine eligibility, determining delegable tasks, case manager and nurse delegator responsibilities, the referral process, and how to authorize this service.

DSHS forms referenced are required to be used. Search by Form Number at Electronic DSHS Forms. Most forms are available in Word and PDF.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Susan Worthington Nurse Delegation Program Manager
360.790.3136 Susan.Worthington@dshs.wa.gov
nursedelegation@dshs.wa.gov

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OVERVIEW

What is Nurse Delegation?

Nurse Delegation is a role within a Registered Nurse (RN) Scope of Practice. It allows an RN to delegate specific skilled nursing tasks to nursing assistants or home care aides, also called Long-Term Care Worker (LTCW) for eligible clients who have partially met or unmet skilled nursing task needs. The laws and rules for Community Nurse Delegation are found in Revised Code of Washington (RCW) and Washington Administrative Code (WAC).

RCW 18.79.260 Registered nurse - Activities allowed - Delegation of tasks

(1) A registered nurse under his or her license may perform for compensation nursing care, as that term is usually understood, to individuals with illnesses, injuries, or disabilities.

(2) A registered nurse may, at or under the general direction of a licensed physician and surgeon, dentist, osteopathic physician and surgeon, naturopathic physician, optometrist, podiatric physician and surgeon, physician assistant, advanced registered nurse practitioner, or midwife acting within the scope of his or her license, administer medications, treatments, tests, and inoculations, whether or not the severing or penetrating of tissues is involved and whether or not a degree of independent judgment and skill is required. Such direction must be for acts which are within the scope of registered nursing practice.

(3) A registered nurse may delegate tasks of nursing care to other individuals where the registered nurse determines that it is in the best interest of the patient.

(a) The delegating nurse shall:

(i) Determine the competency of the individual to perform the tasks.

(ii) Evaluate the appropriateness of the delegation.

(iii) Supervise the actions of the person performing the delegated task; and

(iv) Delegate only those tasks that are within the registered nurse's scope of practice.

b) A registered nurse, working for a home health or hospice agency regulated under chapter **70.127** RCW, may delegate the application, instillation, or insertion of medications to a registered or certified nursing assistant under a plan of care.

(c) Except as authorized in (b) or (e) of this subsection, a registered nurse may not delegate the administration of medications. Except as authorized in (e) or (f) of this subsection, a registered nurse may not delegate acts requiring substantial skill and may not delegate piercing or severing of tissues. Acts that require nursing judgment shall not be delegated.

(d) No person may coerce a nurse into compromising patient safety by requiring the nurse to delegate if the nurse determines that it is inappropriate to do so. Nurses shall not be subject to any employer reprisal or disciplinary action by the nursing care quality assurance commission for refusing to delegate tasks or refusing to provide the required training for delegation if the nurse determines delegation may compromise patient safety.

(e) For delegation in community-based care settings or in-home care settings, a registered nurse may delegate nursing care tasks only to registered or certified nursing assistants under chapter **18.88A** RCW or home care aides certified under chapter **18.88B** RCW. Simple care tasks such as blood pressure monitoring, personal care service, diabetic insulin device set up, verbal verification of insulin dosage for sight-impaired individuals, or other tasks as defined by the *nursing care quality assurance commission are exempted from this requirement.

(f) The delegation of nursing care tasks only to registered or certified nursing assistants under chapter **18.88A** RCW or to home care aides certified under chapter **18.88B** RCW may include glucose monitoring and testing.

Delegable Task Examples

Tasks that **may** be delegated for the stable and predictable client, include but are not limited to:

- Oral medication and administration
- Topical medication administration
- Nasal sprays
- Eye drops
- Gastrostomy tube feedings (including medication administration)
- Wound care must be simple, non-complex, does not require frequent nurse assessment and evaluation as determined by the delegating nurse.
- Blood glucose monitoring
- Insulin or non-insulin injectables for the treatment of diabetes
- Non-sterile tracheal and oral suctioning

NOTE: Other nursing tasks may be determined appropriate by the delegating nurse. Please also refer to the Washington State Board of Nursing for updated law and rule.

Tasks that are **prohibited by RCW and WAC** from being delegated are:

- Administration of medications by injection (by intramuscular, intradermal, subcutaneous, intraosseous, intravenous, or otherwise) with exception of insulin injections.
- Sterile procedures
- Central line maintenance
- Anything that requires nursing judgement.

To assist with decision making, the Washington State Board of Nursing has a delegation decision-tree. WAC 246-840-940 Washington state nursing care quality assurance commission community-based and in-home care setting delegation decision tree.

ELIGIBILITY FOR DELEGATION SERVICES

For delegation to occur, **clients must be assessed as stable and predictable by the delegating RN** and reside in an approved Home and Community Based setting.

Criteria for Delegation

- Stable and predictable condition means a situation in which the individual's clinical and behavioral status is known and does not require the frequent presence and evaluation of a registered nurse. RCW 18.79.260(3)(e)(iii)
- The Client can then possibly receive RN delegation for the LTCW to perform the skilled nursing task.
- Clients with medical conditions that are stable and predictable may receive nurse delegation if they reside in the following settings:
    - Their own home
    - Licensed Adult Family Homes (AFH).
    - Licensed Assisted Living Facilities (ALF); *or*

- Community residential programs for people with developmental disabilities, certified by DSHS.

See AUTHORIZING PAYMENT section *Who Can Delegate* for details.

- Before a client can receive delegation, you must determine that the client:
  a) Has an "unmet" or "partially met" need for a skilled task (per CARE) such as medication management, and either:
     a. Lacks the informal support to provide the delegated task, *or*
     b. Is unwilling or unable to self-direct their care.
  b) See Chapter 3
- Resides in an approved community setting; ***and***
- Medicaid Care Services (MCS) and State Funded LTC for Non=Citizens receiving personal care under the state-funded programs can also receive RND services. *See Chapter 7g.*

  – Community First Choice (CFC)
  – CFC + Community Options Program Entry System (COPES)
  – Roads to Community Living (RCL)
  – New Freedom
  – Residential Support Waiver (RSW)
    - ALTSA only pays for ND if the client lives in an AFH.
  – Developmental Disability Administration (DDA) Services
  – MAC/TSOA

CASE MANAGER RESPONSIBILITIES

**If a nursing referral is not triggered in CARE, the case manager CAN use their professional judgement to MAKE a referral if the circumstances warrant a nurse consultation.

CARE Documentation

General

- Identify the client's "unmet" or "partially met" need(s) for a skilled nursing service.
- Document need for RN Delegation in CARE or GetCare. LTC Manual Chapter 3 Assessment and Care Planning.

- If there is NO delegator available, the LTCW cannot perform the delegated task and a plan for the accomplishment of the task from an informal support is required.
- A temporary Plan of Care must be developed if the LTCW does not have the appropriate training and credentials. This temporary plan must be put in place until the LTCW has completed all the requirements.
- If nurse delegation is in place, identify Nurse Delegation and IP or Agency as providers in the *Treatment* Section of the medical screen and assign the nurse delegator and paid personal care provider(s) to the task on the *Supports* screen. For medication management, assign the nurse delegator and paid personal care provider(s) on the *Supports* screen.
- When selecting providers from the Provider List in the Treatment screen, select all relevant future providers including the Nurse Delegator. Per the Assessor's Manual 39.1.2 - "This is done so that the care plan specifically indicates how the individual's ongoing care needs will be met."
- For treatments, if nurse delegation is not yet in place, identify Nurse Delegation and IP or Agency in the *Treatment*s section as providers and add a comment that the task will be delegated when the provider completes the training. Indicate in the comments section that delegation is being set-up but is not yet in place.
- For medication management, if nurse delegation is not yet in place, state in the Comments box that the task will be delegated when the provider completes the training. Indicate in the comments section that delegation is being set-up but is not yet in place.
- In the meantime, if the treatment/medication management is being performed by an informal provider, identify the informal provider on the *Supports* screen and assign the task. Reassign the task to the delegating nurse and paid provider after the IP and/or agency provider has completed the Nurse Delegation training. See LTC Manual Chapter 11 Consumer Directed Employer
- For transferring a case, if delegation is in place at the time of transfer, the receiving agency is not required to do a reassessment unless the client's condition and needs have changed or unless the annual reassessment is due.

Service Episode Record (SER)

- Document **all** communication with the RND (this is important for billing and tracking), to include:
  - Referrals, when sent and when returned.
  - Referrals for the Skin Observation Protocol
  - Phone calls and/or emails
  - Changes in client's condition

- Client's authorized representative changes (or their contact information)
- Financial eligibility changes

Medication Screen

- Select "must be administered."
- If applicable, indicate which medication is delegated.
- If applicable, indicate which medications do not require delegation.

Treatment Screen

- Select provider type who will be performing the delegated task for the temporary plan of care.
- Indicate that the LTCW is providing the delegated task and describe the treatment being provided.
- Indicate the provider for each treatment being provided.

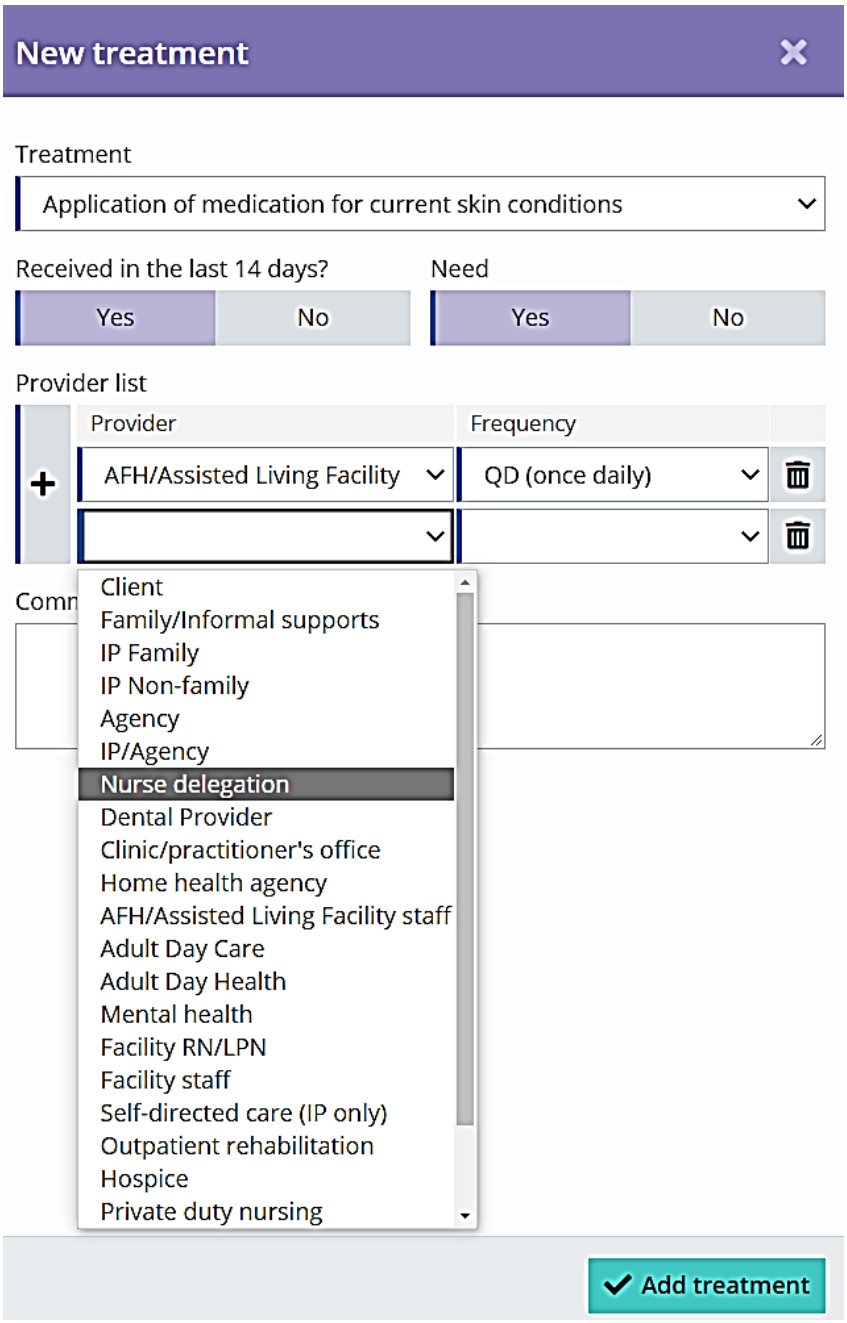
Supports Screen

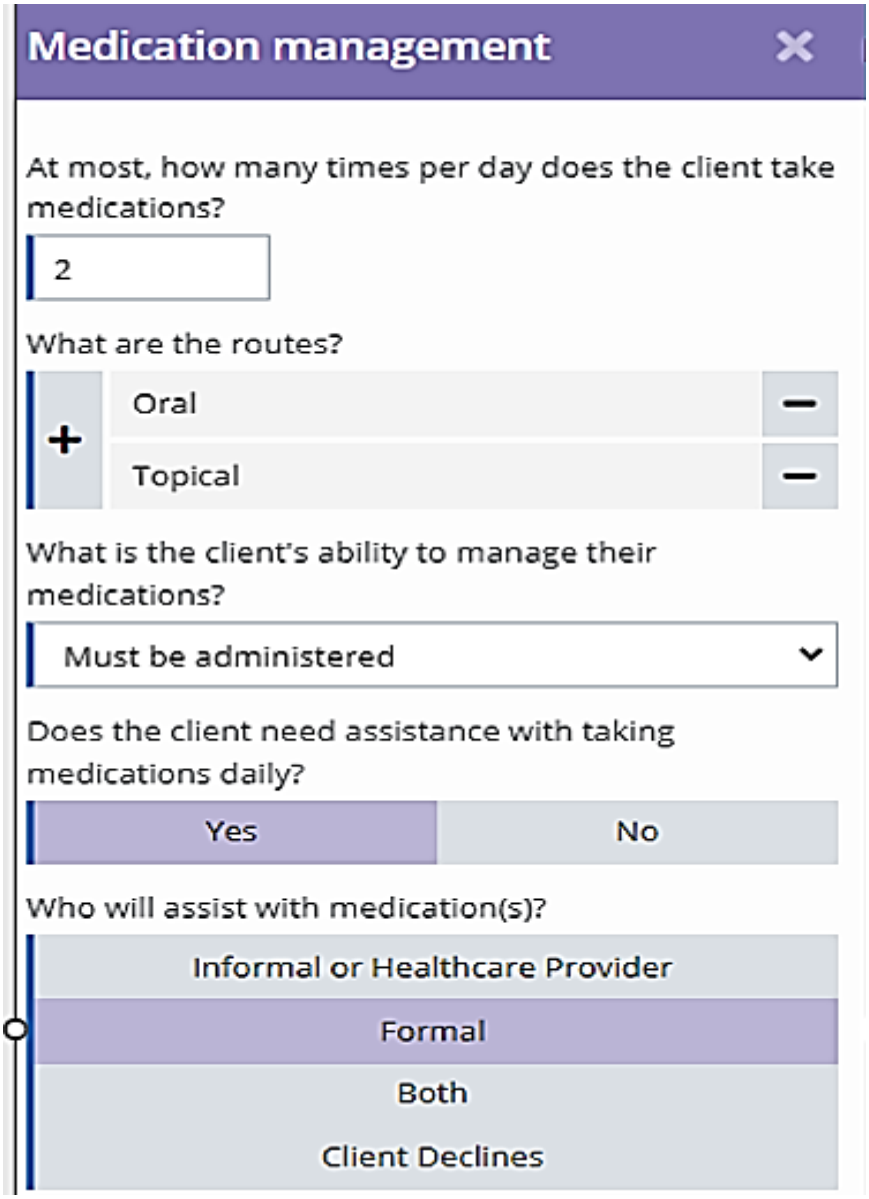
- If the treatment/medication management is being performed by an informal provider, identify the informal provider on the *Supports* screen and assign the task. Reassign the task to the delegating nurse and paid provider after the IP and/or agency provider has completed the Nurse Delegation training. See LTC Manual Chapter 11 Consumer Directed Employer.

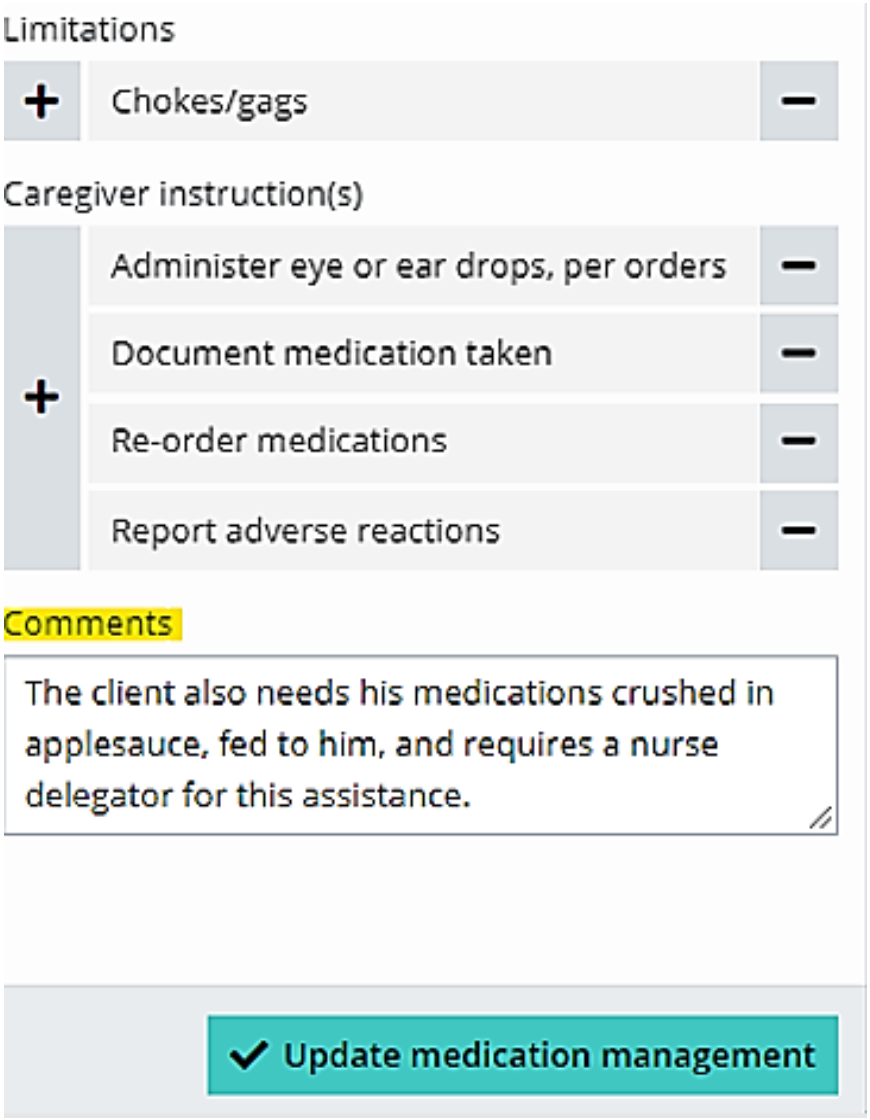
ADDITIONAL RESOURCES

- LTC Manual Chapter 11 Consumer Directed Employer.
- Care Web Help
- Chapter 8 Residential Services
- Chapter 7g State Funded Programs

Examples from CARE




Medication management
At most, how many times per day does the client take medications?
2
What are the routes?
Oral
Topical
What is the client's ability to manage their medications?
Must be administered
Does the client need assistance with taking medications daily?
Yes
No
Who will assist with medication(s)?
Informal or Healthcare Provider
Formal
Both
Client Declines



- Comments: This can remind why the client needs delegation and that one has been referred.

GetCare Documentation for TSOA

- Ensure the medication management level of assistance coding in the most current NFLOC assessment is "must be administered" or "must be administered daily".
  - If neither of these are selected, then the care receiver is not eligible for ND services related to medication management.
- Document in a Progress Note that the Home Care agency confirmed their LTCW assigned to the client meets the ND training requirements. This would be the Agency Provider (AP).
- Add the RND's name and contact information to the Contacts section.
- Ensure the ND service has been included in the care plan including what task(s) are being delegated.
- Scan and upload the Nurse Delegation Referral and Communication Form 01-212 that was sent the RND into the client's Electronic File Cabinet.
  - Upload page 2 of this Referral form when the RND returns it to you with the results of the initial ND assessment.
  - Document all contacts with the RND in a progress note.

REFERRALS FOR NURSE DELEGATION

General timeframe Factors for Responding to All Nursing Referrals:

- Business Week Monday-Friday; Excludes Holidays and Weekends.
- Time Clock starts next business day. Example: Assessment Done Friday 5/1 (2 business days clock starts) Monday 5/4.
- All staff must make sure to manage the coverage to stay within timeline.
- A plan for the accomplishment of the nursing task by an informal support is required when there is not a formal support in place.

LTCW

- Ensure the LTCW has active credentials and training to be delegated.
  - For In-home clients:

- CDWA Chapter 11
- Agencies must ensure their employees meet all the appropriate credentials.

– Clients in an AFH or ALF: facility management is responsible for having staff already trained to provide delegated tasks when they accept a client who requires ND. (This may need to be confirmed prior to sending RN referral.

RN Delegator

- Contact a contracted RND, (preferably by phone for initial contact) to verify they are available and accepting new clients.
  - Contracted Nurse Delegators DSHS **Intranet** site;
  - Contracted Nurse Delegator DSHS **Internet** site
- Once verification has been obtained from the RND, authorize ND in CARE or GetCare and send a referral to the RND.
  - Make referral using Nurse Delegation Referral and Communication Form 01-212. It must include:
    - Authorization number
    - Client demographics
    - ACES ID #
    - Current CARE or GetCare assessment
    - Individual support plan (if applicable)
    - Positive behavior support plan (if applicable)
    - Consent Form 14-012 (Release of Information)

Nurse Delegation Referral Timeframe

- 2 business days - CM is required to make referral.
- 2 business days - Nurse is required to confirm receipt of the referral.
- 5 business days - Nurse will review file and reach out to client, family member(s) or POA/Guardian and make phone contact and home visit. *** **If the nurse is unable to make timeline, document all efforts and barriers, inform case manager supervisor, and make contact as soon as possible.**
- **10 business days** - Complete all documentation.

Skin Observation Protocol (SOP) Referral

Please refer to steps below:
When a client triggers the SOP during assessment/reassessment ***and*** there is currently and RND serving that client, send the a referral using the HCS/AAA Nursing Services Referral Form 13-776.

- The RND must use these forms and return to CM:
  - HCS/AAA Nursing Services Referral Form 13-776.
  - Basic Skin Assessment (13-780).
  - Pressure Injury Assessment and Documentation (13-783) (For each pressure injury assessed).

Nurse Delegator For HCS/AAA SOP/Nursing Triggered Referrals

In the situation where the Nurse Care Consultant (NCC) or RN Case Manager is unavailable, authorized staff may refer the Nursing Trigger – Skin Observation Protocol, to **any** available Contracted Nurse Delegator, who will address **all** other nursing triggers at the same time. All RNs are expected follow the listed timeframes for SOP. ** Please refer to DDA Policy 9.13 for DDA SOP referral

Staff will use this form to send a referral to the RND HCS/AAA Nursing Services Referral Form (#13-776)

- HCS/AAA Nursing Services Referral Form 13-776.
- Basic Skin Assessment (13-780).
- Pressure Injury Assessment and Documentation (13-783) (For each pressure injury assessed).

*Staff must ensure that you receive the above forms are received back in the specified timeframe.

➢ **Triggered Nursing Referral Timeframe SOP (ALTSA):** Chapter 24 Nursing Services

- 2 business days - CM is required to make referral.
- 2 business days - Nurse is required to confirm receipt of the referral.
- 5 business days - Nurse will review file and reach out to client, family member(s), or POA/Guardian and make phone contact. **** **If the nurse is unable to make timeline, document all efforts and barriers, inform case manager supervisor, and make contact as soon as possible.**
- 20 working days to make visit if necessary and complete documentation.
- **Total 29 working days**

- **Triggered Nursing Referral Timeframe (excluding SOP):**
  - 2 business days - CM is required to make referral.
  - 2 business days - Nurse is required to confirm receipt of the referral.
  - 10 business days - Nurse will review and use nursing judgment if phone contact and/or visit to client is necessary and will document all actions. ** **If the nurse is unable to make timeline, document all efforts and barriers, inform case manager supervisor, and make contact as soon as possible.**
  - 15 business days - Complete all documentation.
  - **Total 29 working days**

Authorizing Payment

Only RNs or Home Health agencies under Nurse Delegation contract with DSHS can be paid to provide ND services.

Assisted Living Facility

- Home and Community Services (HCS) will not pay an RN to delegate in a licensed ALF. The payment relationship for RN delegation is between the nurse and the ALF facility.
- If a licensed ALF also has a contract as a DDA Group Home, DDA may pay for ND services.

Adult Family Home

- RNs who own an AFH may also be paid for ND services in addition to their daily rate when they have a DSHS RN Delegation contract.
  **However, ALTSA will not pay an RN delegator to provide services in an Private Duty Nursing contracted AFH. That is considered a duplication of services.

Authorized Delegation Units

- RND is authorized for 100 units per month with P1 Service Code H2014 with Modifier U5 for the duration of the client's CARE plan. The system will allow you to authorize services for 1200 units for up to 12 months.
- If a client needs more than the maximum number of authorized units (100 u/month), the RND is responsible for requesting additional units through the Nurse Delegation Program Manager (NDPM). DSHS Form 13-893 Nurse Delegation: Request for Additional Unit. Once approved, the NDPM will notify CM and RND.

Note: For DDA clients, ND services may be provided to individuals served by certified community residential programs for the developmentally disabled. See DDA Policy 6.15

Transferring Cases

If the LTCW does not have the required credentials and training before you transfer the case, you must:

- Provide information to the LTCW on the training requirements and process.
- Encourage the LTCW to complete all requirements as soon as possible.
- Ensure a temporary plan of care is in place to meet the client's nursing needs until the LTCW has fulfilled the requirements.
- Communicate to the receiving agency the current plan and the future plan of the LTCW performing the delegated task once training has been completed and then document in SER that communication occurred (and method of communicating).

The receiving agency must monitor the training and registration process for the LTCW. After the LTCW's training and registration requirements have been met, the agency needs to send a referral to a contracted ND with the authorization for payment.

Note: These instructions do not pertain to MAC/TSOA cases.

Authorization of Nurse Delegation services; hospital or institutional

- When a client resides in or admitted to an institutionalized setting, the case manager may request a DSHS contracted Nurse Delegator to assess the client to determine the appropriateness of delegation and begin the delegation process.
- Services will be authorized under an ALTSA Recipient Aid Category (RAC) 3490 State Only Adjusted Payment (SOAP) or DDA RAC 3930 State Funded Community Support Services.

Authorization of Nurse Delegation services for a new client who is not currently on services

- Please follow steps below:
  1. We must use state only funds via ALTSA RAC 3490 State Only Adjusted Payment (SOAP) or DDA RAC 3930 State Funded Community Support Services to pay for nurse delegation services while client is in a hospital or institutional setting.

2. Add the RAC on the RAC eligibility screen with start/end dates that match the dates of service that the client is in the institutional setting.
3. Create a social service authorization for nurse delegation services.
4. Because the client does not yet have personal care or other community services the service line will generate the following error, #30115 "Nurse Delegation services can only be authorized with certain other service.
5. This error should be forced by the ALTSA Nursing Delegation Program Manager or the DDA case manager's s supervisor or a DDA Payment Specialist.

Authorization of Nurse Delegation services for an existing client

- Please follow steps below:

1. We must use state only funds via the ALTSA RAC 3490 State Only Adjusted Payment (SOAP) or DDA RAC 3930 State Funded Community Support Services to pay for nurse delegation services while client is in an institutional setting.
2. We will need to add the RAC and split the social service authorization to reflect the dates the client is not in a community setting.
3. Add a RAC on the RAC eligibility screen with start/end dates that match the dates of service that the client is in the institutional setting.
4. On the current nurse delegation authorization service line, complete the following:
    - Change the start date on the current service line to match the start date of the 3490/3930 RAC.
    - Change the end date on the same service line to match the end date of the 3490/3930RAC.
    - Change the number of units to reflect the units approved for the time client is in the institutional setting.
    - Enter a comment.
    - Hit "Submit." By changing the start date, end date, and the units the service line will split resulting 3 service lines; 1 service line will be for dates prior to institutional admission, dates during admission, and dates after discharge.
5. Because the client is not eligible for community services like personal care while in an institutional setting, the service line should generate the following error: #30115 "Nurse Delegation services can only be authorized with certain other service."
6. This error should be forced by the ALTSA Nursing Delegation Program Manager or the DDA case manager's supervisor or a DDA Payment Specialist.

Splitting Social Service Lines in CARE

Examples

1) The client lives in a residential setting, and they were authorized nurse delegation services from 5/1/2023 to 12/31/2023. Client was admitted to the hospital on 9/4/2023 and will discharge 9/10/2023:

- Update RAC eligibility screen:
  - Change the end date on the residential RAC to 9/3/2023.
  - Add the 3490 or 3930 RAC for 9/4/2023-9/9/2023.
  - Add a new residential RAC with a start date of 9/10/2023 and an end date that matches the end of the plan period.
- Update the current nurse delegation authorization:
- Change the Start date to 9/4/2023.
- Change the End date to 9/9/2023.
- Update the Units to reflect what was approved during these dates.
  - By changing **both** date fields **and** another data field (like the units or reason code) this edit is going to result in **3** service lines**;** one line will end 9/3/23, 1 line will go from 9/4/23-9/9/23, and another line will start at 9/10/23 with an end date that matched the original end date. After the service line splits, you will want to update the approved units on each of the affected lines.
- Update the Reason Code
- Add a processing comment.
- Select the submit button.

2) The client lives in a residential setting, and they were authorized nurse delegation services from 5/1/2023 to 12/31/2023. Client was admitted to the hospital on 9/4/2023 and will discharge 9/10/2023. A bed hold was approved for 9/4/2023-9/9/2023 resulting in the RND service line ending 9/3/2023:

- Update RAC eligibility screen:
- Change the end date on the residential RAC to 9/3/2023.
- Add the 3490 or 3930 RAC for 9/4/2023-9/9/2023.
- Add a new residential RAC with a start date of 9/10/2023 and an end date that matches the end of the plan period.

- Create 2 new service lines for the RND service (complete the authorization service line reason code):
- Create 1 line that will match the dates of the SOAP RAC.
- Create another line that has a start date matching the new residential RAC and an end date that matches the end of the plan period.

DELEGATOR RESPONSIBILITIES

See "Nurse Delegation Forms" for full list of forms, titles, and how to access.

- Respond to DSHS/AAA staff within two working days of receiving referral. Sign and return Page 1, **DSHS Form 01-212 Nurse Delegation Referral and Communication**
- Verify the LTCW's have approved training and credentials to become delegated. **DSHS Form 10-217 Nurse Delegation Nursing Assistant Credentials and Training**
- Obtain consent using **DSHS Form 13-678 Pg 1 Nurse Delegation: Consent for Delegation of Nursing Tasks** from the client or the client's authorized representative to provide delegation.
- Assess the client and document findings, to ensure they are stable and predictable, and their overall care needs to determine whether delegation is appropriate for the specific situation and task. (DSHS does not have an approved assessment form, the delegating RN must use their own form to document assessment)
- Communicate the results within 5 business days of the initial assessment to the CM or NCC, utilizing page 2 of the **DSHS Form 01-212 Nurse Delegation Referral and Communication**.
- Complete **DSHS Form 14-484 Nurse Delegation Nursing Visit** at each nursing visit including LTCW training and observation.
- Teach the LTCW to perform the nursing task(s). Use form **DSHS 13-678 Pg 2 Nurse Delegation Instructions for Nursing Task**
- Assess and monitor the LTCW's performance and continued appropriateness of the delegated task(s) every **90 days** or more frequently as needed.
  - If the LTCW is delegated to administer insulin, the RND will assess the client and monitor continued competence of the LTCW. The frequency is determined by the RCW and WAC for Nurse Delegation. RCW 18.79.260 and WAC 246-840-930

  - The RND can determine to assess each LTCW more frequently if necessary.
  - Document using **DSHS Form 14-484 Nurse Delegation Nursing Visit**

- Document and perform all delegation activities as required by law, rule, policy, and contract.
- When rescinding ND, work with the CM/NCC, the client, and other identified parties; and
  - Nurse completes DSHS Form 13-680 Nurse Delegation Rescinding Delegation
  - WAC 246-840-960 states the registered nurse delegator may rescind delegation of the nursing task. The registered nurse delegator initiates and participates in developing an alternative plan for continuing the task. Please refer to WAC for more details.
- Respond as required to the CM request for the **Skin Observation Protocol** (Chapter 24) if currently serving the client.
- Report client changes in condition or needs to CM.
- Use ProviderOne for billing for documented services in a timely manner. Please use a billing tracker for records. May use DSHS Form 06-200 Nurse Delegation Billing
- Respond to ND Program Manager inquiries regarding billing, contract monitoring, and other concerns related to role performance.
  - The Program Manager is responsible for monitoring the nurse's contractual performance including communication, frequency of visits, documentation, and payments/billing.

CONSUMER DIRECTED EMPLOYER CHAPTER 11

1. **Individual Provider (IP)**
   - CM opens authorization to RN delegator and sends the RN the delegation referral form.
   - If the RN delegator approves nurse delegation with an IP, the CM will notify CDWA by phone/email.
   - CDWA will verify the IP(s) credentials/training & will notify the RND if all requirements are satisfied.
   - If IP lacks training, CDWA will initiate training process & notify the RND once the IP is trained.

2. **Agency Provider (AP)** may obtain their training through a DSHS agency approved community trainer. The Agency is responsible for ensuring the AP meets the requirements for delegation.

   Find a Training Class (DSHS)

   - Nurse Delegation 9 hours
   - Nurse Delegation – Diabetes 3 hours
   - Basic Training
   - Mental Health & Dementia Specialty

Training for Long-Term Care Worker (LTCW)

Basic Training

Includes one of the following:

a) Fundamentals of Care
b) Revised Fundamentals of Care
c) The 40-hour Basic Training is part of the HCA curriculum (HCA training is 75 hours)
d) In DDA Supported Living agencies, the DDA 32-hour training meets the Basic Training requirement up to January 1, 2016.

   - If employed after January 1, 2016, the 40-hour CORE Basic Training is required for all DDA SL employees.

Requirements

The LTCW must:

1. Have one of the following ACTIVE credentials from the Washington Department of Health per RCW 18.79.260:

   a) Nursing Assistant-Registered (NA-R)
   b) Nursing Assistant-Certified (NAC)
   c) Home Care Aid-Certified (HCA-C)

2. Complete the 9-hour "Nurse Delegation for Nursing Assistants" training in addition to the Basic Training
3. **PLUS,** the 3-hour "Special Focus on Diabetes" training if they will be administering insulin.
4. Provide proof of completing Basic Training:

- NAC or HCA-C: Assumed through state certification.
- NA-R: See Exempt or Non-Exempt Table

EXEMPT	NON-EXEMPT
If the LTCW worked 1 day from January 1, 2011, to January 6, 2012, they are exempt from taking the Basic Training. Needs to provide proof of working 1 day within this timeframe *and* provide their Basic Training certificate.	The LTCW is required to take the 40-hour Basic Training if: • They did not work 1 day January 1, 2011, to January 6, 2012, *or* • Is unable to provide proof of employment *and* their Basic Training certificate. A non-exempt NA-R must be dually credentialed until passage of the Prometric test. Upon passing the test, the NA-R credential does not need to be renewed annually. Only the HCA-C credential needs to be renewed annually.

RELATED RCWS AND WACS

RCW 18.79	Nursing Care
RCW 18.79.260	Activities Allowed – Delegation of Tasks
RCW 18.88A	Nursing Assistants
RCW 74.39.050	Self-Directed Care (Individuals with functional disabilities)
WAC 246-840	Practical and Registered Nursing
WAC 246-840-910	Delegation of Nursing Tasks to Nursing Assistants or Home Care Aides
WAC 246-840-930	Criteria for Delegation
WAC 246-840-940	Delegation Decision Tree
WAC 246-335-420	Home Care Agency Delivery of Services
WAC 246-945	Medication Assistance
WAC 246-980-010-990	Home Care Aide Rules

WAC 388-71	Home and Community Services and Programs
RCW 74.39A.250	Individual Provider
WAC 388-76	Adult Family Home Minimum Licensing Requirements
WAC 388-78A	Assisted Living Facility Licensing Rules
WAC 388-112A	Residential Long-Term Care Services Training
WAC 388-106	Long-Term Care Services
WAC 388-106-0300	Services Provided Under COPES
WAC 388-106-1900	Services Provided Under MAC and TSOA
WAC 388-110	Contracted Residential Care Services
WAC 388-112A	Residential Long-Term Care Services Training

ACRONYMS

AFH	Adult Family Home
ALF	Assisted Living Facility
ALTSA	Aging and Long Term Support Administration
CFC	Community First Choice
CM	Case Manager
CNC	Community Nurse Consultant
COPES	Community Options Program Entry System
DDA	Developmental Disability Administration
DOH	Department of Health
DSHS	Department of Social and Health Services
HCA-C	Home Care Aide Certified
IP	Individual Provider
LTCW	Long-Term Care Worker
MAC	Medicaid Alternative Care
NA-C	Nursing Assistant Certified
NA-R	Nursing Assistant-Registered
ND	Nurse Delegation
RAC	Recipient Aid Category
RCL	Roads to Community Living
RND	Registered Nurse Delegator
RSW	Residential Support Waiver

SEIU	Service Employees International Union
SER	Service Episode Record
TSOA	Tailored Supports for Older Adults

WEB RESOURCES AND FORMS

DSHS/ALTSA

Individual Providers - Home Care Aide Certification

Nurse Delegation Program

DSHS Contracted Nurse Delegator (internal)

DSHS Contracted Nurse Delegator (external)

ALTSA Long-Term Care Policy Manual

Department of Health (DOH)

Washington State Board of Nursing

WA State Credential Verification for RNs, LPNs, and ARNPs

Multistate (MSL) RN or LPN in another state use: Nursys.com

** Primary source verification of licensure for an RN or LPN practicing in Washington State with an out of state MSL is not available on the Provider Credential Search.

Nurse Delegation Forms:

DSHS Forms page:

01-212	ALTSA Nurse Delegation Referral & Communication Case/Resource Manager
06-200	Nurse Delegation Billing Form
10-217	Credentials and Training Verification
13-678 Page 1	Consent for Delegation Process (available in 9 languages)
13-678 Page 2	Instructions for Nursing Task
13-678A	PRN Medication

13-678B	Assumption of Delegation
13-680	Rescinding Delegation
13-681	Change in Medical Orders
13-893	Request for Additional Units
13-903	DDA Request for Additional Units
13-484	Nursing Visit

Legal Services

Chapter 14 Legal Services Program purpose is to provide information about elder rights and increase access to services provided for seniors. This is a required program under the Older Americans Act (OAA). Each state sets a minimum percentage of the Area Agencies on Aging (AAA) OAA, Title III-B budget for legal services. Washington State has set this percentage at 11%.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Caroline Wood ALTSA, Legal Assistance Developer
360.725.3466 caroline.wood@dshs.wa.gov

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BACKGROUND

Long-Term Care Manual Chapter 14, provides supporting procedures, processes, and resources to Area Agencies on Aging within Washington State required to provide Older American Act, Legal Service Programs.

LEGAL SERVICE PROCEDURES

Area Agencies on Aging contract with suitable legal services providers. The provider must meet the standards as set out in this chapter. The provider receives referrals from community agencies including AAAs, HCS and DDA field offices, case managers and Information and Assistance/Aging and Disability Resource Center (I&A/ADRC) providers. Appropriate referrals fit a priority area of law.

PRINCIPLES AND PROGRAM DEFINITIONS

The Legal Services Program provides access to the justice system by offering representation by a legal advocate (attorney, paralegal, or law student). The focus is on socially and economically needy older individuals who are experiencing civil legal problems. This service will often be the only way for these individuals to obtain trained legal help.

Legal problems must be within the priority areas that are established to reflect local needs. Legal Services Programs are to foster a cost-effective, high quality service that is integrated into the aging services network. Providers should develop and maximize the use of other available resources.

TARGET POPULATION

The target population is persons 60 years of age or older for OAA Title III B legal assistance.

The program should focus on those individuals with the greatest economic or social needs. Particular attention should be given to low-income, minority individuals, the rural elderly or older individuals with disabilities.

SERVICES PROVIDED

Nothing in this section or the program standards is intended to prohibit any attorney from providing any form of legal assistance to an eligible client, or to interfere with the fulfillment of any attorney's professional responsibilities to a client.

1. At a minimum, the following forms of individual legal assistance are provided:
    a) Legal advice;
    b) Brief legal services such as phone calls, letter writing, document review and drafting, or negotiation;
    c) Representation at administrative hearings;
    d) Representation in court;
    e) Referral to other legal resources.

2. The following optional services may also be provided:
    a) Education and training;
    b) Backup and training for the I&A/ADRC Program, Case Managers, and the Long-Term Care Ombudsman Program volunteers;
    c) Resource development designed to expand services. Resource development includes coordination with Legal Services Corporation (LSC) grantees, training private attorneys, and pro bono program development;
    d) Organizational representation of elder citizens' organizations, groups and coalitions who work on priority areas of the law and on issues and advocacy affecting low-income seniors.

PRIORITY AREAS OF LAW

Aging Network, HCS and DDA staff may refer cases to the Legal Services providers. Attorneys resolve cases based on a classification of the case or problem. Each provider may have a different system of classification, which may be based on the possible legal remedy or the local situation. What a non-attorney classifies as a housing problem may be classed by the lawyer or paralegal as a due process case.

It is important to provide the Legal Services screener with a concise, but detailed, set of facts to allow for a decision to interview for representation, or to refer the case, or to help make a referral to another, more appropriate resource.

As resources are limited, clients with problems in the locally preferred major categories must receive services before clients with problems in other categories.

1. Major Statutory Categories:
    a) Income Maintenance
    b) Health Care
    c) Long-term care
    d) Nutrition
    e) Housing
    f) Utilities
    g) Protective services;
    h) Defense of/from guardianship
    i) Abuse
    j) Neglect
    k) Age Discrimination

2. Statutory vs. Real Priorities and Abilities:
    a) Some statutory priority cases are not addressed by local legal services providers.

        One example is litigation of age discrimination cases which is costly and may be fee generating. Therefore, direct legal assistance providers should help identify causes of age discrimination and, where appropriate, refer older persons to other legal channels including the Equal Employment Opportunity Commission.

b) Similar situations exist with respect to abuse, neglect, financial exploitation and defense of guardianships.

In Washington State, the cost of an attorney to defend an alleged incompetent person in a guardianship case is paid for by the county. Abuse, neglect and financial exploitation are either fee generating or are handled by an Assistant Attorney General or local prosecuting attorney. Often, community education and establishment of referral sources will be more appropriate than litigation.

c) Fee generating cases are often hard to define and the legal services provider is best able to do this.

IDENTIFYING & REFERRING PEOPLE WITH LEGAL NEEDS

Some types of cases are easy to identify. Persons who are denied services need advice on how to proceed in filing or asking for a fair hearing. They may need substantive representation at the hearing. Evictions and utility shut-off cases require hearings, and may lead to negotiations with housing authorities or lawsuits.

Other cases are not so easy. Some people may want to apply for long-term care, but do not want to have a lien on their house. Someone may need help with the legality of caring for a grandchild or in dealing with the managed care provider.

The current best practice is to "over-refer" because of the changes in the legal services system.

Feedback from the provider as to appropriateness of the referral will allow refinement of the process over time. For certain types of cases there will be other resources in the local community. This process of referral and feedback may be set up as a formal system, or the referral source will ask for this feedback as referrals are made. The attorney can disclose that a referral is appropriate or that a different referral would be more appropriate, but the substance of the case often cannot be discussed.

- Example: If your community has a strong elder law section of the bar or a strong estate planning group then questions pertaining to gifts and asset planning can and should be referred to them. However, there may be a benefit to having groups such as the Northwest Justice Project (NJP) make these referrals. The community may receive pro bono services for certain clients or the attorney may be better able to classify the case. Most attorneys are willing to answer questions about how they do referrals and what they need from a referral source.

Ongoing regular informal communication between the AAA and the legal services provider must occur to ensure awareness of the legal needs of the targeted population in the community and to ensure that the local priorities reflect local legal needs.

Making Referrals

Which agency should I make referrals to?

1. Legal Services in Washington State
    a) **Northwest Justice Project (NJP)**
    NJP has received the federal Legal Services Corporation (LSC) contract. As an LSC, NJP is the highest tiered provider of legal services meeting the federal guidelines and standards required to be recognized as Washington State's LSC. NJP provides intake services and screening statewide.

    By making referrals to the local NJP the client will either be helped by their staff or sent on to the appropriate office. This may be pro bono work; or regarding a fee generating case, to an attorney who will do the case without a retainer fee. This will allow efficient sorting of cases and easier access to services.

    Northwest Justice Project will be able to classify the problem, do some initial interviewing, and place the case with the most appropriate provider.

    Project CLEAR (Coordinated Legal Education, Advice and Referral)

    <u>Outside King County</u>

All Ages	Call 1-888-201-1014
For Seniors (age 60 and over)	Call CLEAR*Sr statewide 1-888-387-7111

    <u>Inside King County</u>

All Ages	Call 2-1-1
People facing foreclosure	Call 1-800-606-4819

    b) **Columbia Legal Services**
    Columbia Legal Services deals with all non-federal funding sources. In 2019 they changed their strategic focus away from older adults and OAA priorities. <u>In 2020, they will no longer be a contracted legal service provider.</u>

2. Most AAAs contract with Northwest Justice Project. Some AAAs still contract with providers other than Northwest Justice Project in their local areas.

How do I make a Legal Services referral?

1. Develop a concise statement of facts which you know or have been communicated by the client.
2. Call the local NJP office. Make an effort to do this while the client is present or have the client make the call. You may also give the information to the legal representative of the client.
3. Follow up by contacting the client or legal representative.

INTAKE/CASE HANDLING STANDARDS

Each legal assistance provider has to have procedures for the following:

1. Non-Acceptance of Cases: A procedure that determines the circumstances and criteria under which cases are not accepted. There must also be a means of communicating this non-acceptance to the client.

2. Case Acceptance: Providers must have a uniform written case acceptance process. This process includes consideration of the following criteria:
    a) Age
    b) Type of legal problem
    c) Priority of legal problem
    d) Minority or limited English-speaking status
    e) Fee generating possibilities
    f) Extent of legal expertise required
    g) Impact on present caseloads
    h) Urgency of problem
    i) Available alternatives

3. The provider should have criteria for emergency case acceptance.
    a) **Retainers:** Every client whose case is accepted for representation, signs and receives a copy of a retainer agreement which may be supplemented by a letter.

    b) **Grievance Procedure:** A grievance procedure must exist for individuals who believe they have been improperly denied service or who are dissatisfied with the legal assistance provided. The procedure is set up to attempt to resolve grievances at the lowest possible level.

RESOURCES

Rules and Policies

Older American's Act	Section 306 OAA, at 42 USC 3026 Older Americans Act Title III, Part B, Legal Assistance
Legal Assistance	45 CFR 1321.71

Federal

Administration for Community Living (ACL)	• Cultural Competency Resources • Toolkit for Serving Diverse Communities
Elder Abuse	• National Center on Elder Abuse • USC - Center on Elder Mistreatment Toolkit
Elder Law	• National Center on Law & Elder Rights • Justice in Aging
LGBTQ	• LGBT Aging Center National Senior Hotline 1-888-234-7243 or Help@LGBThotline.org • Inclusive Questions Guide 2016

State

Seniors	• Legal Voice - Handbook for Washington Seniors, Legal Rights & Resources (English) 2016 - Manual de la tercera edad en el estado de Washington (Spanish) 2016 • Washington Law Help Seniors 60+
Guardianship	• 11.88 RCW Guardianship • Alternatives to Guardianship • Family & Volunteer Guardian's Handbook How to be an Effective Guardian (2010)

- The Fundamentals of Guardianship The National Guardianship Association (NGA) NWJP 10-2012
- Guardian ad Litem Handbook 2015 edition
- Kinship Legal Support Resources and Information
- Legal Voice
  - Options for Grandparents and Other Nonparental Caregivers (English) 2017
  - Opciones para los abuelos y otros cuidadores que no son los progenitores (Spanish) 2018

General

- Latino/a Bar Association
  - Law Clinics (Espanol) on topics including Immigration, Family, Consumer & Finance (includes Creditor/Debtor issues), Landlord-Tenant Issues, Criminal, Personal Injury, and Employment
- Moderate Means Program (MMP)
  A state-wide, reduced-fee (lo-bono) lawyer referral service formed through a partnership with the Washington State Bar Association (WSBA) and the three law schools in Washington. MMP offers referrals in the areas of family, housing, and consumer law for those with household incomes between 200% and 400% of the federal poverty level.
- Northwest Justice Project (NJP)
  Legal Services Corporation grantee for Washington State
  - **Senior Legal Hotline (CLEAR*Sr)** 1-888-387-7111
  - Domestic Violence
  - Native American Unit
  - Community Outreach Materials *(available in English, Arabic, Korean, Russian, Somali, Spanish, and Vietnamese)*
  - Get Help (English), Chinese, Korean, Russian, Somali, Spanish, Tagalog, Vietnamese
- Washington Law Help
  - Resources in Multiple Language

Ombudsman

- Washington State Long-Term Care Ombudsman Program

Acronyms

AAA	Area Agencies on Aging
ADRC	Aging and Disability Resource Center
ALTSA	Aging and Long-Term Support Administration
DDA	Developmental Disabilities Administration
HCS	Home and Community Services
I&A	Information and Assistance
LSC	Legal Services Corporation
NJP	Northwest Justice Project
OAA	Older Americans Act

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
2/7/2020	Caroline Wood	1. Columbia Legal Services in King County is no longer contracted to serve OAA clients in 2020	HXX-XXX
10/23/17	Caroline Wood	1. General formatting updates for easier reading 2. Created clear Section Summary with integrated hyperlinks/bookmarks 3. Removed obsolete reference links to training tools 4. Added extensive Resource options for Legal Services to support aging services network, Older American Act priorities, target marketing, and language support options 5. Added new DSHS Legal Assistance Developer contact information while deleting obsolete contact information 6. Core content and structure remains unchanged	H17-078

APPENDIX

APPENDIX A: Northwest Justice Project – Washington State Office Location

SEATTLE - MAIN OFFICE (King)
401 Second Avenue S, Suite 407
Seattle, WA 98104
206-464-1519

1-888-201-1012
Fax: 206-624-7501
Client Intake - call 211

ABERDEEN (Grays Harbor & Pacific)
218 N. Broadway, Suite 1
Aberdeen, WA 98520
360-533-2282
1-866-402-5293 toll free
1-888-201-1014 (CLEAR - Client Intake)
Fax: 360-533-2932

BELLINGHAM (Whatcom, Skagit, San Juan, Island)
1814 Cornwall Avenue
Bellingham, WA 98225
360-734-8680
1-800-562-8836
1-888-201-1014 (CLEAR - Client Intake)
Fax: 360-734-0121

BREMERTON - Satellite Office
216 6th Street
Bremerton, WA 98337
360-377-6378
Fax: 360-377-6385

COLVILLE - Satellite Office
132 West 1st Avenue
Colville, WA 99114
509-684-7652
1-800-303-7050
Fax: 509-684-4541

EVERETT OFFICE (Snohomish)
2731 Wetmore Avenue, Suite 410
Everett, WA 98201
425-252-8515
1-888-201-1017
1-888-201-1014 (CLEAR - Client Intake)
Fax: 425-252-5945

KENT - Satellite Office
124 4th Avenue S, Suite 240
Kent, WA 98032
253-480-6125
1-855-682-0795
Fax: 253-852-6050

LONGVIEW (Cowlitz & Wahkiakum)
1338 Commerce Avenue, Suite 210
Longview, WA 98632
360-425-1537
1-866-402-7971
1-888-201-1014 (CLEAR - Client Intake)
Fax: 360-578-0241

OLYMPIA (Thurston, Mason, Lewis)
711 Capitol Way S., Suite 704
Olympia, WA 98501
360-753-3610
1-888- 212-0380
1-888-201-1014 (CLEAR - Client Intake)
Fax: 360-753-0174

OMAK - Satellite Office
28 N. Main Street [alley entrance]
P.O. Box 3569
Omak, WA 98841
509-422-2345
Fax: 509-422-2866

SPOKANE (Spokane, Whitman, Lincoln, Ferry, Pend Orielle, & Stevens)
1702 W. Broadway
Spokane, WA 99201
509-324-9128
1-888-201-1019
1-888-201-1014 (CLEAR - Client Intake)
Fax: 509-324-0065

TRI CITIES (Benton, Franklin, Walla Walla, Columbia, Garfield, & Asotin)
1313 N. Young Street, Suite D
Kennewick, WA 99336
509-547-2760
1-800-310-6076
Fax: 509-547-1612

WALLA WALLA - Satellite Office
38 E. Main, Suite 207
Walla Walla, WA 99362
509-525-9760
1-800-289-0581
1-888-201-1014 (CLEAR - Client Intake)
Fax: 509-525-9895

YAKIMA (Yakima & Kittitas)
311 N. 4th Street, Suite 201
Yakima, WA 98901
509-574-4234
1-888-201-1018
1-888-201-1014 (CLEAR - Client Intake)
Fax: 509-574-4238

PORT ANGELES (Clallam & Jefferson)
1020 Caroline Street
Pt. Angeles, WA 98362
360-452-9137
1-866-402-4452
1-888-201-1014 (CLEAR - Client Intake)
Fax: 360-452-4053

TACOMA (Pierce & Kitsap)
715 Tacoma Avenue South
Tacoma, WA 98402
253-272-7879
1-888-201-1015
1-888-201-1014 (CLEAR - Client Intake)
Fax: 253-272-8226

VANCOUVER (Clark, Klickitat, & Skamania)
500 W. 8th, Suite 275
Vancouver, WA 98660
360-693-6130
1-888-201-1020
1-888-201-1014 (CLEAR - Client Intake)
Fax: 360-693-6352

WENATCHEE (Chelan, Douglas, Okanogan, Grant, & Adams)
300 Okanogan Avenue, Suite 3A
Wenatchee, WA 98801
509-664-5101
1-888-201-1021
1-888-201-1014 (CLEAR - Client Intake)
Fax: 509-665-6557

APPENDIX B. Map of Civil Aid Legal Providers

Communicating with Individuals with Limited English Proficiency (LEP) or Sensory Disability (SD) in Medicaid Programs – Guidance for AAA staff

The purpose of this chapter is to explain requirements to communicate effectively with persons who do not or have limited ability to speak, read, write, or understand English ensuring equal access to Aging and Long-Term Support Administration (ALTSA) administered Medicaid services and programs and to describe language assistance services and explain how to use them.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Linda Garcia Language and Disability Program Manager
360.968.9745 linda.garcia1@dshs.wa.gov

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AUTHORIZING SOURCES

Title VI of the Civil Rights Act of 1964 42 U.S.C. § 2000d	https://www.justice.gov/crt/fcs/TitleVI-Overview
Americans with Disabilities Act (ADA) of 1990 42 U.S.C. chapter 126	https://www.ada.gov/pubs/adastatute08.htm
Title 34 CFR (Education) 104 and 45 (Public Welfare) CFR 84 Nondiscrimination on Basis of Handicap in Programs or Activities Receiving Federal Financial Assistance	https://www.federalregister.gov/documents/2017/01/03/2016-31236/nondiscrimination-on-the-basis-of-disability-in-programs-or-activities-receiving-federal-financial
RCW 49.60.030 Freedom from Discrimination	https://app.leg.wa.gov/RCW/default.aspx?cite=49.60.030
RCW 74 Public Assistance	https://app.leg.wa.gov/RCW/default.aspx?Cite=74
National CLAS Standards	https://thinkculturalhealth.hhs.gov/clas/standards
WAC 10-08-150	https://app.leg.wa.gov/WAC/default.aspx?cite=10-08-150
WAC 388-03	https://apps.leg.wa.gov/WAC/default.aspx?cite=388-03
WAC 388-271	https://app.leg.wa.gov/WAC/default.aspx?cite=388-271

IDENTIFYING APPLICANTS OR CLIENTS WITH LEP OR SD

AAA staff must identify clients' communication needs at the initial contact, during assessment and re-assessment interviews and:

- Inform or remind clients of their right to requests Language Access services,
- Document specific communication need of the client on the client demographics section of the appropriate application (CARE or GetCare) if applicable,
- If the client has a legal decision maker, AAA staff must document this in the client's electronic record. Include in documentation if the decision maker needs documents translated and into which language.

TYPES OF LANGUAGE ACCESS (LA) SERVICES AAA STAFF MUST PROVIDE

AAAs are expected to provide effective, equitable, understandable, and respectful quality care and services in a manner that is culturally and linguistically appropriate, recognizing different communication needs when communicating orally or in writing and using appropriate Language Access (LA) services or assistive technology.

Types of LA services for effective oral communication with clients:

1. Bilingual or Multilingual Employees providing direct services in needed language(s).
2. Contracted Interpreter Services:
   a. *Spoken Language Interpreter Services* in-person, over the phone (OPI) or video remote interpreting (VRI) technologies.
   b. *Sign Language Interpreter Services* in-person, video remote, or by using assistive technology devices.

Types of LA services for effective written communication with clients:

1. Contracted Translation Services into non-English languages.
2. Materials in Large Print.
3. Braille Transcription Services.
4. Audio Recordings of Written Materials.
5. Other – Closed or Open Captioning of videos; Communication Access Real-Time Transcription, Accessible websites, etc.

LA Services should be provided:

- at no cost to clients,
- in a timely manner,
- by qualified providers and be of high quality,
- in coordination with knowledgeable professionals – SMEs,
- in consideration of individual situation, and
- with cultural awareness and respect.

BILINGUAL OR MULTILINGUAL EMPLOYEES

AAA staff who provide direct services to clients in a language(s) other than English, including Sign Languages, must, at the minimum, demonstrate a proficiency through a process established by the AAA.

CONTRACTED INTERPRETER SERVICES

AAA staff must use interpreters when AAA bilingual staff cannot meet the language needs of the applicant/client.

Spoken Language or Sign Language Interpreter Services in-person, over the phone (OPI) or video remote interpreting (VRI) technologies

AAA can choose to use DES Master Contracts for:

- Interpreter Services, Over the Phone and Video Remote (currently #02819),
- Sign Language Interpreter ASL (currently # 02120 and # 03930) administered by the Office of the Deaf and Hard of Hearing (ODHH) of DSHS, or
- Develop their own contracts.

AAA must pay for all professional in-person and remote interpreter services – over-the-phone interpreting (OPI) or video-remote-interpreting (VRI) provided to the applicants or clients they serve.

Find DES Interpreter Services contracts here: https://apps.des.wa.gov/DESContracts/

Communicating with clients using spoken or sign language interpreter services:

1. Document the use of contracted interpreter services at every scheduled in-person encounter with the client.

2. Spoken language interpreters providing LA services to the clients must be certified, authorized, or recognized by DSHS Language Testing and Certification (LTC) program (WAC 388-03-30) and comply with the DSHS code of professional conduct (WAC 388-03-50.) Some languages of limited diffusion may not have DSHS certified/authorized professional interpreters. In these cases, the contracted interpreter agency must qualify these interpreters.

3. Sign Language interpreters providing LA services to the clients must maintain their certification through the Registry of Interpreters for the Deaf (RID) www.rid.org and comply with the Code of Professional Conduct.

4. Interpreter service is a purchased service and may not be authorized as a client service.

5. Applicants or clients with LEP or SD (Title XIX, MAC and TSOA) may secure, at their expense, the services of their own interpreter. This **does not** waive the AAA's responsibility to arrange and pay for a professional certified or authorized interpreter. AAA staff must **not allow** the following to serve as interpreters:
    a. Paid Individual Provider (IP) - to avoid possible conflict of interest;
    b. Children under the age of 18 years even if they are not a family member or relative.

6. Staff may use a family member or a friend of the client over the age of 18 in case of **emergency**. Family members and friends cannot receive payment for interpreter services.
    For the purposes of this chapter, emergency means "When no professional interpreter, or translator is available in or out of the state of Washington for a particular language, either in person, by video remote or telephonically and would cause an extensive delay in services for the applicant/client. Staff must document in CARE or GetCare the emergency use of an uncertified or unauthorized interpreter at every in-person interaction with applicant/client.

7. If staff use a family member/friend over the age of 18 to assist in communicating with the applicant or client, they must document in the client's electronic record:
    a. attempts to secure a professional interpreter;
    b. use of family member or friend to assist in communication; and
    c. for SD, use of other options for communication, such as Telecommunication Relay Services (TRS) 711 or 1-800-974-1548, Video-Remote Interpreting (VRI), or other assistive technology.

Note: AAA staff will not need special equipment when calling or receiving calls from individuals with SD. To learn more about TRS, please visit ODHH website page on Telecommunication.

CONTRACTED TRANSLATION SERVICES (WRITTEN MATERIALS)

AAA staff must provide written documents to clients with LEP or SD in the languages or formats clients can read and understand at no charge to the clients and without significant delay.

- AAA staff must not rely on family and friends for providing translation services.
- If the client with LEP or SD is illiterate or has cognitive limitations and has a formal or informal decision maker, AAA staff must provide documents in a language or a format that the decision maker can read and document it in the client's electronic record.
- If the client is illiterate and cannot read English or their primary language, AAA staff must document it in the client's electronic record and describe how staff obtained consent or required signature.

Translating client specific letters

AAAs can choose to use DES Master Contract– Translation Services-Written Word (currently # 04218), Category 5 Client Specific or develop their own contract. AAAs must pay for all professional translation services provided to the applicants or clients they serve.

Find DES Translation Services contract here: https://apps.des.wa.gov/DESContracts/.

Translating documents generated in the CARE and GetCare systems into foreign languages and getting those documents in Large Print (LP)

AAA staff must use the current ALTSA vendor for translations of CARE and GetCare system generated documents and follow the established process for requesting document translation into foreign languages or converting into Large Print (LP) format.

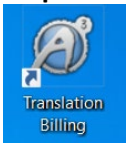
Use Translation-Billing EXE application generating secure email when requesting translated document(s) or needing document(s) in LP.

Step by step instructions for requesting CARE or GetCare documents in client's language or in LP:

Inside the Firewall:

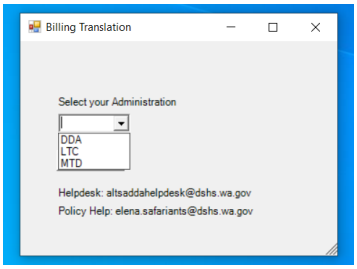
Step 1 - Create a separate PDF for each document needing translation, naming it according to the selection ("Planned Action Notice - PAN" or "Service Summary - SS" or "Assessment Details – AD", etc.) you make in the "Translation-Billing EXE" application; do not merge documents together and do not scan or ZIP (compress) them.

Step 2 – Find "Translation-Billing EXE" application.



This will be an icon on your desktop that can be loaded by your local IT staff.

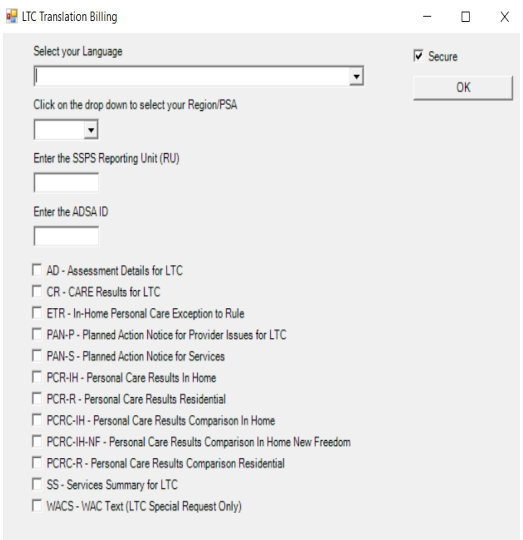
Step 3 – Run "Translation-Billing EXE" application for CARE or GetCare documents. Once launched, it will prompt you to identify information about your administration/program.

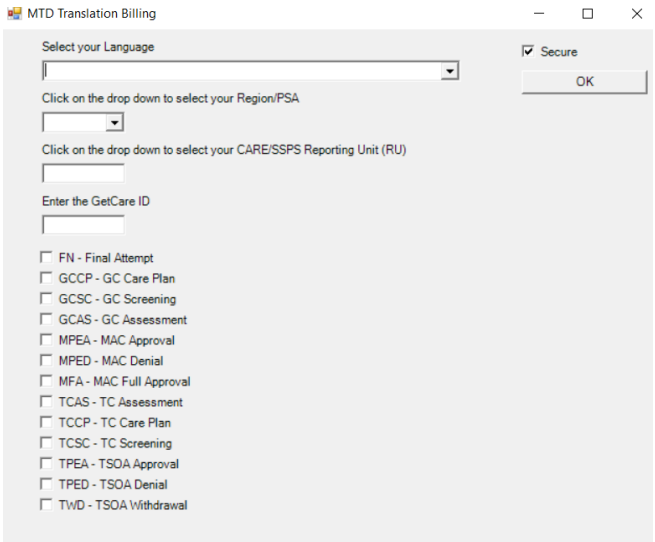


Step 4 - After making initial selection (LTC or MTD), the user will need to **enter** and **select** from the drop down list the following required data fields:

- Language Code
- Region/PSA
- Reporting Unit (RU)
- Client's ALTSA/CARE ID
- Document Type(s): Check the boxes corresponding to the document type(s) you need translated for each client. You must send a separate email for each client who needs translation of the documents. However, you may send multiple documents to be translated for a specific client in one email.

NOTE: If any of the fields are unfilled or filled with incorrect or extraneous information such as attached files do not match the file names in the "Subject" line, PDFs are not created directly from the CARE or GetCare system, etc., the vendor may decline your request for translation and request you resubmit it.





After completing all the data fields click OK; a secure e-mail will automatically be created, and time stamped with the filled "To" and "Subject" fields.

DO NOT CHANGE THESE E-MAIL FIELDS! The codes mean something to the contractor and help make the process more efficient.

Step 5 – In the body of the e-mail you may include special handling instructions or additional information such as the name of the language marked as OT (other) in the EXE application.

Step 6 – Attach the PDF document(s) for translation to the e-mail you created in Step 1 and properly selected in Step 4.

Step 7 – Pause and double check your translation request and then press "**Send**" from your E-mail system. Once you submit your request, your request cannot be changed.

Step 8 – The Contractor will acknowledge the receipt of your request and return the translated documents through the secure email.

NOTE: Make sure you do not send new translation requests in the same email chain of old requests.

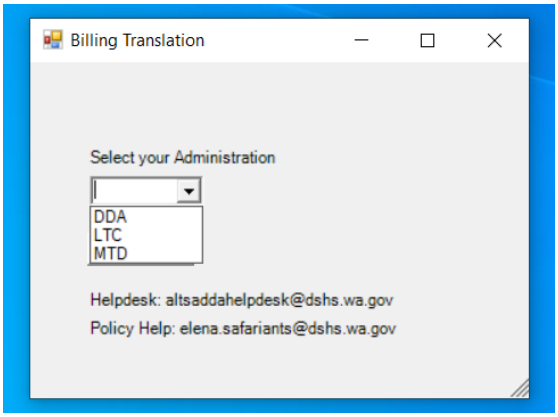
Outside the Firewall:

Step 1 - Create a separate PDF for each document needing translation, naming it according to the selection ("Planned Action Notice - PAN" or "Service Summary - SS" or "Assessment Details – AD", etc.) you make in the "Translation-Billing EXE" application; do not merge documents together and do not scan or ZIP (compress) them.

Step 2 – Find "Translation-Billing EXE" application.

This will be an icon on your desktop that can be loaded by your local IT staff.

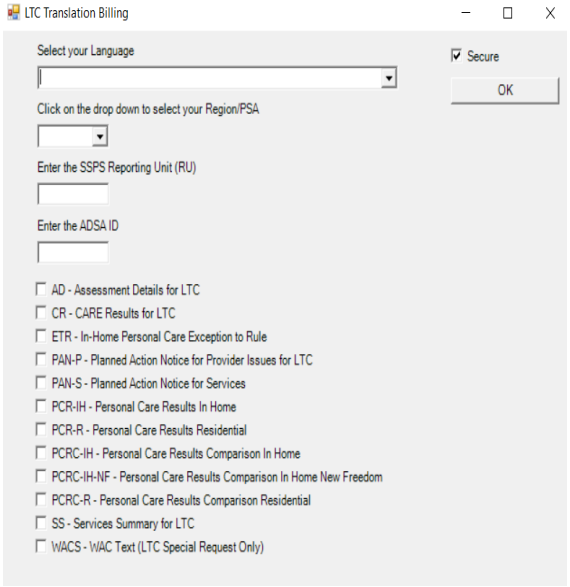
Step 3 – Run "Translation-Billing EXE" application for CARE or GetCare documents. Once launched, it will prompt you to identify information about your administration/program.

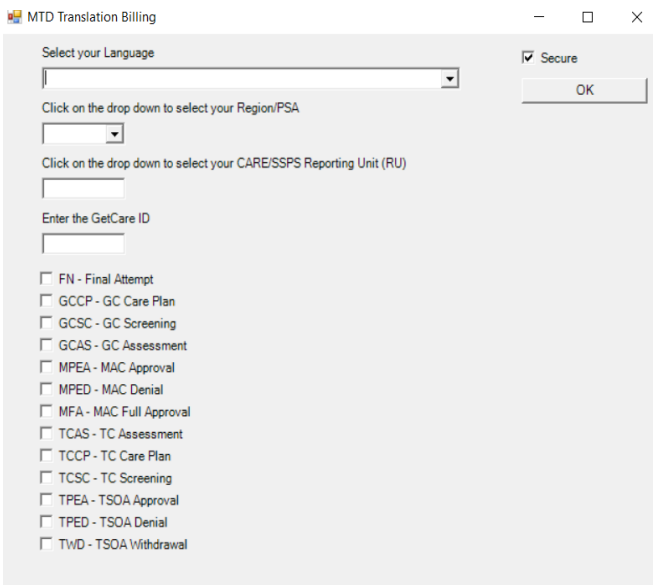


Step 4 - After making initial selection (LTC or MTD), the user will need to **enter** and **select** from the drop down list the following required data fields:

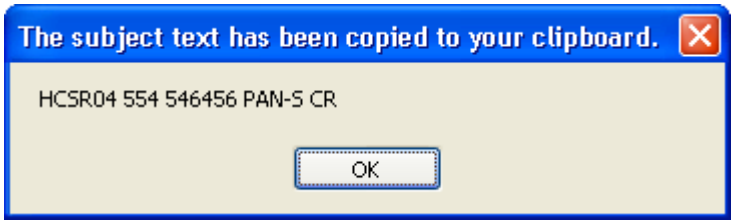
- Language Code
- Region/PSA
- Reporting Unit (RU)
- Client's ALTSA/CARE ID
- Document Type(s): Check the boxes corresponding to the document type(s) you need translated for each client. You must send a separate email for each client who needs translation of the document(s). However, you may send multiple documents to be translated for a specific client in one email.

NOTE: If any of the fields are unfilled or filled with incorrect or extraneous information such as attached files do not match the file names in the "Subject" line, PDFs are not created directly from the CARE or GetCare system, etc., the vendor may decline your request for translation and request you resubmit it.





Step 5 - After completing all the data fields, the following message will be displayed containing the data you just entered:



DO NOT CHANGE THESE E-MAIL FIELDS! The codes mean something to the contractor and help make the process more efficient.

If you have Outlook, it will also generate a new email message with the "To:" and "Subject:" lines completed. **Click "OK"**.

If you **DO NOT** have Outlook, take the following steps:

Step 6 - Access your e-mail system and

- create an e-mail addressed to wa.translations.2123@prisma.com;
- navigate to the subject line of this e-mail;
- press and hold the CTRL key and type the letter V. This will place the information that you completed in **Step 4** into the subject line of your e-mail.

Step 7 - Attach the document(s) for translation to e-mail and press "**Send**" from your agency's secure e-mail system.

Receiving your Translated CARE and GetCare Documents

When the Contractor has completed translation of your document, they will send a secure e-mail back. Open and save and/or print each documents individually.

Turnaround time frames for CARE and GetCare document translation

a. 4 business days for correspondence which requires keying-in or formatting of previously translated text in all languages.
b. 8 business days for correspondence which requires keying-in, formatting, and new translation.
c. 10 business days for 10 or more pages requiring keying-in, formatting, and new translation.

NOTE: Staff should only communicate with the Contractor using the Translation-Billing EXE application. Contractor will email case management staff through this system. Case management staff should follow up on job orders through the same email chain. This makes it easier for the Contractor to follow up and bill local offices correctly. Make sure you do not send new translation requests in the same email chain for old requests.

Paying for translation of CARE/GetCare/TCARE documents

Contractor will determine what requires translation and keying-in and will bill in accordance with the contractual agreement:

- DSHS/ALTSA will pay for the translation of the system's templates.
- AAA are responsible for the cost of translating the text inserted into the templates.

Sending translated CARE documents to Hub Imaging Unit (HIU)

When sending CARE documents to the Hub Imaging Unit (HIU) for the Document Management System (DMS), send English and translated versions of all documents together with the exception of documents listed below. These documents in English are stored in CARE; send only translated versions of:

- Assessment Details (*only send for translation if the client has requested a copy*);
- CARE Results (CARE Results are only sent when the PCR/PCRC does not print as part of the PAN. This should only occur for the New Freedom Program);
- Planned Action Notices for Providers and Services;
- Personal Care Results Comparison (PCR/PCRC) – In-home and Residential; and
- Service Summary not generated and stored in CARE*. (If the Service Summary record is not stored in CARE, send the English version along with the translated version to HIU).

NOTE: The English documents are the official versions, so to reduce risk of legal complaint, the client and/or representative with LEP must sign both the English and translated versions. The English and translated versions should always be sent to the client and/or representative with LEP at the same time and should be signed on the same date.[1]

Storing MAC and TSOA translated documents in GetCare File Cabinet

For MAC and TSOA programs, the translated version of documents must be stored in the client's GetCare electronic file cabinet. GetCare stores the English versions of system-generated documents.

Translating DSHS official forms, publications, and other general communication materials or getting those in Large Print (LP)

- Always check the DSHS Forms intranet and internet site to find translated forms by entering the DSHS form number, title, language needed, or program.
- For DSHS publications, check Publications Library to find already existent translations by entering DSHS publication number, program/topic, or language.
- Please check these sites periodically for the most current version of the documents for downloading, as documents undergo revisions.
- Please check ALTSA Translated Documents to find program documents not listed on the DSHS Forms website or in Publications Library.

[1] If using Voice Signature, see Voice Signature Script attachment in Chapter 3 Appendix.

- If you do not find the document in the needed language, you will need to initiate a new translation request. AAA designated staff will contact Linda Garcia at (360) 968-9745 or dshsaltsalep@dshs.wa.gov indicating the document number or name and the language(s) needed.
- DSHS/ALTSA will be responsible for payments on translations of DSHS forms, publications and program specific documents.

Best practice: Field staff should send translated documents at the same time as the English version to applicants/clients.

Materials in Large Print (LP)

Generally, LP documents have font size of 18 or 20 point. If the client needs DSHS forms, publications, and program specific documents in LP, please ask what size font is most convenient. You can request DSHS forms in LP by contacting Linda Garcia at dshsaltsalep@dshs.wa.gov.

If client needs CARE/GetCare documents (such as PANs, Care Plans, etc.) converted into LP, AAA staff may request LP the same way they request translations into foreign languages using Translation-Billing EXE application and choosing LP – Large Print from the dropdown list in "Select your Language" section.

Braille Transcription

For clients who are blind and read documents transcribed in Braille, submit the request by sending needed documents as attachments and indicating Braille Grade (1 or 2) via secure email to Linda Garcia at dshsaltsalep@dshs.wa.gov. DSHS/ALTSA will be responsible for payments.

The Contractor – WSSB Ogden Resource Center will send completed Braille transcription directly to the client along with the copy of the original document.

AAA staff will obtain the client's consent or required signature on the original document, as documents in **Braille cannot be photocopied or signed**. If the client has a guardian or DPOA, document that the guardian or person with DPOA discussed decisions related to client's care prior to obtaining a signature or receiving consent.

ALTSA ADA/LEP program manager will send an email to the requestor that will include:

- A statement that the text was transcribed into Braille and sent to the client;
- The date when the packet was mailed and UPS tracking number;
- A notification if the packet was returned as undeliverable and the date of the notification.

AAA staff will document this information in client's electronic record.

Documents in other alternate formats

If you need documents in other alternate formats (recordings, real-time transcriptions, etc.), please contact ALTSA ADA/LEP Program Manager, Linda Garcia at (360) 968-9745 or dshsaltsalep@dshs.wa.gov.

RESOURCES

https://www.lep.gov/

https://www.ada.gov/effective-comm.htm

Federal Register :: Nondiscrimination in Health Programs and Activities

Acronyms

AAA	Area Agency on Aging
AD	Assessment Details
ADA	Americans with Disabilities Act
ALTSA	Aging and Long-Term Support Administration
ASL	American Sign Language
AT	Assistive Technology
CARE	Comprehensive Assessment Reporting Evaluation
CFC	Community First Choice
COPES	Community Options Program Entry System
DES	Department of Enterprise Services
HIU	Hub Imaging Unit
IP	Individual Provider
LA	Language Access
LEP	Limited English Proficiency
LP	Large Print
LTC	Language, Testing and Certification
MAC	Medicaid Alternative Care
ODHH	Office of Deaf and Hard of Hearing
OPI	Over the Phone Interpreter
PAN	Planned Action Notice
PCR	Personal Care Results
PCRC	Personal Care Results Comparison
PSA	Program Service Area
RID	Registry of Interpreters for the Deaf
RU	Reporting Unit
SD	Sensory Disability
SS	Service Summary
TSOA	Tailored Supports for Older Adults
VRI	Video Remote Interpreter
WAC	Washington Administrative Code

Glossary

WORD	DEFINITION
Area Agency on Aging (AAA)	A unit of local or tribal government designated by the state to address the needs and concerns of all older persons at the regional and local levels.
Auxiliary Aids	Includes qualified interpreters, assistive listening systems (loop FM, and infrared), television captioning and decoders, video tapes, both open and closed captioned, TTYs, transcriptions, readers, taped texts, Braille, and large print materials. Any similar device or service needed to make spoken or aural (heard) language accessible is also considered an auxiliary aid.
Certified or Authorized Interpreter (for Spoken Languages)	A person who has passed the required DSHS interpreter examination, offered by DSHS Language Testing and Certification (LTC) program, or has passed a DSHS recognized interpreter examination offered by another organization.
Certified or Authorized Translator (for written documents)	A person who has passed the required DSHS written translation examination, offered by DSHS LTC, or has passed a DSHS recognized written translation examination offered by another organization.
Certified or Qualified Sign Language Interpreter	A person who obtained national interpreter certification (certified) by taking national performance and knowledge tests and/or has demonstrated ability (qualified) to interpret or transliterate effectively, accurately, and impartially, both receptively and expressively.
Client	A person who applies for, or receives, Medicaid LTSS services from DSHS.
Emergency	When no professional interpreter, or translator is available in or out of the state of Washington for a particular language, either in person, by video remote or telephonically and would cause an extensive delay in services for the applicant/client. Staff must document in CARE or GetCare the emergency use of an uncertified or unauthorized interpreter at every in-person interaction with applicant/client.
Interpretation	As used in this document, the transfer of an oral communication from one language to another.
Language Access (LA) Services	Describes services that agencies use to bridge the communication barrier with individuals who cannot effectively communicate in English. It's a full spectrum of oral, written, and assistive technology services available to ensure access to programs and services for population with limited English proficiency (LEP) or Sensory Disability (SD).
Limited English Proficiency (LEP)	A limited ability or inability to speak read and/or write English well enough to communicate effectively. Clients determine if they are limited in their ability to speak, read, write, or understand English. *This definition includes persons with sensory disabilities.*

Sensory Disability (SD)	A disability of the senses (e.g. sight, hearing, smell, touch, taste, spatial awareness), generally refers to disabilities related to hearing, vision, speech, or a combination (e.g. hard of hearing, deaf, partially sighted, or low vision and/or blind, deaf/blind, or physically unable to speak.)
Sign Language and Sign Systems	Visual or tactile ways of communicating thoughts, ideas, and feelings through American Sign Language or manual signs and gestures with specifically defined vocabulary.
Translation	The transfer of written communication from one language to another.
Primary/Preferred Language	The language that a client identifies as the language in which the person prefers to communicate verbally and/or in writing.
Written Communication	DSHS publications, Department forms and documents that: • Describe services, client's rights and responsibilities, or changes in benefits, eligibility or service; • Request information from a client, a response on the part of a client, or notify a client of an adverse action; or • Require a client's signature or informed consent.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
5/23/2025	Linda Garcia	• Moved chapter info to template with new DSHS logo & made general formatting changes. • Updated table of contents • Added ALTSA LEP email address to translating dshs forms, publications, etc. section • Added ALTSA LEP email address to Materials in Large Print Section • Added ALTSA LEP email address to Braille Transcription section • Added ALTSA LEP email address to Documents in Other Alternate Formats section • Replaced link under Resource section – Nondiscrimination in Health Programs • Moved Definitions into glossary • Added acronym section • Added Revision History	

Communicating with Individuals with Limited English Proficiency (LEP) or Sensory Disability (SD) – Guidance for ALTSA and DDA staff

The purpose of this chapter is to explain requirements to communicate effectively with persons who do not or have limited ability to speak, read, write or understand English ensuring equal access to services and programs administered by Aging and Long-Term Support Administration (ALTSA) and Developmental Disabilities Administration (DDA) and to describe language assistance services and explain how to use them.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Linda Garcia ALTSA Language and Disability Program Manager
360.968.9745 linda.garcia1@dshs.wa.gov

Jeff Flesner DDA Strategic Advisor Logistics, and Access Planning, Pro-Active Equity
360.890.0249 jeff.flesner@dshs.wa.gov

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AUTHORIZING SOURCES

Title VI of the Civil Rights Act of 1964 42 U.S.C. § 2000d	https://www.justice.gov/crt/fcs/TitleVI-Overview
Americans with Disabilities Act (ADA) of 1990 42 U.S.C. chapter 126	https://www.ada.gov/pubs/adastatute08.htm
Title 34 CFR (Education) 104 and 45 (Public Welfare) CFR 84 Nondiscrimination on Basis of Handicap in Programs or Activities Receiving Federal Financial Assistance	https://www.federalregister.gov/documents/2017/01/03/2016-31236/nondiscrimination-on-the-basis-of-disability-in-programs-or-activities-receiving-federal-financial
RCW 49.60.030 Freedom from Discrimination	https://app.leg.wa.gov/RCW/default.aspx?cite=49.60.030
RCW 74 Public Assistance	https://app.leg.wa.gov/RCW/default.aspx?Cite=74
National CLAS Standards	https://thinkculturalhealth.hhs.gov/clas/standards
WAC 10-08-150	https://app.leg.wa.gov/WAC/default.aspx?cite=10-08-150
WAC 388-03	https://apps.leg.wa.gov/WAC/default.aspx?cite=388-03
WAC 388-271	https://app.leg.wa.gov/WAC/default.aspx?cite=388-271
DSHS AP 7.20	OJCR - DSHS-AP-07-20.pdf - All Documents (sharepoint.com)
DSHS AP 7.21	OJCR - DSHS-AP-07-21.pdf - All Documents (sharepoint.com)
DSHS AP 18.82	OJCR - DSHS-AP-18-82.pdf - All Documents (sharepoint.com)

IDENTIFYING APPLICANTS OR CLIENTS WITH LEP OR SD

ALTSA and DDA staff must identify and document clients' communication needs at the initial contact, during assessment and re-assessment interviews and

- Inform or remind applicants/clients of their right to requests Language Access services at no cost to them and document it in electronic service record (e.g. Service Episode Record – SER);
- Document specific communication need of the client on the Client Demographics screen in CARE;
- If the client has a legal decision maker, ALTSA and DDA staff must document this in electronic service record. Include in documentation if the decision maker needs an interpreter and/or documents translated and into which language.

TYPES OF LANGUAGE ACCESS SERVICES ALTSA AND DDA STAFF MUST PROVIDE

All agencies receiving federal financial assistance are required to provide effective, equitable, understandable, and respectful quality care and services in the manner that is culturally and linguistically appropriate, recognizing different communication needs when communicating orally or in writing and using appropriate Language Access (LA) or Assistive Technology (AT) services.
Staff will use LA or AT services when establishing, implementing or monitoring a client's plan of care and communicating with a client and/or client's formal or informal support or decision makers with LEP or SD.

Types of LA and AT services for effective oral communication with clients:

1. Bilingual or Multilingual Employees providing direct services in needed language(s).
2. Contracted Interpreter Services:
   - *Spoken Language Interpreter Services* in-person, over the phone (OPI) or video remote interpreting (VRI) technologies.
   - *Sign Language Interpreter Services* in-person or by using video remote and other assistive technology devices.

Types of LA and assistive technology services for effective written communication with clients:

1. Contracted Translation Services into non-English languages
2. Materials in Large Print
3. Braille Transcription Services
4. Audio Recordings of Written Materials
5. Other – Closed or Open Captioning of videos; Communication Access Real-Time Transcription, Accessible websites, etc.

LA Services must be at no cost to clients and provided:

- In a timely manner;
- By qualified providers and be of high quality;
- In coordination with knowledgeable professionals – Subject Matter Experts (SME);
- In consideration of individual situation; and
- With cultural awareness and respect.

BILINGUAL OR MULTILINGUAL EMPLOYEES

ALTSA and DDA staff who provide direct services to clients in a language(s) other than English, including Sign Languages, must, at the minimum, demonstrate through the process established by DSHS:

- Their proficiency in English and 'target' language – a foreign or sign language employee intends to use when communicating with clients;
- Knowledge of frequently used terminology; and
- Cultural awareness and sensitivity.

The role of Bilingual/Multilingual employees is to work directly with and assist clients as required in their job description. Normally, bilingual/multilingual employees should not interpret or translate in a third-party capacity on a regular basis. They may periodically interpret or translate in non-client related situations, or in brief, emergent client-related situations.

For more details, see DSHS-AP-18-82.pdf

Currently, DSHS Language Testing and Certification (LTC) program is offering tests to all employees regardless of whether they are in a designated dual language position. Employees who wish to take tests simply need to contact LTC at dshsct@dshs.wa.gov to begin the process. If they would like to test using their work time, they will need their supervisor's permission; they can also test using their leave time if they wish – in this case, they do not need to get supervisor's approval. For additional information, visit Language Testing & Certification - Home (sharepoint.com).

CONTRACTED INTERPRETER SERVICES

ALTSA and DDA staff must use interpreters when:

- Applicant or client requested the LA service
- Establishing eligibility for services for client with LEP or SD
- Client with LEP or SD accesses services provided by ALTSA and/or DDA
- Necessary for Quality Assurance purposes

Staff must consider the availability of interpreter resources. Staff should consult with their administration's Language Access Advisor for assistance in determining the most appropriate method of verbal communication – in-person, over-the-phone (OPI), or video remote interpreting (VRI).

In-Person Spoken Language Interpreter Services

Staff must use interpreters for spoken languages who are certified, authorized, or recognized by DSHS Language Testing and Certification (LTC) program (WAC 388-03-30) and comply with the DSHS code of professional conduct (WAC 388-03-50). Some languages of limited diffusion may not have DSHS certified/authorized professional interpreters. In these cases, the interpreter services contractor must qualify these interpreters.

Applicants or clients with LEP or SD may secure, at their expense, the services of their own interpreter. This ***does not*** waive the ALTSA (HCS/APS/RCS) and DDA staff responsibility to arrange and pay for a professional (certified, authorized or recognized) interpreter.

Rules for communicating with clients using spoken language interpreter services

1. Document the use of contracted spoken language interpreter services at every encounter with the client.
2. Staff shall not authorize spoken language interpreter service as a client service. Interpreter service is a purchased service.
3. ALTSA and DDA staff shall **not allow** to serve as interpreters:
   - Paid Individual Providers (IP) - to avoid possible conflict of interest;
   - Children under the age of 18 years even if they are not a family member or relative.
4. Staff may use a family member or a friend of the client over the age of 18 in case of emergency. For the purposes of this chapter, emergency means "When no professional interpreter, or translator is available in or out of the state of Washington for a particular language, either in person, by video remote or telephonically and would cause the applicant/client an extensive delay regarding application or reauthorization of services". Family members and friends cannot receive payment for interpreter services.

5. If staff used a family member/friend over the age of 18 or other Language Access services or auxiliary aids to assist in communicating with the applicant or client, they must document the following in the client's electronic record:
   - Attempts to secure a professional interpreter;
   - Use of family member or friend to assist in communication; and
   - Use of other options for communication, such as OPI or VRI modalities.

Requesting Spoken Language In-Person Interpreter Services

1. Use current language access service contracts to request In-person interpreter services:
   a. HCA Interpreter Service contract K2474, currently **Universal Language Service (ULS)** DSHS must use the ULS on-line scheduling system to request interpreters and manage job requests - HCA Universal | Universal Language Services

   To request access to the ULS on-line scheduling system for **new Requesters,** contact your regional language access coordinator. Instructions on how to request a new requester account with ULS can be found in the Appendix.

   Available resources for Requesters provided by the Contractor:
   Requester Guides: https://hcauniversal.com/requester-guides/
   Requester FAQ: https://hcauniversal.com/requester-faq/
   Requester Training videos: Requester Webinars – HCAUniversal

   *To register you **organization** with Universal Language for interpreter services through the Washington State Health Care Authority (HCA) Interpreter Services (IS) Program, follow instructions at the following link - Provider Registration – HCAUniversal*

   b. DES Interpreter Service contract 06821 – Contractor, currently **Four Corners Translation, LLC**. Use on-line scheduling system to schedule In-Person interpreter services - https://stateofwa.interpretmanager.com/app/account/sign-in

   To request access to the Four Corners on-line scheduling system, contact your regional language access coordinator. The regional language access coordinator will send an email request to the ALTSA Language Access program manager, Linda Garcia (dshsaltsalep@dshs.wa.gov)

   The email should include the staff member's name, email address and the role (User or Requester Administrator) the staff member is to be assigned within the Four Corners system.

   Once the email is received, the new User will receive an email Invite to the Four Corners platform and must complete the Onboarding process as outlined in the Four Corners Platform Guide. **Staff should review the Onboarding process in the Four Corners User**

Guide BEFORE acting on the email Invite. The Invite is time sensitive and will expire after 24 hours. Additional resources for the Four Corners contract can be found on the Language Access SharePoint site. See Appendix for sample interpreter request.

NOTE: DSHS staff can choose to use either contract, as both the HCA contract **K2474** (ULS) and the DES contract **06821** (Four Corners) provide services following the guidelines of the Collective Bargaining Agreement (CBA). The Language Access Provider (LAP) CBA can be found at the following link: https://ofm.wa.gov/sites/default/files/public/labor/agreements/23-25/nse_lap.pdf

2. In the event the vendors, who provide CBA covered services, are unable to fill an interpreter request, staff should use DES Spoken Language Interpreter Services contract, currently #18222.
   a. To request pre-scheduled interpreter services from vendors under DES contract 18222, staff must complete form 17-123.[1]
   b. Staff will use form 17-123 as the request for services.[2] See **instructions** in Appendix.
   c. Vendors who have agreed to provide interpreter services under DES contract 18222 can be found on the DES contract summary page - https://apps.des.wa.gov/DESContracts/Home/ContractSummary/18222

3. If no DES vendor has language resources for an in-person appointment, DSHS staff can seek **off-contract** interpreter services providers.
   a. Use DSHS Form 17-123[3] for placing a request and complete "Documentation for Using Non-Contracted Vendors" form[4] to justify going off the contract.
   b. These forms serve as a backup documentation to invoices from vendors. Thoroughly complete each form and obtain required signatures.
   c. Give a copy of each form to your Business Manager and save a copy in the client file.
   d. Send copies of completed forms to ALTSA Language and Disability Program Manager at dshsaltsalep@dshs.wa.gov.

NOTE: Do not use these forms when using a family member or a friend of the client.

Sign Language Interpreter Services

Use Sign Language contracts administered by the DSHS/ALTSA Office of the Deaf and Hard of Hearing (ODHH). They oversee two sets of contracts:

[1] Check DSHS Forms site to ensure use of most current form.
[2] If choosing Four Corners do not use scheduling platform to request services under contract 18222.
[3] Check DSHS Forms site to ensure use of most current form.
[4] See document in Appendix.

1. Contracts for Sign Language Interpreter services are managed in partnership with Department of Enterprise Services (DES) for general requests.

2. Direct DSHS contracts for crucial/urgent appointments, in-person only.

See more information and request form links on the Sign Language Interpreter Request Links page.

1. Communicating with clients using ODHH Sign Language Interpreter Services contracts

a. Submit the appropriate form from the Sign Language Interpreter Request Links page. Make sure to provide all required information and as much detail as possible. This helps the contractor understand the specific need and book an appropriate interpreter or team. The interpreter will sign an online service verification form later. You do not need to sign this.
b. Sign Language interpreters providing LA services to the clients maintain their certification through the Registry of Interpreters for the Deaf (RID) www.rid.org and comply with the Code of Professional Conduct.
c. Document the use of the contracted Sign Language interpreter services at every encounter with the client in the client's electronic record.

If you have questions about **Sign Language Interpreter Services** contracts, contact: Berle Ross, Sign Language Interpreter Services Program Manager - (360) 339-4559, Email: berle.ross@dshs.wa.gov.

For more information about services available for individuals who are Deaf, Deaf-Blind, hard of hearing, Deaf and disabled, late-deafened, or speech disabled, please contact ODHH - Office of the Deaf and Hard of Hearing (wa.gov) or https://www.dshs.wa.gov/altsa/odhh

2. Calling or receiving calls from someone who has a SD

You do **not** need any special equipment when calling or receiving calls from individuals who are Deaf, Deaf-Blind, hard of hearing or speech disabled. Telecommunication Relay Service (TRS) uses operators, called communications assistants (CAs), to facilitate these telephone calls between people with hearing and speech disabilities and other individuals.

Please visit website of the ODHH to learn about how people who are Deaf, Deaf-Blind, hard of hearing, Deaf and Disabled, late-deafened, or speech disabled use different ways to make phone calls:
Telecommunications - https://www.dshs.wa.gov/altsa/odhh/telecommunication

Over the Phone and Virtual Remote Interpreter Services for spoken languages (OPI/VRI)

***Pre-Scheduled** language access needs*:

Use when…

a. DSHS staff are unable to procure an **In-Person** interpreter for a **pre-scheduled** appointment. Staff may use DES contract 06821 to request Over-the-Phone interpreter **(OPI)** or Video Remote Interpreter **(VRI)** services using the Four Corners platform *(see* Four Corners Platform Guide).
b. These services are to be used for **pre-scheduled** appointments only as outlined within the Collective Bargaining Agreement. For **On-Demand** service needs, please see below.

***On-Demand** language access*

Use when…

a. The individual with LEP needs urgent/emergent assistance;
b. A qualified in-person or OPI/VRI[5] interpreter is not available for a **pre-scheduled** appointment;
c. There are no qualified in-person or OPI/VRI* interpreters serving language(s) or dialect(s) needed.

Staff are also allowed to utilize On-Demand OPI services when they become aware within 24 hours before the start of a pre-scheduled appointment that a qualified in-person interpreter will not be available.

ALTSA and DDA employees have access to the On-Demand OPI resource through DSHS contracts with two Contractors:

- Language Link
- 911 Interpreters

Account codes/numbers have been set up for ALTSA APS, HCS, MSD/OAS, and RCS and for DDA with both vendors.

ALTSA and DDA staff **must not share** Account codes/numbers assigned for their individual region, division, section, or program with others. For information on rates, specific accounts and instructions on how to place a call, please contact:

- **ALTSA** – Linda Garcia, Language and Disability Program Manager (360) 968-9745, linda.garcia1@dshs.wa.gov
- **DDA** – Jeff Flesner, Strategic Advisor Logistics, and Access Planning, Pro-Active Equity

[5] DES contract 06821- OPI/VRI modalities

(360) 407-1581, jeff.flesner@dshs.wa.gov

CONTRACTED TRANSLATIONS SERVICES (WRITTEN MATERIALS)

ALTSA and DDA staff must provide written documents to the clients with LEP or SD in the languages or formats clients can read and understand at no charge to the clients and without significant delay.

- ALTSA and DDA staff must not rely on family and friends for providing translation services.
- If the client with LEP or SD is illiterate and cannot read English or their primary language, ALTSA and DDA staff must provide documents in a language or a format that the client prefers and document it in the client's electronic record. Staff must also document it in the client's electronic record how they obtained consent or required signature.
- If the client with LEP or SD has cognitive limitations and has a formal or informal decision maker, staff must provide documents in a language or a format that the decision maker can read and document it in the client's electronic record.

Translating DSHS official forms, publications, and other general communication materials (Categories 1-4) or getting those documents in large print (LP)

Always check the following:

- DSHS Forms intranet and internet site to find translated forms by entering the DSHS form number, title, language needed, or program.
- Publications Library to find already existent translations by entering DSHS publication number, program/topic, or language.
- ALTSA Translated Documents to find program documents not listed on the DSHS Forms website or in Publications Library.
- Voter Registration - Agency-based Voter Registration Forms | WA Secretary of State for availability of translated materials.

Please check these sites periodically for the most current version of the documents for downloading, as documents undergo revisions. If you do not find the document in the needed language, you will need to initiate a new translation request. You can request translation of DSHS Forms, DSHS Publications, and other general communication materials (materials other than DSHS forms or publications) by reaching to the following persons:

- **ALTSA** staff will contact Linda Garcia at (360) 968-9745 or dshsaltsalep@dshs.wa.gov
- **DDA** staff will contact Nikki Paulis at nichole.paulis@dshs.wa.gov or Dallas Hightower at (360) 407-1538 or Dallas.Hightower@dshs.wa.gov (backup)

Please indicate the document number, name and the language(s) needed.

Getting DSHS Forms in Large Print (LP)

If the client requires a DSHS form in Large Print (LP) English, please ask applicant or client what size of font is most convenient. In general, LP documents have font size of 18 or 20 point.

- ❖ You can request DSHS forms in LP by contacting Millie Brombacher at (360) 664-6048 or millie.brombacher@dshs.wa.gov

Best practice: All English and translated forms and publications (new or revised) must be posted on the Forms or Visual Communications websites at the same time. Field staff should send translated documents at the same time as the English version to applicants/clients.

Client Specific Translations

- To request translation of letters, notices, DSHS forms filled by client or staff, reminders, etc. please use DSHS Form 17-120.[6]

- Staff may send Translation Request and client specific documents needing translation to any of the four vendors listed in the "To:" section of form 17-120. See instructions in Appendix.

- **Remember** to add the word [secure] to the subject line of your email to protect client's information.

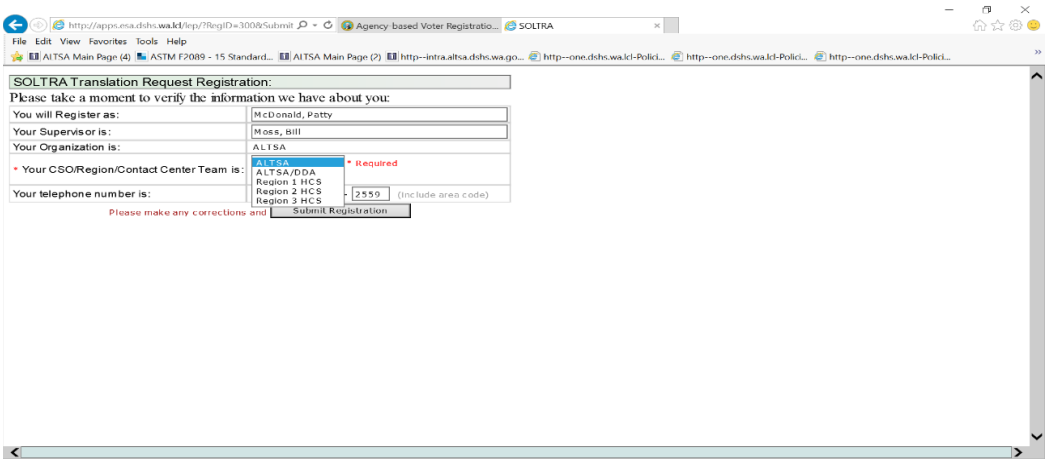
- Contact your Translation Coordinator if you have any questions regarding this category of translation work.

State Online Language Translation Request Application (SOLTRA) for ALTSA and DDA Financial Staff Only

SOLTRA Translation Application

This application, developed and maintained by DSHS/ESA IT staff, generates order forms, logs and tracks client specific translation requests completed by contracted vendors.
Only public benefit specialists (PBS) of ALTSA and DDA have access to this system. To request access for SOLTRA, contact: Linda Garcia at (360) 968-9745 or dshsaltsalep@dshs.wa.gov.

[6] Check DSHS Forms site to ensure use of most current form.



Translating documents generated in the CARE system into foreign languages and getting those documents in large print (LP)

ALTSA and DDA staff must use the current vendor for translations of CARE system generated documents and follow the established process for requesting documents translation into foreign languages or converting into Large Print (LP) format.
Use Translation-Billing EXE application generating secure email when requesting translated document(s) or needing document(s) in LP.

Step by step instructions for requesting CARE documents in client's language or in LP:

Step 1 – Create document PDF separately for each document needing translation, naming it according to the selection ("Planned Action Notice - PAN" or "Service Summary - SS" or "Assessment Details – AD", etc.) you make in the "Translation-Billing EXE";" application; do not merge documents together and do not scan or ZIP (compress) them.

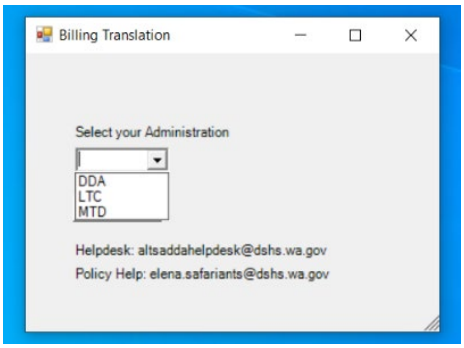
Step 2 – Find "Translation-Billing EXE" application.

This will be an icon on your desktop that can be installed by local IT staff or manually by:

1. Accessing the Software Center. Click the search field on your lower left task bar "**Type here to search**" and then type "**Software Center.**"

2. After entering the center, search for "**Translation Billing.**"
3. Click and install the application.

Step 3 – Run "Translation-Billing EXE" application for CARE documents. Once launched, it will prompt you to identify information about your administration/program.

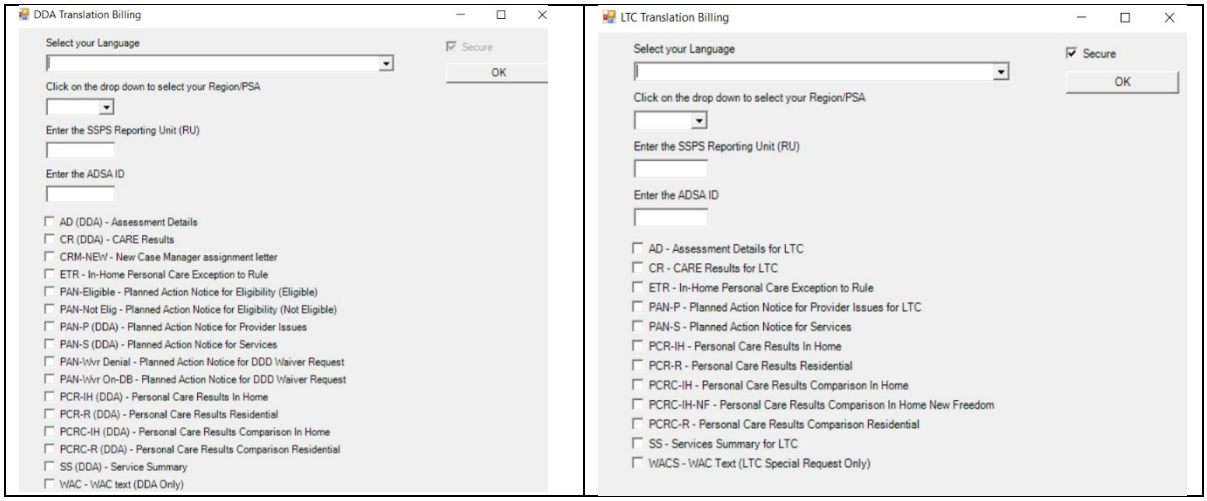


Step 4 – After making initial selection (DDA or LTC), you will need to **enter** and/or **select** from the drop down list the following required data fields:

- Language Code
- Region
- Reporting Unit (RU): You must know or find out about your Reporting Unit and **enter** or **select** it.
- Client's ALTSA/CARE ID
- Document Type(s): Check the boxes corresponding to the document type(s) you need translated for the client. You must send separate email for each client who needs translation of the documents.

NOTE: If any of the fields are unfilled or filled with incorrect or extraneous information, attached files do not match the file names in the "Subject" line, PDFs are not created directly from the CARE system, etc. the vendor may decline your request for translation and request you resubmit it.

DDA	LTC



After completing all the data fields click OK; a secure e-mail will automatically be created with the filled "To" and "Subject" fields.

> **NOTE: DO NOT CHANGE THESE E-MAIL FIELDS!** The codes mean something to the contractor and help make the process more efficient.

Step 5 – In the body of the e-mail you may include special handling instructions or additional information such as the name of the language marked as OT (other) in the "Translation-Billing EXE" application a duplicate file or modifications to a prior submitted request.

Step 6 – Attach the document(s) for translation to e-mail you created in Step 1 and properly marked in Step 4.

Step 7 – Pause and double check your translation request and then press "**Send**" from your E-mail system. Once you submit your request, your request cannot be changed.

> **NOTE:** You must communicate to Prisma of any submission mistakes or if you believe you might have submitted a duplicate request.

Step 8 – The Contractor will acknowledge the receipt of your request and send the translated documents by return email through the secure email of the "Translation-Billing EXE" application.

> **NOTE:** Make sure you do not send new translation requests in the same email chain of old requests.

Receiving your Translated CARE Documents

When Contractor has completed translation of your document, they will send a secure e-mail back. Open and save and/or print each documents individually.

Turnaround time frames for CARE documents translation

- 4 business days for correspondence which requires keying-in or formatting of previously translated text in all languages.
- 8 business days for correspondence which requires keying-in, formatting, and new translation.
- 10 business days for 10 or more pages requiring keying-in, formatting, and new translation.

NOTE: Staff should only communicate with the Contractor using the translation billing-"Translation-Billing EXE" application. Contractor will email ALTSA/DDA staff through this system. ALTSA/DDA staff should follow up on job orders through the same email chain. This makes it easier for the Contractor to follow up and bill local offices correctly. Make sure you do not send new translation requests in the same email chain for old requests.

Sending translated documents to Hub Imaging Unit (HIU)

When sending documents to the Hub Imaging Unit (HIU), ALTSA staff must send English and translated versions together of all documents with the exception of documents listed below. These documents in English are stored in CARE; send only translated versions of:

- Assessment Details (only send for translation if the client has requested a copy.)
- CARE Results (CARE Results are only sent when the PCR/PCRC does not print as part of the PAN. This should only occur for the New Freedom Program.)
- Planned Action Notices for Providers and Services.
- Personal Care Results Comparison (PCR/PCRC) – In-home and Residential; and Service Summary not generated and stored in CARE: If the Service Summary record is not stored in CARE, send the English version along with the translated version to HIU.

NOTE: While the English documents are the official versions, the client and/or representative with LEP must sign both the English and translated versions. The English and translated versions must always be sent to the client and/or representative with LEP at the same time and should be signed on the same date. [7]

[7] If using Voice Signature, see Voice Signature Script attachment in Chapter 3 Appendix.

Materials in Large Print (LP)

If the client needs any other than DSHS forms and CARE documents in LP, please ask what size of font is most convenient for the client to read. In general, LP documents have font size of 18 or 20 point.
You can request DSHS ALTSA and DDA documents in LP by contacting:

- **ALTSA** – Linda Garcia, dshsaltsalep@dshs.wa.gov
- **DDA** – Nikki Paulis @ nichole.paulis@dshs.wa.gov or
  Dallas Hightower @ dallas.hightower@dshs.wa.gov (backup)

Braille Transcription

For clients who are blind and read documents transcribed in Braille:

- **ALTSA** staff must place the request by sending needed documents as attachments and indicating Braille Grade (1 or 2) via secure email to Linda Garcia at dshsaltsalep@dshs.wa.gov.
- **DDA** staff must place the request by sending needed documents as attachments and indicating Braille Grade (1 or 2) via secure email to Nikki Paulis at nichole.paulis@dshs.wa.gov or Dallas Hightower at dallas.hightower@dshs.wa.gov. (backup)

The Contractor (WSSB Ogden Resource Center) will send completed Braille transcriptions directly to the client along with the copy of the original document.

ALTSA and DDA staff will obtain the client's consent or required signature on the original document, as documents in **Braille cannot be photocopied or signed**. If the client has a guardian or DPOA, you must document that the guardian or DPOA discussed decisions related to their care prior to obtaining a signature or receiving consent.

ALTSA Language and Disability program manager or **DDA** Translations Coordinator will send an email to the requestor that will include:

- A statement that the text was transcribed into Braille and sent to the client;
- The date when the packet was mailed and UPS tracking number;
- A notification if the packet returned as undeliverable and the date of the notification.

NOTE: Staff will document this information in client's electronic record.

Documents in other alternate formats

If you need documents in other alternate formats (recordings, real-time transcriptions, etc.), contact:

- **ALTSA** – Linda Garcia, LEP, ADA & Voter Registration Assistance Program Manager (360) 968-9745, linda.garcia1@dshs.wa.gov
- **DDA** – Jeff Flesner, DDA Language Access and Logistics Administrator (360) 407-1581, jeff.flesner@dshs.wa.gov

Tips for Working with Spoken and Sign Language Interpreters

Spoken and sign language interpreters are trained professionals bound by a code of ethics, which includes adherence to strict confidentiality. The interpreter is there to facilitate communication only and can neither add nor omit any information exchanged by communicating parties at any time. See Working with Spoken Language Interpreters and Working with Sign Language Interpreters in Appendix.

Documenting the use of language access services

Staff must document the use of contracted spoken language interpreter services and the use of translation services at every encounter with the client.

Best Practices:

a. If using interpreter services, best practice is to add the name of the language access vendor, the certified interpreter's interpreter ID number and/or interpreter's name to the client's case record.
b. If worker is a certified bilingual employee and is authorized to provide direct services to LEP, deaf, and/or deaf-blind clients is providing own interpretation, this should be noted in the case record.
c. When using written translation services, best practice is to document when form, publication or other communication materials were sent for translation, when translation(s) was received, when sent to client, when sent to Barcode, etc…
d. If using a friend or family member of the client due to an emergency situation, staff must document the following in the client's electronic record:
    - Attempts to secure a professional interpreter;
    - Use of family member or friend to assist in communication; and
    - Use of other options for communication, such as OPI or VRI modalities.

RESOURCES

Glossary

WORD	DEFINITION
Area Agency on Aging (AAA)	A public or private non-profit agency designated by the state to address the needs and concerns of all older persons at the regional and local levels.
Auxiliary Aids	Includes qualified interpreters, assistive listening systems (loop FM, and infrared), television captioning and decoders, video tapes, both open and closed captioned, TTYs, transcriptions, readers, taped texts, Braille and large print materials. Any similar device or service needed to make spoken or aural (heard) language accessible is also considered an auxiliary aid.
Certified or Authorized Interpreter (for Spoken Languages)	A person who has passed the required DSHS interpreter examination, offered by DSHS Language Testing and Certification (LTC) program or has passed a DSHS recognized interpreter examination offered by another organization.
Certified or Authorized Translator (for written documents)	A person who has passed the required DSHS written translation examination, offered by DSHS LTC, or has passed a DSHS recognized written translation examination offered by another organization.
Certified or Qualified Sign Language Interpreter	A person who obtained national interpreter certification (certified) by taking national performance and knowledge tests and/or has demonstrated ability (qualified) to interpret or transliterate effectively, accurately, and impartially, both receptively and expressively.
Client	A person who applies for, or receives, services from DSHS or AAA.
DSHS Certified Bilingual Employee	A DSHS staff member who has passed the required DSHS Bilingual Skills Test(s) or sign language evaluation and is authorized to provide direct services to LEP, deaf, and/or deaf-blind clients and employees.
Emergency	When no professional interpreter, or translator is available in or out of the state of Washington for a particular language, either in person, by video remote or telephonically and would cause an extensive delay in services for the applicant/client. Staff must document in CARE the emergency at every in-person interaction with applicant/client.
Interpretation	As used in this document, the transfer of an oral communication from one language to another.
Language Access (LA) Services	Describes services that agencies use to bridge the communication barrier with individuals who cannot effectively communicate in English. It's a full spectrum of oral, written, and assistive technology services available to ensure access to programs and services for population who are limited English proficient (LEP) or have Sensory Disability (SD).

Limited English Proficiency (LEP)	A limited ability or inability to speak read and/or write English well enough to communicate effectively. Clients determine if they are limited in their ability to speak, read, write or understand English. *This definition includes persons with sensory disabilities.*
Sensory Disability (SD)	A disability of the senses (e.g. sight, hearing, smell, touch, taste, spatial awareness), generally refers to disabilities related to hearing, vision, speech, or a combination (e.g. hard of hearing, deaf, partially sighted or low vision and/or blind, deaf/blind, or physically unable to speak.)
Sign Language and Sign Systems	Visual or tactile ways of communicating thoughts, ideas, and feelings through American Sign Language or manual signs and gestures with specifically defined vocabulary.
Translation	The transfer of written communication from one language to another.
Primary/Preferred Language	The language that a client identifies as the language in which the person prefers to communicate verbally and/or in writing.
Written Communication	• DSHS publications, forms and documents that: ○ Describe services, client's rights and responsibilities, or changes in benefits, eligibility or service; ○ Request information from a client, a response on the part of a client, or notify a client of an adverse action; or ○ Require a client's signature or informed consent.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
5/23/2025	Linda Garcia	• Moved chapter info to template with new DSHS logo and made general formatting changes • Updated SME titles and contact info for ALTSA and DDA throughout chapter. • Updated Table of Contents numbering • Moved definitions to glossary • Updated link to DSHS AP 18.82 under Bilingual or Multilingual Employee section • Under Requesting Spoken Language In-Person Interpreter Services section -Moved ULS New Requester Account document into Appendix and added text that document can be found in Appendix. -Changed email address for ALTSA Language Access program manager	

		-Updated link to new Language Access SharePoint site • Moved ALTSA Interpreter Request Example document to Appendix and added text to where document can be found. • Added section on DES contract 18222, Step by step instruction document added to Appendix, added link to DSHS form 17-123 • Added link to DSHS form 17-123 for Off Contract section, moved "Documentation for Using Non-Contracted Vendors" form to Appendix. • Sign Language Interpreters Services section – updated contract information, added new links for requesting sign language interpreters, updated current resource links. • Client Specific Translations – added links to DSHS Form 17-120, added instructional document to Appendix • Tips for Working with Spoken and Sign Language Interpreters – moved embedded documents to Appendix. • Added section on Documentation • Added Glossary • Added Revision History • Added Appendix	

APPENDIX

ULS - New Requester Account S

ALTSA Interpreter Request example - 8

DES 18222 - Instructions.pdf

Documentation for Using non-Contract

Client Specific Translation Request

Working with Spoken Language Ir

Working with Sign Language Interprete

Assistive Technology Program – State Only Fund

Chapter 16 describes how we provide financial assistance for assistive technology services and devices for adults who are eligible for:

- Adult Protective Services
- Older Americans Act programs
- Waiver services

These adults have **no other funding source** for the assistive technology request and live at home or in other settings.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Linda Garcia Assistive Technology Program Manager
360.968.9745 linda.garcia1@dshs.wa.gov

TABLE OF CONTENTS

POLICY OVERVIEW

It is the Aging and Long Term Supports Administration (ALTSA) policy that the state-funded services under this program be consumer-driven and demonstrate respect for the rights of persons with disabilities to live as safely and independently as possible in their own community. **State Funds for this program are limited per fiscal year.**

Program funds cover expenses for assistive devices and services, which have no *other funding source*. The program targets to

- Increase the person's functional independence;
- Maximize the person's health and safety;
- Emphasize the central role of the individual in planning for and using the service or device;
- Increase the availability of assistive technology in rural areas and to individuals with limited English speaking abilities;
- Increase the likelihood that adults will stay in their own homes and communities.

PROCEDURES

The Assistive Technology (AT) Program – State only Fund may authorize the purchase of equipment/devices and/or services when there is *no other funding source* available.

Determining Need and Eligibility

When determining need and eligibility for the Assistive Technology Fund, staff must:

1. Document the need based on input from the person with the disability, for specific assistive devices and services in CARE SER notes;
2. Explore all other funding sources **before** submitting the final request to the AT Fund. Other possible funding sources include:
   a) Durable Medical Equipment (DME) – administered through the Health Care Authority;
   b) Waiver services such as Specialized Medical Equipment and Supplies, Environmental Modifications and Client Training (COPES only provides DME, and non-DME);
   c) New Freedom Waiver;
   d) Roads to Community Living and Washington Roads;
   e) Community First Choice State Plan (PERS Units only available under Community First Choice State Plan);
   f) Community Transition or Sustainability Services - CTSS (WAC 388-106-0960, 0965.)

The AT Fund can purchase specialized medical equipment and supplies if the equipment is denied by the funding source or not a covered service under the state plan (see Core Services, Chapter 7). The AT Fund will not supplement HCBS Waiver services such as Specialized Medical Equipment and Supplies and Environmental Modification. The discharge allowance should be used first if an individual is leaving a nursing facility. Other possible funding sources include Medicare, Division of Vocational Rehabilitation, Veterans Administration, Labor and Industries, and private insurance.

When determining need and eligibility outside of CARE for APS or Older Americans Act clients, staff must via secure email to AT Fund Program Manager:

1. Document the need based on input from the person with the disability, for specific assistive devices and services.
2. Gather any other pertinent information from other people involved in the individual's life such as other caseworkers, family, medical providers, etc.
3. Explore all other funding sources before submitting the final request to the AT Fund.

Service Authorization and Approval Requirements

1. Consult the AT Fund Program Manager, Linda Garcia, at (360) 968-9745, or email at linda.garcia1@dshs.wa.gov to see if there are available funds in the AT Fund or to discuss the client's disability issues, resources and other potential funding sources. **Because funding is limited, do not start the process before you contact the AT Program Manager.**

2. Participants of the program may contact AT Fund Program Manager directly by email or by calling 360-968-9745 to discuss AT needs and resources.

To request approval for AT project services, staff must provide:

- The specific nature of the request;
- CARE Service Summary and Assessment Detail if available;
- The name of the service or device;
- The costs of the service/device, if known;

Email the request to Linda Garcia at ALTSA headquarters, at linda.garcia1@dshs.wa.gov.

AT Fund Program Manager will authorize approval, ordering and payment for the requests and services. ALTSA Headquarters fiscal staff will process reimbursements to the vendor. Northwest Access Fund (www.nwaccessfund.org) is the contracted vendor who will assist the person with the disability to research, purchase the approved equipment, and provide training on how to properly use and maintain equipment.

Summary

The Case Manager/Social Worker must supply the following information to the AT Fund Program Manager within 10 working days of discussion with the AT Fund Manager:

- The specific nature of the request;
- The name of the service or device;
- The costs of the service/device, if known;
- Specific information about the person with the disability, CARE documents if available.

All requests are taken on a first come first serve basis. There are no waiting lists.

The AT Program Manager will deny requests upon depletion of the annual allocated funds.

Case management staff may submit additional AT Fund requests for the same client at the beginning of each state fiscal year.

RESOURCES

Glossary

WORD	DEFINITION
Assistive Technology (AT)	Devices and services that facilitate the ability of people by making the most of functional opportunities in all environments.
Assistive Technology Devices	Any item, piece of equipment, or product system, whether acquired commercially off-the-shelf, modified or customized, that increases, maintains, or improves the functional capabilities of individuals with disabilities. AT devices include, but are not limited to environmental control devices, communication devices and DME equipment, minor vehicle modifications under $10,000. The modification to the privately owned by the individual vehicle must not cost more than the vehicle is worth.
Assistive Technology Services	Services that assist persons with disabilities to select, acquire, or use assistive technology devices. AT services include but are not limited to: OT and PT evaluations, short-term training, selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices. Because of the limited funding, services for this project are short-term, less than four months.
Durable Medical Equipment (DME)	Equipment, that can withstand repeated use, and which use serves a medical purpose when supplied to individuals with an illness, injury or disability. DME includes, but is not limited to wheelchairs, walkers, specialty beds, and mattresses.

Non-Durable Medical Equipment	Single or multiple use supplies that are time-limited, such as diapers or catheter bags.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
5/22/2025	Linda Garcia	• Moved info to template with new DSHS logo & made general formatting changes • Updated table of contents • Added glossary • Added revision history section	

Family Caregiver Support Program Policy and Procedure Manual

Policies and procedures for Area Agency on Aging staff working in the TCARE Screening and Assessment tool. The TCARE tool is imbedded in the GetCare system.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Dana Allard-Webb Family Caregiver Support Services Program Manager
360.725.2552 danna.allard-webb@dshs.wa.gov

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BACKGROUND

Supporting unpaid family caregivers keeps Washington families together and means less people will need to access more costly in-home and residential services. These unpaid family caregivers need support to help prolong their ongoing caregiving activities as well as ensure their own mental and physical health stays intact while coping with related challenges. Research suggests that it is helpful to understand how a caregiver is feeling about their role in order to tailor the support to their individual needs.

The Family Caregiver Support Program (FCSP), established in 2000, is available in every county in Washington and offers unpaid family caregivers tailored services and resources. There are two goals for the FCSP:

- To provide information and support to unpaid family or other unpaid caregivers (whose care receivers are not involved with the Medicaid funded Long-Term Care service system), and
- To postpone or prevent the need for more expensive forms of care for adults (care receivers) needing ongoing care or supervision.

In 2007, the legislature revised 74.41.050 RCW mandating development of an evidence-based tailored caregiver assessment and referral tool. There was also legislative intent to have greater consistency in both policy and services within the FCSP. The Tailored Caregiver Assessment and Referral (TCARE®) protocol was the model that best matched the legislative mandate and intent. The company that officially oversees the management of TCARE® is Tailored Care (TCARE®Incorporated). Find more information regarding TCARE at https://www.tailoredcare.com.

Beginning July 2009, the Washington TCARE application provided the TCARE® tool for the FCSP. The TCARE® process is based on the premise that providing the right service at the right time best supports those unpaid family caregivers who are burdened by their caregiving responsibilities. TCARE® includes screening, assessment, consultation and service planning elements, designed to be utilized with the FCSP and is administered through the Area Agencies on Aging (AAA).

TCARE® is a theory-driven protocol designed to identify measures of caregiver burden and stress and produce recommended services and supports to address those stressors. The goals, strategies and services are determined based on the results of a screening and assessment using multidimensional measures of caregiver burdens and uplifts, depression scores, identity discrepancy as well as care receiver Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) scores. This protocol identifies and prioritizes services using a person centered planning process targeted to support the caregiver's abilities to provide care for the care receiver as well as to better care for themselves. The certified TCARE assessor is tasked with helping caregivers build insight into their caregiving journey so they can use information and skills provided to prepare them for future needs of their care receiver. Skilled and supported caregivers are more likely to navigate a caregiving journey with better physical and mental health.

Aging and Long-Term Support Administration (ALTSA) administers FCSP through funds primarily received from state and federal monies as well as other funding and unpaid supports. Start this section on new page.

FCSP CAREGIVER ELIGIBILITY

Who is Eligible to Receive FCSP Services?

Under the Washington State FCSP, an eligible "family caregiver" is an individual who is a spouse, relative or friend who has primary responsibility for the care of an adult with a functional disability* and who does not receive financial compensation for the care provided. (RCW 74.41)

Under the National FCSP (Title IIIE – Older Americans Act), an eligible "family caregiver" is an adult family member or other "informal" (unpaid) caregiver, age 18 and older, who is providing care to either an individual, 60 years of age and older or to an individual of any age with Alzheimer's disease and related disorders.

*The term functional disability refers to any reduction in the adult's ability to perform essential activities of everyday life. These activities are necessary to maintain health, independence and quality in an adult's life.

Can Caregivers who Live Outside of Washington Participate in FCSP?

Please refer to local AAA policy.

It is not a state requirement that caregivers live in the state of Washington. Caregivers must be caring for a care receiver who lives in Washington.

What is Considered Financial Compensation?

If an individual receives wages for the care they provide to the care receiver, these wages are considered financial compensation. However, if transportation or lodging/room & board is offered to a family member to make it possible for them to provide care, these types of costs are allowable and not considered as financial compensation.

How is the Caregiver Age Requirement Different from State (SFCSP Funding Rules) to National (NFCSP Funding Rules)?

The age of the caregiver is not specified under the statute for the State FCSP(SFCSP), whereas under the National FCSP(NFCSP) the caregiver must be an adult, 18 and over, in order to be served.

What is the Priority Caregiver Population for State FCSP?

The state legislature's priority population for the State FCSP (SFCSP) is unpaid family caregivers whose care receivers are not receiving Medicaid funded, Long-Term Care Services (e.g., CFC/ COPES, Medicaid Personal Care or MAC/TSOA). The SFCSP is viewed as a resource to help divert care receivers from the Medicaid long- term care system by way of supporting the unpaid caregiver. When SFCSP support is requested for an unpaid family caregiver whose care receiver is getting a Medicaid funded long-term care service, an Exception to Policy (ETP) should be utilized to track total caregivers served whose care receivers use Medicaid services.

What is the Current Eligibility Threshold for Step 3 for any New Unpaid Caregiver who Enrolls in the FCSP?

In order for a family caregiver to access the full TCARE® system (screening, assessment, consultation/care plan and services as recommended by the TCARE® algorithm) a family caregiver must have either:

- One high score in any of the three burdens (relationship, objective, stress) or in depression or identity discrepancy; or
- A total of three medium scores in the burden scales, depression or identity discrepancy as indicated in the TCARE® screen.

Statewide eligibility thresholds may be changed in the future depending on available funding and/or demand.

NOTE: Please verify your local AAA eligibility policy.

FCSP PROCESSES

At all levels of planning for caregiver services, FCSP encourages family caregivers to seek available low cost and no cost supports (friends, family, faith communities) and other funding sources (e.g., Medicare, Apple Health, health and long-term care insurance, Veteran's benefits) to supplement state and federal FCSP funding.

TCARE Assessor Wisdom: Many caregivers will need more than one contact before agreeing to engage in the TCARE process. Taking time to build a trusting relationship with the caregiver is very important to the process. When the screener/case manager/Family Caregiver Specialist takes time to develop a trusting relationship with the caregiver, the caregiver will be more willing to share information about sensitive subjects like depression and feelings of guilt. That trust will go a long way in helping the caregiver develop insight into their caregiving experience.

Step 1: Gathering Demographic Information

Step 1 level of services in the FCSP protocol is gathering and entering the demographic information into the GetCare system. (See OAAPS minimum data set for guidance on required demographic elements.) When a family caregiver is identified as needing FCSP's Information & Assistance services, the caregiver and care receiver should be entered into the GetCare system. Washington needs the data about the people we serve for planning, reporting and requesting additional state and federal funding. Use progress notes in GetCare to document one time only funding.

Step 2: TCARE Screen

Step 2 level of services begins with the TCARE® Screen. The screen provides a triaging tool compiling questions answered by the unpaid caregiver to assess risk factors for burnout from caregiving task(s). TCARE® screenings can be conducted in a variety of settings: in person, by telephone, or through a self-screen form, called the Family Caregiver Survey. The scores from the TCARE® screen determine unpaid caregiver eligibility for Step 3 Level Benefits.

What screen scores make a caregiver eligible for an assessment?

When using the screen for purposes of assessment eligibility, a caregiver must have a score of **One High or Three Mediums** in any of the following burdens to advance to an assessment, which is the next step in this process.

1 high score in any of the following:		**3 medium scores in any of the following:**
Stress burden		Stress burden
Relationship burden	**OR**	Relationship burden
Objective burden		Objective burden
Depression		Depression
Identity Discrepancy		Identity Discrepancy

Before finalizing a TCARE® Caregiver Personal Survey that has been sent to the local AAA/contractor's office, it is best practice that a TCARE® Screener or Assessor contact the caregiver to discuss their answers and respond to any questions they may have had in filling out the survey. This is especially true for caregivers who speak English as a second language, or don't speak English. The process of contacting the caregiver and entering the screening scores in the GetCare system must be completed within 10 business days.

Step 3: TCARE® Assessment

The full TCARE® Assessment process includes all of the screening questions, as well as assessment questions focused on both the caregiver's experience regarding the kinds and amount of care tasks they provide for the care receiver and the care receiver's health condition. Some of the major areas covered in the assessment: care receiver behaviors, memory issues, Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), cognitive performance questions and diagnoses/conditions.

TCARE CARE PLANNING

One face-to-face visit during the TCARE® assessment or consultation process is required before services can be authorized during the initial assessment/consultation process as well as during subsequent annual TCARE® reassessments/consultations. If the caregiver and care receiver reside together, at least one home visit must occur in the home with both caregiver and care receiver present. This home visit allows the assessor to evaluate the living situation and must be completed before the Care Plan is created. When caregiver and care receiver don't live together, a home visit in the care receiver's home is strongly encouraged, though not required.

NOTE: If a care receiver is unwilling to have a home visit take place, consult with your supervisor and enter a progress note in GetCare.

Step 3 Eligibility

Verify FCSP Caregiver eligibility with your local AAA.

- In order for a family caregiver to access the full TCARE® system (screening, assessment, consultation/care plan and services as recommended by the TCARE® algorithm) a family caregiver must have either:

  - ❖ One high score in any of the three burdens (relationship, objective, stress) or in depression or identity discrepancy; or
  - ❖ A total of three medium scores in the burden scales, depression or identity discrepancy as indicated in the TCARE® screen.

- Statewide eligibility thresholds may be changed in the future depending on available funding and/or demand.

NOTE: If a AAA needs to vary its Step 3 eligibility criteria from that which is stated above, ALTSA FCSP staff must be notified in writing of the reason for this change and approve it prior to the eligibility change being implemented.

TCARE Assessor Wisdom: Some AAAs complete an assessment even if a caregiver doesn't qualify for an assessment. These AAAs believe that an assessment is an opportunity for caregivers to take a look at their journey. If they don't have the score levels to make them eligible by state standards, the AAA doesn't have to choose to support them with respite or other expensive services. Or AAAs can use an ETP if the assessor believes the caregiver will benefit from respite. The thinking behind this is that many caregivers won't understand that they are a caregiver until they answer those questions. The conversations and insight that comes with a TCARE assessment can help the assessor build a trusting relationship. Over time, the caregiver may feel more comfortable in sharing.

The caregiver can remain active in the FCSP if their care receiver does not want to participate in the program. However, in order for the caregiver to receive respite care or other ongoing services, the care receiver needs to be willing to receive care from a respite provider agency that provides in- or out-of-home respite services.

FCSP Policy Reminder: To be eligible for Respite Services paid through FCSP, a caregiver must provide a minimum of 40 hours of care per week (including supervision) or live with the care receiver who needs ongoing help. See WAC 388-106-1210

Available Resources: After completion of an assessment, a caregiver is eligible to receive services associated with the TCARE algorithm selected strategies identified in TCARE® and/or any service the caregiver desires as long as it is available at the local AAA.

FCSP Policy Reminder: TCARE® Assessors employed by a community FCSP TCARE® subcontractor through an AAA are required to inform caregivers of all the relevant, available services in their community, including all FCSP services contracted by the local AAA. This is to ensure that caregivers have sufficient information to make well informed choices on services that may best suit them.

CONSULTATION/CARE PLAN DRAFT

After an assessment is completed, the TCARE® assessor consults with the caregiver to facilitate service planning. The consultation with a caregiver helps to determine which services will comprise the final care plan and helps to explain the potential benefits of the services to the caregiver. It is important that the caregiver understand why the assessor is recommending the services. Helping the caregiver see WHY certain services are being recommended is important and will assist the caregiver to make decisions about what services they will accept.

A draft version of the care plan is developed by the TCARE® assessor after a TCARE assessment is completed. The consultation with a caregiver is a person- centered conversation, that reflects

- The information the caregiver gave during the assessment

- The caregiver's beliefs, preferences and wishes
- The goals, strategies and the algorithm determine which services will be recommended in the draft care plan.
- Only the services accepted by the caregiver will be included on the final care plan.

TCARE Assessor Wisdom: During consultation, it is best practice to talk about wellness and the importance of finding time for respite and relaxation. Including a wellness activity in the care plan will help to remind the caregiver of the importance in managing their own mental and physical health.

Health Goal

It is important to talk with caregivers about a health goal regardless of depression score. Health Goal is to be addressed during the TCARE® Consultation process. Our data reports at least 40% of caregivers in Washington have some signs of clinical depression. Caregiver stresses and burdens, including depression can affect both mental and physical health in caregivers.

What is the Timeframe for Staff to Complete a TCARE® care plan for a family caregiver?

FCSP Policy Reminder: TCARE® Assessment process within CLC/GetCare: For an assessment to be complete, FCSP staff needs to move the assessment from draft to locked status and send the assessment to TCARE Inc. for the TCARE® algorithm to run. In the TCARE® assessment process within GetCare a screen must be moved from draft to locked within 30 calendar days to avoid repeating the screening process with the caregiver. A copy to review function is built into the GetCare/TCARE® system so that responses in the screening can be populated into a new assessment.

The Final Caregiver Care Plan is developed from the draft version of the Caregiver Care Plan. The plan will include the agreed upon services and expected outcomes. Outcomes need to be measurable and specific. For example, instead of stating that a caregiver will learn how to transfer the care receiver from the bed to wheelchair, the assessor might include a statement in the Care Plan that says "Caregiver will report having less back strain upon receiving instruction on safe transfer skills." This will promote conversation at next rescreen.

Since the family caregiver is the client for the TCARE assessment process and care plan, the TCARE® Assessor will request the caregiver's signature on the Caregiver's Care Plan. The caregiver's signature signifies acknowledgment of services and of receipt of the Caregiver Care Plan. Do not delay services if caregiver's signature has not been obtained. The TCARE® Assessor signature is required to acknowledge the agreement between the two parties. The care receiver's signature is not required in FCSP, only the verbal approval.

Available Resources: After completion of an assessment, a caregiver is eligible to receive services associated with strategies identified in TCARE®. **See strategies and services in the appendices at the end of the chapter.**

FOLLOW-UP AND TCARE® RESCREENING

Step	Rescreen every 6 months	Next Steps	Assessment
Caregivers at Step 1 Up to $250. One time funding. If caregivers require further services, a screen will need to be completed.	Best Practice - Follow up with phone call to caregiver to ask if other services are needed.	Discuss benefits of TCARE screen and assessment with caregiver. Encourage screen (caregiver personal survey)	
Caregivers at Step 2 Up to $500 annually.	Send Family Caregiver Survey and response card to caregiver and follow up with a call to answer questions (best practice), or complete over the phone	If screen scores meet assessment eligibility talk with caregiver about benefits of assessment and care plan	Complete Assessment if caregiver is eligible.
Caregivers at Step 3 Full range of services depending on AAA contracted services, policy, community resources and offerings.	Send Family Caregiver Survey and response card to caregiver and follow up with a call to answer questions (best practice), or complete over the phone. If caregiver or care receiver have a significant change in health or disability, complete full assessment process (screen, assessment consultation and care plan)	If there are no changes, document in progress notes. If scores are higher because of a significant change, or if caregiver requests a new assessment, complete a new assessment process.	**Annual Reassessment:** Complete full assessment (screen, assessment, consultation and care plan)

For caregivers at Step 1 or Step 2

When caregivers are not requesting additional FCSP services, a rescreen (or the Family Caregiver Survey) at the six-month follow-up should still be encouraged. The rescreening responses will enable the local and state FCSP staff to learn about the effectiveness of the program and caregivers will be able to see how they are doing as compared to prior screening (e.g., have different score ranges in areas such as burden, stress, depression, etc.). Those who choose not to be rescreened are to be encouraged to call back if their situation or needs change.

When caregivers wish to continue to receive FCSP short-term and limited services and have not reached the annual Step 1 or Step 2 financial cap, they can undergo a rescreen every six months.

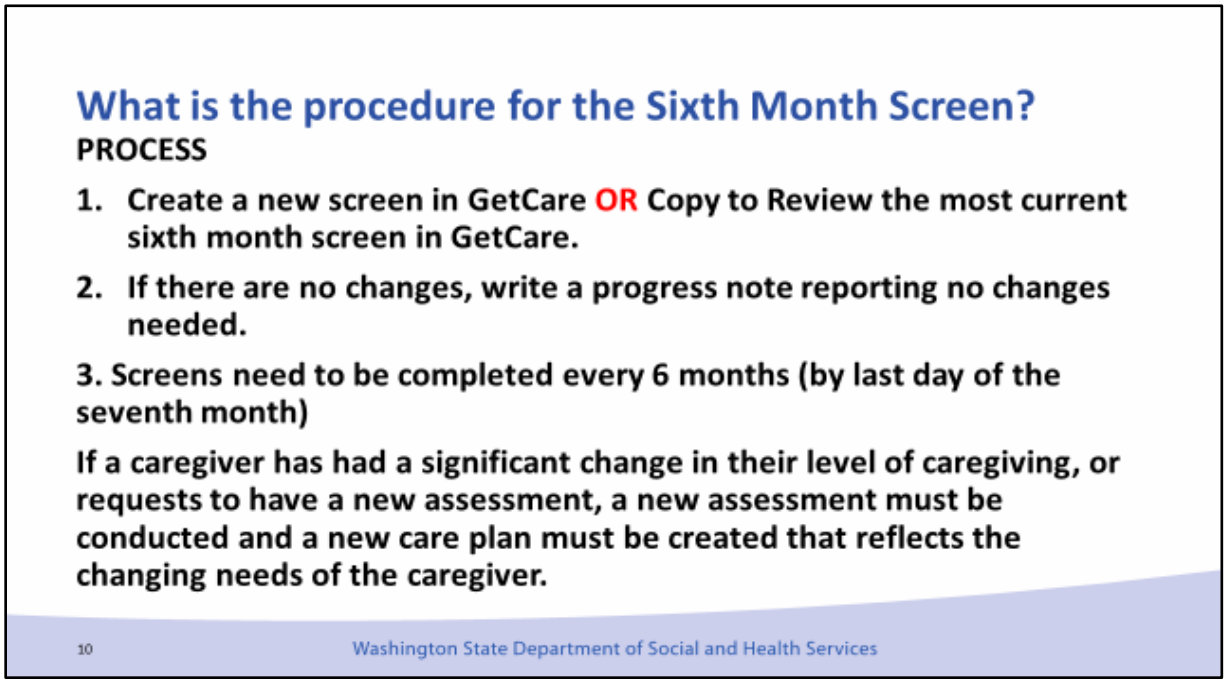
If the caregiver's rescreen results in higher ranges, FCSP staff should consult the AAA's current eligibility threshold to see if the caregiver should be referred for a full TCARE® assessment.

Rescreening for Caregivers at Step 3

All caregivers who have completed a full assessment and wish to continue to receive services must have a completed rescreen at least every **six months** through a self-screen (Family Caregiver Survey), telephone or in-person interview. It is recommended to contact caregiver and talk through Family Caregiver Survey over the phone to ensure the caregiver fully understood questions if they filled out family caregiver survey alone. This is especially important if the caregiver doesn't speak English or speaks English as a second language.

At time of rescreen, the assessor should consult with the caregiver to determine if the services are still helpful and desired. If so, then the assessor will make a case note and continue to include the service in the care plan. In the case of scores worsening, that is very common as most care receiver's conditions are progressive as the caregiver's stresses may be increasing. There may be cases where, without FCSP intervention, the caregiver's stresses would be even higher; so while there is an increase in scores, it is likely that stresses would be even higher without intervention, or the care receiver would have likely been placed in a Long Term Care setting.

If there is a significant change in the health or abilities of the caregiver or care receiver, or if the caregiver asks for a reassessment, a reassessment should be completed.
If no significant change assessment is needed, write a progress note and continue services as needed until annual reassessment.



ANNUAL REASSESSMENT

Caregivers who are at Step 3 and wish to continue services must receive an annual reassessment within 13 months of the most recent assessment regardless of the screening levels. At least one home visit

must take place at some point during the reassessment or consultation process. As caregiving can change dramatically over time, it is important to see the caregiver and the care receiver on an annual basis.

At the annual TCARE® reassessment, if a family caregiver is receiving respite care services and wants to continue to receive them and the TCARE® scores indicate that the caregiver has benefitted from the services, the TCARE® Assessor should determine if the family caregiver is still living with or providing 40 hours per week of care to the care receiver (40 hours includes supervision). If the family caregiver is providing less than 40 hours per week and it looks like the respite services are helping, the AAA, according to their own local policy, can decide whether to reduce or provide continued respite services. For example, the AAA may set the required number of unpaid caregiver hours at a lower lid, e.g., 25 hours a week, to still qualify the family caregiver for respite services. If a family caregiver still lives with the care receiver they would automatically still qualify for respite services depending on the outcome of the reassessment and if the TCARE® Assessor and family caregiver determine that respite services are still a benefit to the caregiver.

Refer to Appendix I - TCARE Screener and Assessor Training

Appendix J - TCARE® Assessor Qualifications and Recertification

Caregivers Caring for Multiple Care Receivers

When a caregiver cares for more than one care receiver, the TCARE Assessor will complete separate assessment processes regarding each care receiver. The reason is that the caregiver may have different tasks they do for each care receiver, the caregiver may feel different stresses and burdens for each care receiver and may benefit from different services regarding each care receiver. For example, a caregiver may feel the need to attend a support group because of the stresses they feel about caring for their care receiver who has Multiple Sclerosis but feels the need for respite services due to caring for someone with Alzheimer's disease.

Check local AAA policy for providing services to caregivers who have multiple care receivers.

If a Step 2 caregiver is caring for two or more care receivers, the caregiver's service package should not exceed a total of $500.00 annually. And, if eligible, a caregiver should be encouraged to proceed to Step 3 to receive a possibly more robust service package.

RESPITE POLICIES

The purpose of respite care is to provide relief for families or other unpaid caregivers of adults (age 18 and over) who are living with functional disabilities. Where available, in-home and out-of-home respite care options can be provided on an hourly and/or daily basis, including 24-hour care for several consecutive days. Staff providing respite care services provide supervision, companionship and personal care services that are usually provided by the primary caregiver. Services appropriate to the needs of individuals with cognitive impairment are also provided. Medically related services, such as administration of medication or injections, are provided by a licensed health practitioner.

Respite providers require a contract. Check with your AAA FCSP Coordinator for a list of your current contracted respite providers before authorizing respite services.

The Washington Administrative Codes (WACs) that direct respite care services are WAC 388-106-1200 through 1230 and included in **Appendix K** of this Policy and Procedure Manual.

AAA Respite Procedures

The AAAs must have a written procedure for:

- Determining, with the caregiver and care receiver, the amount of respite care services authorized, when it will be provided, and the name of the respite agency provider. This information must be included in the caregiver's TCARE® Care Plan.
- Arranging for one-time or ongoing respite care with the agency provider and providing them with the TCARE® Respite Information form.
- Maintaining contact with caregivers to determine further needs and/or changes to the respite care plan.
- Providing a substitute respite care worker if the scheduled worker has to cancel.
- Attempting to provide respite care when a caregiver has an emergency; and
- Monitoring the respite care provider and assessing provider performance to ensure all regulations are followed, including training of staff.

FCSP Policy Reminder: FCSP-funded respite services shall be terminated upon notification of a care receiver participating in COPES or Medicaid Personal Care, MAC/TSOA, a Developmental Disabilities waiver, or living in an assisted living, adult family home or nursing home facility.

Guidelines for Determining Financial Participation for Respite Care Services

The Department requires eligible care receivers to pay part, or all of the cost of respite care services based on their monthly income (above 40% of the State Median Income (SMI). The FCSP staff will administer the sliding fee scale (Sr. Citizens Services Act (SCSA) schedule) which is updated annually, to determine the share of the cost of these services. The related income question is asked in Question #22 in the TCARE® Assessment.

NOTE: Remember to consider other sources of payment such as Medicare and/or Apple Health/Medicaid, health and long-term care insurance or Veteran's benefits for payment towards respite care and other caregiver/care received services.

How is the Participation Fee Determined?

1) There is no charge to the care receiver whose income is at or below 40% of the SMI, based on family size.

2) If the care receiver's gross income is above 40% of the SMI, then, utilizing the SCSA sliding fee scale, the TCARE® assessor will determine the percentage rate the participant is required to pay towards the cost of the respite care services; and

3) If the care receiver's gross income is 100% or more of the SMI, the participant must pay the full cost of the respite care services.

4) If the care receiver is experiencing extreme financial hardship (e.g., high medical expenses) and cannot pay for their share of the cost of the respite care services, the AAA's FCSP Coordinator or Supervisor may grant an ETP and then the Assessor must document this situation in GetCare Progress notes. At the next reassessment, the care receiver's income will be reviewed for financial participation if respite care services are continued.

How is Income Defined?

A general definition for income includes, but is not limited to, all the money received which the participant can use to meet his/her needs, such as cash, pension, wages, Social Security benefits, Veteran's benefits, dividends.
The cost of respite care is determined by the number of hours or days of respite care service authorized and used, and the rate for the service.

Listed below are examples of how FCSP staff shall determine the care receiver's income:

A.1 If the caregiver and eligible care receiver are married to each other, all the monthly income received in either or both names shall be combined and one-half of the total shall be considered the participant's income. Refer to Column One on the current (annual) SCSA sliding fee scale.

A.2 If the caregiver and eligible care receiver are married to each other and there are dependent children in the home, all the monthly income received in either or both parents' names shall be combined and one-half of the total shall be considered the care receiver's income. Refer to the SCSA fee scale column which represents the number of persons in the household less one (ex. for family of 4, use column 3).

Example: One spouse is the care receiver, the other is the caregiver, and they have two children under 18. The couple's combined monthly income is $3,000. One-half the total is $1,500. The monthly income for column 3 (total of persons in the household less one because the husband and wife are counted as one) on the fee schedule is less than 40% of the SMI, so the care receiver does not have to pay participation.

A.3 In a case where both members of a married couple are respite care receivers and the unpaid caregiver is a friend or relative, all monthly income received in either or both names of the married couple shall be combined and then divided in half. Refer to Column One to determine what percentage of cost each spouse would pay.

A.4 If the care receiver is single (not married to caregiver), and the caregiver is a friend or relative, the only monthly income counted toward participation would be that of the care receiver. The only monthly income counted toward participation would be that of the care receiver. Follow the SCSA sliding fee scale by counting the people who are supported by the single care receiver's income to determine the participation amount. The unmarried care receiver is considered head of their own household, even if they live with another relative/caregiver.

A.5 In a case where there are two non-spousal, care receivers living in the same household and are cared for by a relative or friend, each care receiver's income will be considered separately when determining the percentage rate of participation amounts. The cost of the respite service will be pro-rated among the two care receivers. They will share in paying for a percentage of the service (if their income is above 40% of SMI)

A.6 Refer to the fee schedule, Columb One for the appropriate percentage of cost each participant will pay.

NOTE: Under no circumstances is the combined multiple care receiver's participate to exceed the cost of the respite service(s).

A.7 Refer to local AAA policy. In the case of a care receiver who is a veteran receiving Veteran's Aid and Attendance benefits for their long-term care needs, these benefits may be recognized as income and therefore counted. There are many different Aid and Attendance and caregiver programs in the VA with differing rules. It is important to keep in mind that the caregiver cannot be receiving pay through the VA program and also receive FCSP respite care. That caregiver would be considered a paid caregiver and therefore ineligible for FCSP funded respite.

Spectrum of Respite Care Services

AAA Respite Billing Requirements:

1. The AAA's National Family Caregiver Support Program (NFSCP) funding for Respite Care Services is to be used only when the care receiver's income is at or below the 40% SMI or when participation is a financial hardship. All other respite care charges must be billed to the State funded FCSP. For more information go to MB# H12-056 – Procedure, August 9, 2012. Respite Care Services and Other Non-Core Personal Care Services Funding Source Billing Options Related to Participant Contributions.
2. As part of the monthly invoicing to ALTSA, the AAAs must report all funds received from respite care participants by the agencies collecting them. These funds shall only be used within the provider agencies for purposes of the Family Caregiver Support Program.

What Types of Respite Care Providers can be Used in FCSP?

Respite care services are to be contracted with the local AAA. The types of possible respite agency providers that can be contracted include available residential facilities: licensed boarding homes, adult family homes, assisted living, nursing facilities, along with adult day services, home care/home health agencies, and any other providers such as Senior Companion, Volunteer Services, etc. Provider agencies shall be monitored for compliance according to the ALTSA/AAA Policy and Procedures. Respite services may also be provided through an unpaid, network of family, friends and community members.

Family caregivers will be able to choose from available contracted agency providers in their service area. Special requests may be made for cultural, ethnic and language considerations. Caregivers may request a change in agency providers at any time. The array of respite care providers (volunteer and/or paid services) should cover all levels of care including:

A. Companionship, supervision and meal preparation,

B. Help with activities of daily living (e.g., personal care, lifting, turning, transferring, dressing, eating, walking, medication reminders, etc.),

C. Tasks such as catheter care, injections, pressure ulcer care, that require licensed medical or health professionals for respite type care such as a Licensed Practical Nurse or Registered Nurse, and

Out of home services: Adult day services where available (socialization, nursing services, rehabilitation, classes and many other activities) or short-term residential facility stays (nursing homes, assisted living, boarding homes and adult family homes).

There may be instances during a respite episode when transportation to a medical appointment or essential shopping* may be provided to the care receiver by the home care agency worker. (This would apply if the family caregiver would normally be providing transportation but is unavailable during this episode(s) because s/he is taking a respite break.) This service is allowable if the TCARE® Assessor communicates this need in a written form (this could be included in the caregiver's care plan, Respite Care Information Sheet or AAA/Respite Care Authorization form) to the home care agency ahead of time. The home care agency worker will use 1) public transportation (if appropriate) or 2) insured private vehicle, provided the home care agency worker has a valid driver's license/insurance coverage.

*The Medicaid agency home care rate already includes parity for transportation to medical appointments and essential shopping. Because respite care services utilize this same home care rate, it's reasonable to expect transportation to medical appointments or essential shopping can be included in the respite service package.

Transportation for essential shopping would also be permissible under FCSP Supplemental Services when a home care agency is contracted to do housework and errands type services if the TCARE® Assessor communicates this need in a written form and follows the same procedures for the home care agency worker as stated above.

The following WAC pertains to nursing facilities that provide respite care. WAC 388-97-1880.

Respite Care Provider Staffing and Monitoring Standards Licensing and/or certification of any respite staff are the responsibility of the Home Care/Home Health agencies, Adult Day Services and Residential Services. Check with AAA contract staff on the required certification, licensing, training and background checks needed for all contract respite providers.

If an AAA is unable to provide the array of respite services as listed in this section A through D, above, the AAA must contact ALTSA Program Manager for technical assistance regarding adequate provider network.

The AAA must ensure they are utilizing the current respite provider rates and the Annual SMI Schedule (SCSA) to determine care receiver cost contribution/participation.

Rates for Respite Provider Agencies

Rates for In-Home Respite Service Providers

In-home respite care workers shall be paid according to the labor standards and applicable legislation (RCW 74.39A.310). Rates for Home Care Respite Provider Agencies are governed by the following legislation:

RCW 74.39A.310 which requires that the contribution rate for caregiver compensation, paid leave, training and AWHI be paid by the department to home care agencies at the same rate as negotiated and funded in the Collective Bargaining Agreement (CBA) for Individual Providers (IPs) of home care services. This contribution rate is connected to the CBA and is communicated in an MB as changes occur.

Respite care services can contract with home care or home health agencies that employ Nursing Assistant Certified (NAC) staff at their established rate. Nurse delegated tasks are not included within the respite care services.

AAA staff will utilize the latest Management Bulletin on home care rates to determine applicable respite care rates.

Rates for Out-of-Home Respite Providers

Each AAA shall negotiate for an hourly and/or a daily rate with providers whenever possible.

- If an agency provider has only an hourly rate, this rate shall be paid for each hour of respite care used, including 24 consecutive hours of respite care.
- If an agency provider (such as an adult day or residential service) has only a daily rate, the rate shall be paid for 24 consecutive hours or less of respite care used.

- If an agency provider has both an hourly and daily rate, the AAA shall reimburse the provider whichever rate (hourly or daily rate) is lowest.

When a respite episode warrants an exceptional rate for a non-Medicaid funded, out-of-home provider, (e.g., only one facility is available in the area, requires a higher rate, and is still more cost effective than some other type of facility), then the AAA may negotiate an exceptional rate and document it with the subcontractor's contract.

The department shall pay Medicaid facilities the Medicaid rate approved for that facility (e.g., nursing homes, etc.). It shall be unlawful for any facility, which has a Medicaid contract with the department to charge any amounts in excess of the Medicaid rate for services covered, except for any supplementation permitted by the department pursuant to RCW 18.51.070. The participant shall pay for services not included in the Medicaid rate.

The agency provider shall not be paid for more service hours than authorized by the FCSP. Annually, ALTSA will notify AAAs of the current rates paid by the department to providers offering a same level of service by respite care providers.

How Should Respite Care Episodes be Scheduled for Emergent and Non-Emergent Situations?

TCARE® Assessors shall encourage eligible caregivers to schedule episodes of respite care in advance. Requests for respite care, which are of an emergent nature, shall have first priority. An example of such an emergent need for respite would be when the caregiver becomes ill or injured to the extent that the caregiver's ability to care for the care receiver is impaired. It is understood that emergencies may not be able to be resolved if respite resources (e.g. providers) are not available to meet a given caregiver's needs.

In-non emergent situations, respite care is available on a first-come first-served basis provided that sufficient funding resources are available to fill the requests each month. Respite care services are not part of an entitlement program. The amount of respite allotted is based on funding availability along with the needs of the particular caregiver and can vary from time to time.

If respite care cannot be provided, refer to the waiting list criteria noted on page 21. If a cancellation occurs, respite care shall be made available to those on the waiting list according to the service priority categories.

AAA FCSP SPECIAL CIRCUMSTANCES

Caregivers in Crisis

Local AAA policy will determine how best to serve caregivers in crisis. A caregiver should be screened, assessed, and have a completed care plan within 30 calendar days following the crisis if ongoing services exceeding $500 were authorized.

Exceptions to Policy (ETP) and Documentation

Each AAA must develop an ETP process to be followed when exceptional cases arise within FCSP and the TCARE® process. The process must include a written approval process between the assessor and their supervisor or the AAA FCSP program coordinator before authorizing the ETP. For tracking purposes, staff must enter the demographics on the caregiver and care receiver, use progress notes in GetCare to document an exception to policy (ETP). Staff shall discuss ETPs with a supervisor and/or the FCSP Program Coordinator. In addition, a short description of the exception and what action was taken to address the situation is needed in progress notes. The date and name of authorizing party's approval of the ETP (e.g., supervisor or FCSP Coordinator) must also be included in the progress notes.

Examples of ETPs

- A caregiver who is in a crisis can be served with Step 2 or 3 FCSP services without first going through a screening or assessment. A TCARE® screening and/or assessment/care plan must be completed within 30 calendar days if ongoing services are needed.

- A caregiver who needs some supplies or a piece of equipment within Step 1 (if a TCARE® screen has been completed) or Step 2 that exceeds the dollar amount.

- For a caregiver who has Limited English Proficiency (LEP) and is requesting services, supplies or equipment, FCSP screeners and TCARE® assessors are asked to conduct a TCARE® screening/assessment using interpreter services. If this is not feasible, follow the documentation procedures for an ETP.

- If the screener has a "gut feeling" that an existing caregiver who rescreens at less than the eligibility threshold is truly in need of a higher level of service such a Step 2 or Step 3, discuss with supervisor.

- There may be those instances where a family caregiver who is struggling with the caregiving role provides unpaid care to an adult who is receiving Medicaid long- term care services (e.g., CFC/COPES). An exception can be made if there are no other resources available to help the caregiver. This individual can also be served without an ETP at Step 1 with resources like support group referrals, conferences etc. but if other needs occur (e.g., consultation, counseling) an ETP is needed. Respite care services are not permitted.

- In certain situations (e.g., culturally diverse communities), a primary caregiver may not be distinguishable from another family member/unpaid caregiver providing care to the same care receiver. In these circumstances, the total service package for these multiple caregivers should not exceed (in hours or funding) the AAA's limit for one caregiver.

Waiting List Criteria for Counseling Services

If a AAA needs to implement a waiting list for FCSP funded counseling* services, please use the criteria below. The TCARE® ranges (low, medium, and high) will be used to prioritize caregivers on a waiting list. Uplift scores do not count for any of the priorities. Priority one is considered the highest priority.

Priority 1 – All 5 highs

Priority 2 – 4 highs in Depression, Objective, Stress, and Relationship burdens

Priority 3 – 4 highs in Depression, Relationship, Stress, and Identity Discrepancy

Priority 4 – 3 highs and 2 mediums. Highs must include Depression and Relationship burden

Priority 5 – 3 highs and 1 medium. Highs must include Depression and Relationship burden

Priority 6 – 3 highs, no mediums. Highs must include Depression and Relationship burdens

Priority 7 – 2 highs to include Depression and Relationship burden

Priority 8 – 2 highs. One must include Relationship burden

The waiting lists are established only for caregivers who are new to TCARE®. There may be multiple caregivers on a waiting list who are in the same priority category. When an opening becomes available, the caregiver who has been on the list the longest will be served first.

FCSP FREQUENTLY ASKED QUESTIONS

Are There Restrictions on Purchasing Goods or Services Under the FCSP Steps 1-3?

Yes, funding from the FCSP cannot be used to pay for rent, car repairs, computers, entertainment items, vacation expenses, major appliances, gift cards or utility bills. If staff are unsure of allowable items or services, contact ALTSA FCSP Program Managers.

Can a Caregiver Receive FCSP Services if the Care Receiver Lives in an Assisted Living Facility, Paid for Privately?

The state and federal funding sources have different viewpoints on this question:
The State FCSP RCW 74.41, states that the program is to "encourage family and other nonpaid individuals to provide care for adults with functional disabilities at home, and thus offer a viable alternative to placement in a long-term care facility".

For National FSCP (NFCSP), the Older Americans Act defines a caregiver as: An adult family member or another individual, who is an "informal" provider of in-home and community care to an older individual.

Based upon the different definitions, the state FCSP funding should be limited to family caregivers who care for adults at home, whereas the NFSCP can include caregivers who's loved ones live in an Assisted Living Facility. When applying the NFSCP funding, ALTSA staff cautions AAAs about using costly services for caregivers whose care receivers are living in long-term care facilities.

Can an AAA Provide Services to Caregivers who Live in WA State but Care for Family Member Living Outside of the State?

AAAs can provide services to caregivers, on a case-by-case basis, as determined by local FCSP policy.

How Should Caregiver and Care Received Privacy and Confidentiality be Protected?

By its nature, the Family Caregiver Support Program involves collecting sensitive, private information from caregivers and care receivers. Such information must be treated with the utmost care. The Family Caregiver Support, is considered a Health Care Component under HIPAA and therefore is subject to its rules, oversight and penalties. Screen and assessment information is confidential and subject to RCW 42.56.590 and RCW 19.255.010 if a breach occurs. If the TCARE® Assessment and Care Plan involves the sharing of caregivers' responses of any health-related information (e.g., results of the depression scale) AAAs shall get signed consent forms (the AAA can choose the DSHS 14-012 form or similar one) from the caregivers so they are aware that the FCSP staff may share the minimum necessary information with contracted partner programs in order to help provide effective caregiver services. The GetCare database is protected under strict security protocols and AAA security contract language. Only those staff with the proper security clearance and documented confidentially training are eligible to access the system.

For Activities of Daily Living needs and health-related information on the care receivers that will be shared with providers (e.g., respite care providers), a signed consent form (the AAA can choose the DSHS 14-012 form or similar one) should also be utilized and signed by the care receiver or their designated representative.

What Documentation is Needed in the Family Caregiver File When Purchases are Made?

Staff that authorize services under the FCSP are responsible to ensure that, when purchasing goods/services or one-time set-up fees on behalf of an eligible family caregiver, documentation within a family caregiver file (e.g., copies of authorization and billing tracking documents) must include:

- A caregiver's name,
- A description of the goods and services including purchase price,
- Proof (can be verbal verification with caregiver) the goods were purchased, and
- Goods or services were received, the costs verified, and purchase is consistent with needs identified in the TCARE® care plan.
- No cash or gift cards may be offered to family caregivers.

It is important to also consult local AAA policies for additional documentation that may be required.

Can a Care Receiver Receive General Case Management at the Same Time Their Family Caregiver Received FCSP?

Yes, and the FCSP staff should coordinate with the General Case Management staff to optimize service delivery and avoid duplication of efforts and resources.

Can a Caregiver Receive Services Through a Kinship Care Program (Kinship Caregivers Support Program or Kinship Navigator Program), and Simultaneously from the Family Caregiver Support Program?

Yes, as these programs serve different primary care receiver populations (adults versus children), the needs of the caregiver can vary based on their role. The FCSP staff should coordinate with the kinship care staff to optimize service delivery.

TCARE Mentor Tip: If caregiver wants to stay connected to FCSP through Step 1, contact with these caregivers, at least every six months is a good way to determine caregiver's desire for more or less involvement with the FCSP.

Can an Area Agency on Aging Change Eligibility Criteria?

If an Area Agency on Aging must change eligibility criteria, email a summary of plan to the ALTSA Family Caregiver Support Program Manager.

TCARE/GETCARE

For questions and more i-depth tutorials about using TCARE or GetCare, refer to the Help Library in the CLC/GetCare system.

What is the Process for FCSP Inactivation?

To disenroll (inactivate) a FCSP caregiver in GetCare:

- All incomplete or draft Screenings and Assessments must be completed and locked or struck out for each caregiver.
- To "inactivate" the caregiver and care receiver in GetCare, they must be disenrolled from the system by end dating the service enrollment in the enrollment section and selecting disenrollment reason.
- Write a progress note, reporting the reason for disenrollment.

What if There has not Been Any TCARE® Activity for a Caregiver in Many Months?

If there have been no screenings, assessments, care plans or progress notes provided in the caregiver's file for the last year, the caregiver should be disenrolled from services. Check with local AAA policy.

FCSP REPORTS IN ADSA REPORTING (LEGACY)

Several TCARE® Management Reports are available to AAAs on the ADSA Reporting web page, https://adsareporting.dshs.wa.gov/LoginNew.aspx.

These reports are relevant only as historical data. On September 17, 2020, TCARE was integrated into the GetCare system. All assessments and data from September 18 and beyond will be found in GetCare. TCARE Reports in ADSA Reporting include:

- TCARE® 1503 – Active Caregiver Summary
- TCARE® 1504 – Care Plan Service Summary
- TCARE® 1505 – Worker Activity AAA
- TCARE® 1506 – Worker Caseload Tickler
- TCARE® 1063 – Inactive Caregivers by AAA

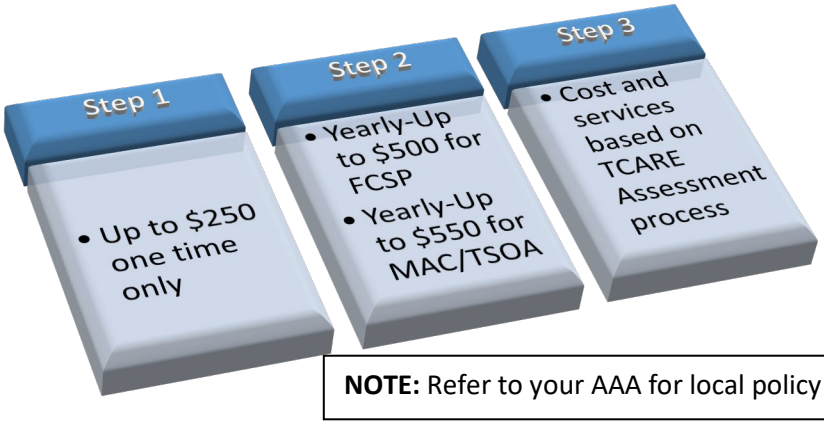
If staff need to access the ADSA Reporting system, contact the FCSP/TCARE Program Manager at ALTSA.

FCSP Reports in GetCare

GetCare has a TCARE Manager Tool that keeps track of TCARE screens and Assessments by case manager similar to ADSA Reporting. See the TCARE Manager under the CLC Set button in the top blue ribbon in the CLC/GetCare system.

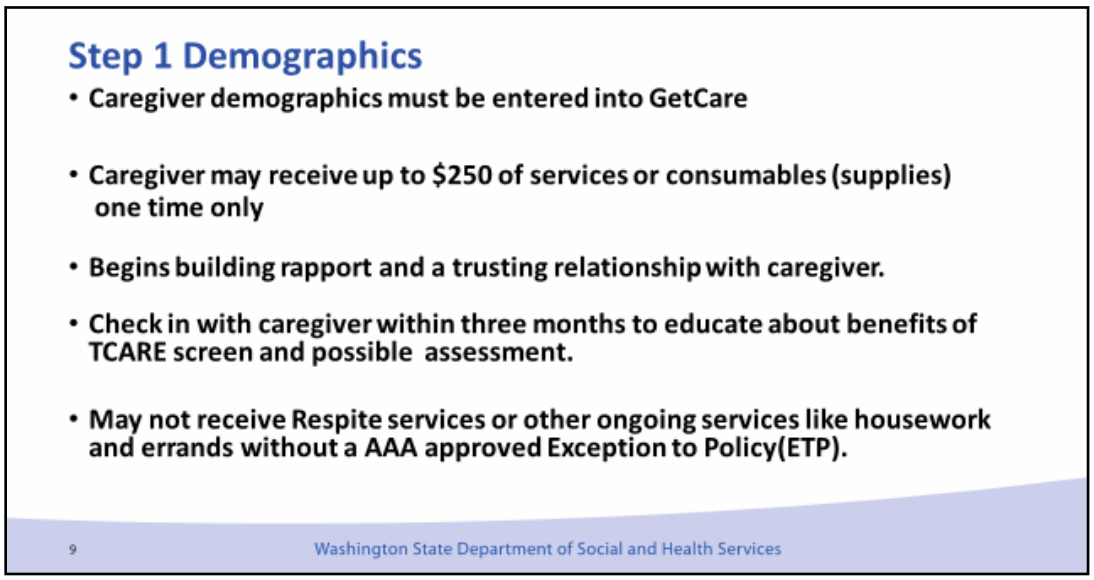
APPENDICES

Appendix A –Step Levels of Support*

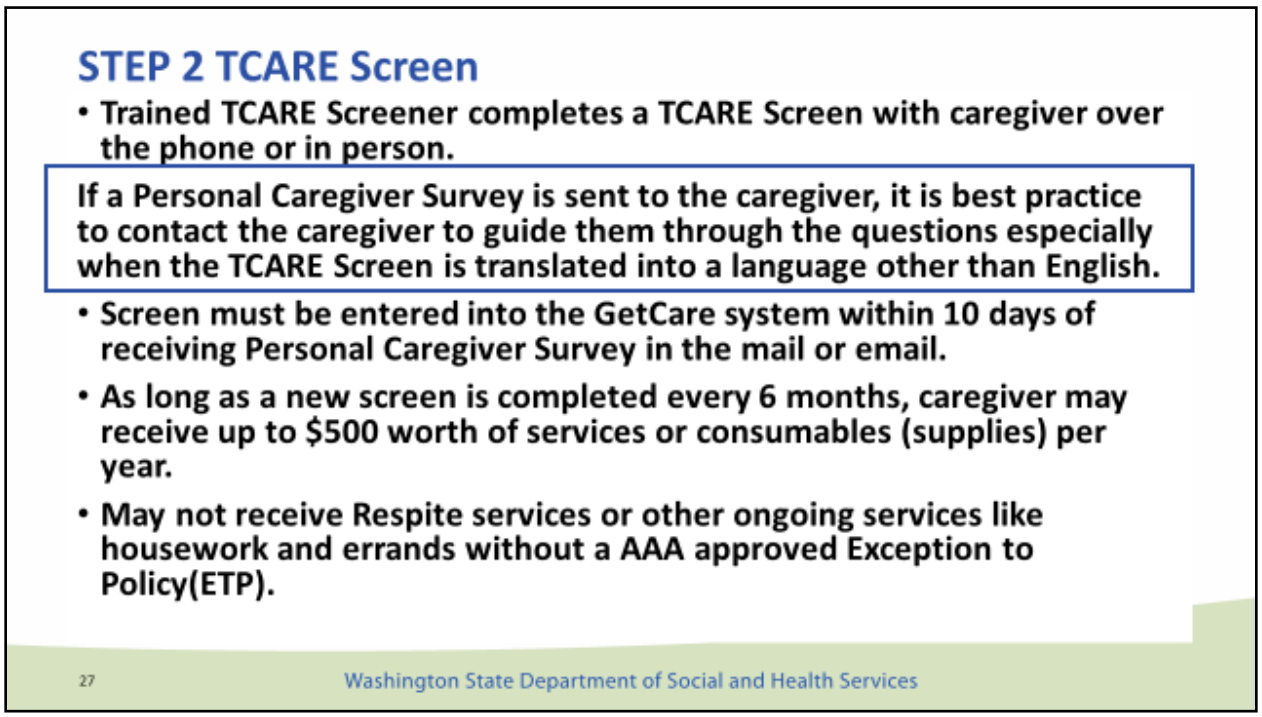


NOTE: Refer to your AAA for local policy regarding funding caps.

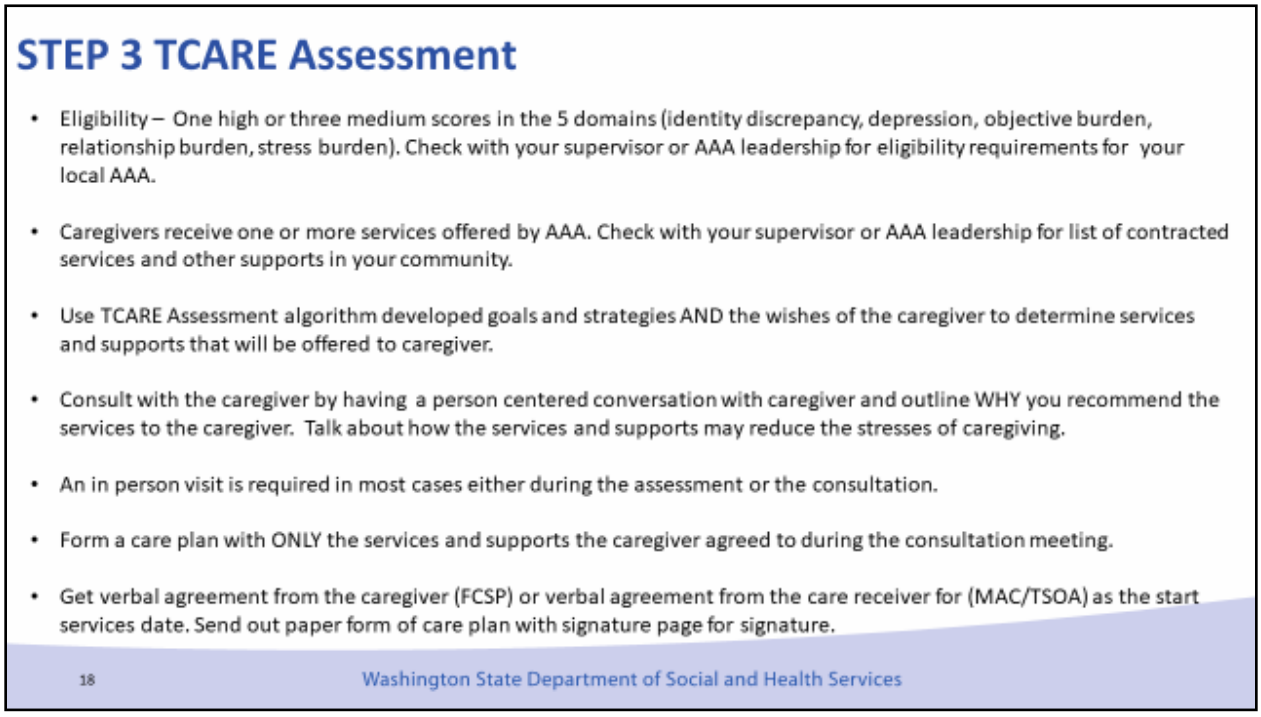
Step 1 Level of Support



Step 2 Level of Support



Step 3 Level of Support



STEP 3 TCARE Assessment

- Eligibility – One high or three medium scores in the 5 domains (identity discrepancy, depression, objective burden, relationship burden, stress burden). Check with your supervisor or AAA leadership for eligibility requirements for your local AAA.
- Caregivers receive one or more services offered by AAA. Check with your supervisor or AAA leadership for list of contracted services and other supports in your community.
- Use TCARE Assessment algorithm developed goals and strategies AND the wishes of the caregiver to determine services and supports that will be offered to caregiver.
- Consult with the caregiver by having a person centered conversation with caregiver and outline WHY you recommend the services to the caregiver. Talk about how the services and supports may reduce the stresses of caregiving.
- An in person visit is required in most cases either during the assessment or the consultation.
- Form a care plan with ONLY the services and supports the caregiver agreed to during the consultation meeting.
- Get verbal agreement from the caregiver (FCSP) or verbal agreement from the care receiver for (MAC/TSOA) as the start services date. Send out paper form of care plan with signature page for signature.

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Appendix B: Service Names by Service Category

Service Category	Service Type Not included in Selection/ Display of Service Name INFORMATION ONLY	Service Name
(0) Other This service category functions as an option for services that do not fit in other service categories.	a) Comfort Therapies (under Health Goal Other), z) Other	Massage
(1) Adult Day Service (Experience time away from care responsibilities)	a) Health model, b) Social model, c) Dementia model, z) Other	Adult Day Care-dementia model Adult Day Health-dementia model Adult Day Health Services Adult Day Care

Service Category	Service Type Not included in Selection/ Display of Service Name INFORMATION ONLY	Service Name
(2) Assistive technologies (Promote safety and functional abilities of care receiver)	a) Emergency response system (medical alert, in home monitoring), b) Home modifications (e.g. ramps, walk in showers, grab-bars), c) Home safety features (e.g. lighting, locks, exit door alarms), d) Assistive devices and care supplies (e.g. low beds, mobility devices, commodes, protective garments), z) Other	Electronic locator bracelet Durable Medical Equipment Home Safety Evaluation Occupational Therapist Evaluation Adaptive Equipment Personal Emergency Response System Care Supplies Physical Therapy Evaluation
(3) Counseling (Develop new perspective and practice skills with feedback)	a) Alternative ways to express anger and frustration, b) Increase level of mastery or confidence, c) Caregiver journey/identity change, d) Develop new way of viewing current situation (Cognitive Reframing), e) Coping Skills, f) Family communication and relationships, g) Understanding and coping with guilt, h) Self-care techniques, i) Stress management techniques, j) Understanding loss and grief, k) Valuing positive aspects of caregiving, l) Problem solving skills, z) Other	Individual counseling Caregiver Counseling
(4.1) Education for caregiver to obtain information about services and assist with planning for the future	a) Available support services and how to obtain them, b) Disease and disease processes (provide basis for accurate assessment of care needs), c) End-of-life planning, decision and care, d) Legal, financial and/or health care planning, e) Safe-guarding care receiver in his/her home (e.g. wander alert services, personal/home safety tips), f) Selecting a suitable living environment, z) Other	Online Caregiver resources Caregiver Advocate Family Caregiver Specialist Dementia Consultation Caregiver Consultation Family Caregiver Training/Education Long Term Care Planning Veteran's Benefits Consultation Caregiver Conference
(4.2) Education for caregiver focused on psycho-social issues and coping skills	a) Alternative ways to express anger and frustration, b) Increase level of mastery or confidence, c) Caregiver journey/identity change, d) Develop new way of viewing current situation (Cognitive Reframing), e) Coping Skills, f) Family communication	Early Memory Loss Support Group Caregiver Consultation Family Caregiver Training Alzheimer's Support Group Powerful Tools For Caregivers Caregiver Conference

Service Category	Service Type Not included in Selection/ Display of Service Name INFORMATION ONLY	Service Name
	and relationships, g) Understanding and coping with guilt, h) Self-care techniques, i) Stress management techniques, j) Understanding loss and grief, k) Valuing positive aspects of caregiving, l) Problem solving skills, z) Other	
(4.3) Education to build caregiving skills (e.g. direct care and communication)	a) Direct care skills (e.g. bathing, dressing, transfer), b) How to ask for help from informal sources (e.g. family, friends, neighbors), c) Skills to communicate with care receiver, d) Skills to communicate with service providers, e) Skills for responding to mood and behavior changes, z) Other	Caregiver Consultation Family Caregiver Training Caregiver Training Caregiver Conference Dietician Consultation
(5) Education for care receiver (Facilitate self-care and/or reduce need for assistance)	a) Improve physical strength, coordination or mobility, b) Skills to increase self-care and independence, c) Reduce expectations for care, z) Other	Falls Prevention Workshop Chronic Disease Self-Management Program Medication Management
(6) Financial and/or Legal Services and Protection (Obtain assistance or counsel)	a) Automatic bill pay (e.g. utility, rent, mortgage), b) Financial assistance or voucher programs (e.g. prescriptions, care supplies, services, housing), c) Legal Services (e.g. estate planning, legal counsel, elder law attorneys), d) Consumer advocacy and protection services (e.g. adult protective services), e) Benefit entitlement programs and/or health insurance plans (e.g. Medicaid, Medicare, LTC Insurance), z) Other	Estate planning/Elder Law Services Benefits Check-up Elder Law Attorney VA Aid and Attendance Advance Medical Directive Information Packet Estate Planning Protective Payee Services
(7) Informal Help Network (Enlist or increase current amount of help)	a) Family and friends (includes family meetings), b) Religious affiliation groups, c) Ethnic/Cultural social club, d) Civic or fraternal organization (e.g. Rotary Club, Lions Club, Jaycees), e) Student group/organizations (e.g. high schools, universities, fraternities), z) Other	Faith based community Religious community In-home respite care (unpaid) Meal Sites Family support Help from Friends Home maintenance/Yard Work Volunteer/Community Service

Service Category	Service Type Not included in Selection/ Display of Service Name INFORMATION ONLY	Service Name
(8) In-home Supports and Services (Reduce responsibility or workload)	a) Chore/Homemaker services, b) Home delivery of meals/groceries, c) Home health care (e.g. nursing, care attendants), d) Personal care, e) Pharmacy delivery, f) Sitter/Companion services, g) Volunteer/Friendly visitor services, z) Other	Housework and Errands In-home Personal Care In-home respite care (paid) Grocery Delivery Service Meals-On-Wheels Bath Aide Home Delivered Meals Volunteer Chore Services Caregiver (private pay)
(9) Living Environments (Introduce alternate source of 24-hour supervision/care)	a) Assisted living or other community based setting b) Nursing home c) Home of another family member or friend z) Other	
(10) Overnight Respite Services (Experience time away from care responsibilities)	a) Facility-based respite, b) Home-based respite, c) Home of another family member or friend, z) Other	Overnight In home Respite Overnight in home of friend/family Overnight Facility-Based Respite
(11) Palliative and/or Hospice Care (End-of-life supports and services)	a) Facility-based hospice, b) Home-based hospice, c) Palliative care consultation/ services, z) Other	Palliative care Hospice Services
(12) Rehabilitation Services (Identify and promote functional abilities of care receiver	a) Occupational Therapy, b) Physical Therapy, c) Speech Therapy, d) Respiratory Therapy, z) Other	Occupational Therapist Consultation Physical Therapy Consultation
(13) Support Groups (Expand and sustain networks of support)	a) Condition or disease focused (including early stage groups for care receiver), b) Emotional support/release, c) Friendship/Peer support, d) Skill development, z) Other	Family Caregiver Support Group Support Group for Adult Children Early Memory Loss Support Group Alzheimer's Support Group Online Support Group Disease-based Support Group

Appendix C: TCARE® Strategies and Associated Services

This section illustrates the types of strategies utilized in TCARE® and examples of services that could be offered.

A		Strategies to change personal rules for care
B		Strategies to reduce or minimize workload
	B1	Reduce care needs of care receiver
	B2	Reduce difficulty of care and tasks
	B3	Introduce alternate source for care to provide respite
C		Strategies to support positive self-appraisal (enhance or affirm current identity & behavior)
	C1	Reject negative appraisal
	C2	Reinforce positive aspects of identity
D		Strategies to reduce generalized stress
E		Strategies to improve overall health

Strategies A, C, and D (Defined Above)

- Caregivers Workshop Series
- Powerful Tools for Caregivers
- Wellness Programs
- Caregiver Education
- Counseling*
- Legal, Financial, Health Care Planning
- Support Groups
- Caregiver Education

*Counseling within the FCSP is defined as Individual or Family Counseling that can be provided by the following professionals who hold a current license with the Washington State's Department of Health:

- Psychiatrists
- Psychologists
- Psychiatric advanced registered nurse practitioners (ARNPs)

- Psychiatric mental health nurse practitioners-board certified (PMHNP-BCs)
- Mental health counselors
- Independent clinical social workers
- Advanced social workers
- Marriage and family therapists

Strategy B (Defined Above)

- Equipment and Supplies, PERS (e.g., Assistive Technologies)
- Caregiver Education – Information and Skills (including evidence-based (EB) interventions, e.g., STAR-Caregivers (STAR-C), RDAD (Reducing Disability in Alzheimer's Disease), Home Care Aide Training
- Care Receiver Education – Improve Health, Strength and Self Care, including Evidence Based interventions (e.g., Chronic Disease Self-Management /Living Well classes, Diabetes Self -Management Program and Chronic Pain Self -Management Programs)
- Financial and Legal Planning, setting up Bill Pay process
- Transportation
- Home Delivered Meals/Grocery Deliveries
- Pharmacy Delivery
- Rehabilitation Services (e.g., OT/PT)

Higher care needs: In TCARE®, services that provide a break from caregiving are identified under the categories of Informal Help Network, In-Home Supports and Services (Personal Care), Adult Day Services, Overnight Respite Services.

Examples of Services:

- Adult Day Services - Adult Day Health, Dementia and Social Day Care
- Chore/Homemaker Services – e.g., housework and errands type service
- Personal Care or Home Health Services
- Out-of-Home and In-Home Respite

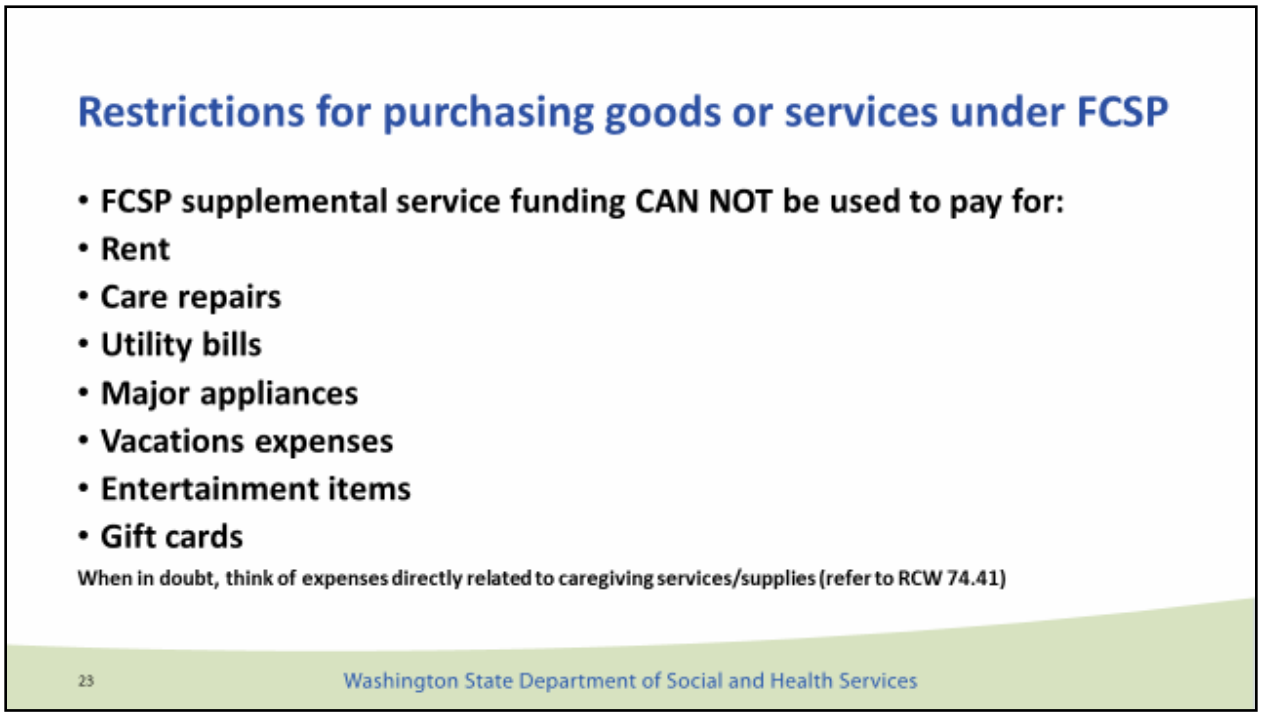
Strategy E (Defined Above)

Example of Services:

- Mental and Physical Health Evaluation
- Alcohol and Drug Abuse Evaluation

Wellness Services – Services to keep caregiver healthy that do not include those services related to emotional health. Emotional Health services belong in Strategies A, B, C and

Appendix D: Restrictions for Purchasing Goods and Services



Appendix E: FCSP Core Services Definitions for OAAPS Reporting

OAAPS FAMILY CAREGIVER SUPPORT PROGRAM CORE SERVICES	OAAPS SERVICE DEFINITIONS
Information Services (Outreach) **Non-Registered Service** OAAPS Unit/Bar Code: 1 Activity/.79.51 Information Services (Outreach Activities)	Information Services OAAPS Definition: Access Assistance—Case Management—A public and media activity that conveys information to unpaid caregivers about available services, including in-person interactive presentation, booths/exhibits, or radio, TV, or Web Site Events.
Access Assistance-Information and Assistance **Non-Registered Service** **OAAPS Unit/Bar Code: 1 Contact/.79.2a.2 Access Assistance—Information and Assistance**	A service that provides the individuals with current information on opportunities and services available to the individuals within their communities.
Access Assistance – Care Coordination **Registered Service** OAAPS Unit/Bar Code: 1 Hour/.79.2a.1 Access Assistance— (Screens, Assessments/Coordination of services)	A service provided to an unpaid caregiver, at the direction of the unpaid caregiver, by an individual who is trained or experienced in the coordination skills that are required to deliver services and supports.

Support Services **Counseling -- Registered Service** **Training-- Registered Service** **Support Groups – Non-registered Service or Registered Service** OAAPS Unit/Bar Code: 1 Hour/.79.5c Support Services (Counseling, Support Groups & Trainings)	**Counseling**—A service designed to support unpaid caregivers and assist them in decision-making and problem solving. This service must be provided by a qualified counselor and includes individual and group sessions **Training**—A service that provides unpaid caregivers with instruction to improve knowledge and performance of specific skills relating to caregiving. These specific skills may include, but are not limited to, activities related to health, nutrition, and financial management; providing personal care; and communicating with health care providers and other family members. **Support Groups --** (nonregistered or registered) —A service led by an individual who meets state/territory policy requirements to facilitate caregiver discussion of their experiences and concerns and develop a mutual support system.
Respite **Registered Service** OAAPS Unit/Bar Code: 1 Hour/.79.5d.3 Respite Services—Overnight & .79.5d.4 Respite Services—Other	Respite Care—A services which offers temporary, substitute supports or living arrangements for care recipients. It provides a brief period of relief for the unpaid caregiver. There are four types of respite: 1. In-Home Respite 2. Out-of-Home Respite (Day) 3. Out-of-Home Respite (Overnight) 4. Other
Supplemental Services **Registered Service** OAAPS Unit/Bar Code: 1 Unit/.79.4.a Supplemental Services—Assistive Technology/DME/PERS, .79.4.b Supplemental Services—Consumable Supplies, .79.4.c Supplemental Services--Home Modifications/Repairs, .79.4.d Supplemental Services—Legal/Financial Consultation, .79.4.e Supplemental Services—Homemaker/Chore/Personal Care, .79.4.f Supplemental Services—Transportation, .79.4.g Supplemental Services—Nutrition Services, .79.4.h Supplemental Services--Other	Goods and services provided on a limited basis to complement the care provided by unpaid caregivers • Assistive Technology/Durable Medical Equipment/Emergency Response • Consumable Supplies • Home Modifications/Repairs • Legal and/or Financial Consultation • Homemaker/Chore/Personal Care • Transportation • Nutrition Services • Other

Appendix F: TCARE® Screener, Assessor Training and Assessor Monitor

TCARE® Screener Training

TCARE Screener Training is completed by self-study in the form of power point slides. The Power Point slide deck can be found in the GetCare Help Library under Caregiver Programs.

TCARE® Assessor Online Training

A TCARE® Assessor must complete TCARE® Inc online Assessor training and be certified by Tailored Care Inc. before using the TCARE® Assessment Tool in GetCare.

Training Process

AAA Supervisor will enter an Issue Manager Request in GetCare with the following information:

- Name of assessor trainee
- Phone number
- Email address
- AAA and office or network agency
- All other information GetCare needs for access to MAC/TSOA, etc.

Next Steps

1. ALTSA FCSP/TCARE Program Manager will provide access to GetCare with requested role permissions.
2. ALTSA FCSP/TCARE Program Manager will contact TCARE Inc to register assessor trainee.
3. TCARE Inc will email training process to trainee and provide link to training.
   Use Google Chrome, Firefox, Safari or Microsoft Edge to access TCARE Inc. Training site.

NOTE: Assessor trainees cannot use the TCARE assessment in GetCare until they have completed the TCARE Assessor exam and have a training certificate from TCARE Inc.

Our TCARE Assessor Trainees will use the Washington Assessor Training section of TCARE Inc Training. Trainee will:

- View all courses
- Take all quizzes
- Complete Walk Throughs and Case Studies
- Complete Hands-on Exercises
- Pass TCARE Assessor Final Exam

4. Supervisor will assign an experienced, knowledgeable TCARE assessor to mentor new assessor.

5. Assessor Trainee will assess a caregiver and complete the entire TCARE process; TCARE screen, TCARE assessment, consultation and care plan with assistance as needed from mentor.
6. AAA will train new TCARE Assessor about local policy, MTD, FCSP, GetCare depending on staff position.

NOTE: Many TCARE Assessor Trainees report that having a mentor while they are working through their first assessment processes is very helpful in learning to become an accomplished Assessor.

Monitoring/Quality Assurance

It is recommended that a supervisor review three TCARE® caregiver cases (which includes entering demographics through the completion of care plan) and provide a mentor who is TCARE certified and provide feedback to each newly certified TCARE® assessor within their first three months. After the first year, it is recommended that a minimum of two TCARE® caregiver cases be reviewed for each assessor to ensure program quality. Examples of some case review templates will be available on the ALTSA TCARE® resource page.

Appendix G: TCARE® Assessor Qualification and Recertification

TCARE Assessor Qualifications

Staff administering the full TCARE assessment/consultation and service planning must meet the minimum qualifications of an AAA Case Manager. These qualifications include the following minimum education and experience requirements:

1. A Master's degree in behavioral or health sciences and one year of paid on-the-job social service experience; or
2. A Bachelor's degree in behavioral or health sciences and two years of paid on-the-job social service experience; or
3. A Bachelor's degree and four years of paid on-the-job social service experience.

NOTE: If a staff member does not meet these minimum requirements, a waiver in form of a letter must be submitted to ALTSA FCSP/TCARE Program Manager that includes an explanation of the qualifications, experience and reasons for recommendation of the staff

Recertification of TCARE® Assessors

If a TCARE assessor has a lapse of more than a year in using the TCARE assessment process, the assessor will visit the TCARE Inc Training site to refresh their knowledge of the philosophy and process of TCARE

and complete other updates in training determined by their AAA. If assessor doesn't have access to the TCARE Inc training site, contact the FCSP/TCARE Program manager at ALTSA.

Appendix H: WACs and RCWs

FCSP Related Washington Administrative Codes (WACs) and Revised Codes of Washington (RCW)

The following rules apply to clients receiving services in Family Caregiver Support Program. HCS works in partnership with Area Agencies on Aging to provide quality service delivery in all counties.

RCW	
Section 74.41.010	Legislative Findings
RCW 74.41.020	Intent
RCW 74.41.030	Definitions
RCW 74.41.040	Administration – Rules - Program Standards
RCW 74.41.050	Family Caregiver Long-term Care Information and support services—Respite Services, evaluation of need, caregiver abilities
RCW 74.41.060	Respite Care Program - Criteria
RCW 74.41.070	Family caregiver long-term care information and support services - data
RCW 74.41.080	Health care practitioners and families not impaired
RCW 74.41.090	Construction—chapter applicable to state registered domestic partnerships -- 2009
RCW 74.41.900	
WAC	
WAC 388-106-1110	Am I eligible for SCSA-funded services at no cost?
WAC 388-106-1115	What income and resources are exempt when determining eligibility?
WAC 388-106-1120	What if I am not eligible to receive SCSA-funded services at no cost?
WAC 388-106-1200	What definitions apply to respite care services through the family caregiver support program?
WAC 388-106-1205	What are respite care services?
WAC 388-106-1210	Who is eligible to receive respite care services through the family caregiver support program?
WAC 388-106-1215	Who may provide respite care services through the family caregiver support program?

Respite Care Services Washington Administrative Codes (WACs) and Revised Codes of Washington (RCW)

RCW	
Section 74.41.010	Legislative Findings
RCW 74.41.020	Intent
RCW 74.41.030	Definitions
RCW 74.41.040	Administration – Rules - Program Standards

RCW 74.41.050	Family Caregiver Long-term Care Information and support services—Respite Services, evaluation of need, caregiver abilities
RCW 74.41.060	Respite Care Program - Criteria
RCW 74.41.070	Family caregiver long-term care information and support services - data
RCW 74.41.080	Health care practitioners and facilities not impaired
RCW 74.41.090	Construction—chapter applicable to state registered domestic partnerships -- 2009
RCW 74.41.900	
WAC	
WAC 388-106-1110	Am I eligible for SCSA-funded services at no cost?
WAC 388-106-1115	What income and resources are exempt when determining eligibility?
WAC 388-106-1120	What if I am not eligible to receive SCSA-funded services at no cost?
WAC 388-106-1200	What definitions apply to respite care services through the family caregiver support program?
WAC 388-106-1205	What are respite care services?
WAC 388-106-1210	Who is eligible to receive respite care services through the family caregiver support program?
WAC 388-106-1215	
WAC 388-106-1220	How are respite care providers reimbursed for their services through the family caregiver support program?
WAC 388-106-1225	Are participants required to pay for the cost of their respite care services through the family caregiver support program?
WAC 388-106-1230	What determines emergent and non-emergent respite care services through the family caregiver support program?

Appendix I: Commonly Used Acronyms and Abbreviations

AAA	Area Agency on Aging
ADL	Activities of Daily Living
IADL	Instrumental Activities of Daily Living
ALTSA	Aging and Long-Term Support Administration
CFC/COPES	Community Living Connections/Community Options **Program Entry System**
CMS	Centers for Medicare and Medicaid
ETP	**Exception to Policy**
ETR	**Exception to Rule**
FCSP	Family Caregiver Support Program

HCS	Home and Community Services
IADL	Instrumental Activities of Daily Living
NFCSP	National Family Caregiver Support Program
MAC/TSOA	Medicaid Alternative Care/Tailored Supports for Older Adults
OAA	Older Americans Act
RCW	**Revised Code of Washington**
SCSA	Senior Citizens Services Act
SFCSP	State Family Caregiver Support Program
SMI	State Median Income
TCARE	Tailored Caregiver Assessment and Referral
WAC	**Washington Administrative Code**

REVISION HISTORY

Date	Made By	Change(s)	MB #
5/22/2025	Dana Allard-Webb	Moved to new template	N/A
5/11/2021	Dana Allard-Webb	Changes due to GetCare/TCARE Integration Changes for 6-month screen policy TCARE Screener and Assessor Training TCARE Assessor	H21-050
2/28/2022	Dana Allard-Webb	Removed NAPIS language Changed TCARE Assessor and Screener Training Process	H22-

Kinship Caregivers Support Program (KCSP) Policies and Procedures

This chapter serves as guidance and information on the provision of Kinship Caregivers Support Program (KCSP) services. The Kinship Caregivers Support Program is intended to provide supportive funding to kinship caregivers who would be at great risk of being unable to maintain the caregiving role without the supports KCSP provides.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Rosalyn Alber Kinship & Lifespan Respite Program Manager
360.584.2450 rosalyn.alber@dshs.wa.gov

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BACKGROUND

The Kinship Caregivers Support Program (KCSP) funds are to support kinship caregivers (grandparents and other relatives) statewide who are at great risk of being unable to maintain the caregiving role without additional financial support at the time a child(ren) come to live with their relatives, as well as after the initial period.

The KCSP funds are provided solely for Area Agencies on Aging (AAAs), or their designated subcontractors to authorize services or items to support children within kinship families.

COLLABORATION AND OUTREACH FOR THE KCSP

- In carrying out the KCSP, each AAA must coordinate the activities of the agencies or the designated subcontractor with the activities of other public and private agencies or organizations providing services for kinship caregivers.

- The AAA and any of its KCSP subcontractor(s), must provide a listing/description of the KCSP for the public to view on the AAA's/subcontractor's website(s), and/or brochure(s) and in the Community Living Connections county resource directory

- The AAA and/or its subcontractor must conduct culturally relevant outreach to kinship caregivers and to possible referral agencies.

KINSHIP CAREGIVER ELIGIBILITY

Persons eligible to receive funding from KCSP include a grandparent (or step grandparent) or other adult relative who is:

A. raising a child(ren), age 18 or younger child*; and

B. related by blood or marriage to the child(ren); and

C. living with the child(ren) in Washington State; and

D. the primary caregiver of the child(ren) because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver of the child(ren); and

E. the parent(s) is consistently absent from the home

F. raising the child(ren) either with a legal relationship, such as legal custody, adoption or informally; and

G. at risk of not being able to continue kinship caregiving without additional financial support services.

*Unless the youth who is older than 18 and attends high school and has documentation to verify school enrollment.

VERIFICATION OF PRIMARY CAREGIVING RELATIONSHIP

The KCSP staff should request that the Kinship caregiver provide current (produced within the last 12 months) verification of his/her primary caregiving relationship to the child(ren) they are raising from a reliable source. For example, if the caregiver has custody paperwork dated more than 12 months from request for KCSP assistance, another current form of documentation must be provided. The verification source must be documented in the client's paper or online GetCare file. And if that is not feasible, this should be noted in the caregiver's file.

Examples include:

A) legal custody court documents,

B) medical provider,

C) parental consent agreement, notarized when possible

D) school documentation,

E) tax return,

F) DSHS award letter for services, e.g., TANF Child Only Grant, Food Assistance,

G) Social Security information,

H) lease agreements where a relative child is listed, or Section 8 Housing vouchers which list relative children,

I) an official letter from the kinship caregiver's Tribal governing body, or social service office,

J) As a last option, a letter from a faith/religious community leader.

K) As a last resort signed "Declaration of Health Care Consent"

L) If the kinship caregiver does not have any documented proof, the KCSP staff must receive permission from the caregiver to contact an appropriate professional or agency, or to make a home visit to verify the primary kinship care relationship.

Verification Documents Relationship

1. If possible, obtain the documents from the client or collateral agency (e.g., other state agencies such as DSHS or DCYF) electronically.

2. If the family has ability to send and respond by email confirming the declaration of relationship, consent and understanding their responsibility of services this may be accepted as their signature.

3. If electronic or in person methods are not feasible, send a copy of screening/intake, consent, and declaration form by mail for signature with a postage-paid return envelope. Do not delay the services because these forms are not signed and returned.

4. We can rely on the documented verbal approval of the client to authorize services.

5. Document the person's name, date the screening took place on the screening/intake form and other necessary information in case notes.

Ineligible Caregivers

Persons who are ineligible to receive funding from the KCSP include kinship caregivers who are:

A. A licensed foster care parent receiving foster care payments for the relative child; or

B. A relative who is an unlicensed caregiver and has an assigned Department of Children Youth and Families (DCYF) case worker for the child(ren) in their care. They may be eligible for DCYF funds for concrete goods which are available through the assigned caseworker to support placement.

USES FOR THE KCSP FUNDS

The KCSP funds are to be used to purchase approved items or services which benefit the child(ren)/youth being raised by kinship caregivers to help pay for the cost of meeting one of more of their urgent needs. Alternate payment sources must be exhausted prior to authorizing payments. Those kinship caregivers experiencing the most urgent/ needs have the highest priority. Depending on the needs presented by the kinship caregivers, more than one need may be addressed by the KCSP funds during a three-month period, however, caregivers may utilize the funds for additional needs up to 2 times every 12 months.

Approved items and services for which the KCSP funds can be used, but are not limited to include:

A. First/last month's rent or utility hook-ups for relatives who must move, in order to take a child into their home.

B. Rent and/or utility assistance may be available on a case-by-case basis after all other rent/utility supports are accessed and when a family is at risk of eviction and/or utility shut-off (a shut off/eviction notice is not required). *Documentation of the amount owed is required (i.e., lease, bill, statement).

C. Household items, e.g., child bedding, furniture, cleaning supplies, toilet paper

D. Child's personal care items, e.g., diapers, hygiene products which meet the need(s) of the child.

E. Payment for legal packets or mediation services. Facilitation of guardianship or adoption action is an option for relatives when all relevant parties agree upon the action. These services may include payment for court facilitators, court fees, Guardian Ad Litem (GAL) and/or Court Visitor, home study, and attorney fees. AAAs should establish lids for legal fees. For example, $1,000 for court fees, etc.

F. Gas and bus vouchers/car repairs needed to transport or provide for the child.

G. Food**

H. Children/Youth's clothing (may include adult sizes).

I. Counseling for the kinship caregiver and child(ren) to address issues such as trauma.

J. School related supplies and fees, e.g., uniforms, musical instrument rentals, field trips, computers/tablets when these items are unavailable from other sources and required for academic use.

K. Sports and youth activity registrations, fees, uniforms, and related equipment.

L. Durable medical equipment or assistive technology devices/equipment to benefit the child not covered by Medicaid or other health insurance.

M. Medications for the child not covered by Medicaid or other health insurance.

N. Tutoring.

O. Safety items, e.g., medication lock boxes, safety locks.

P. Interpreter services; or

Q. Supervision for child(ren) during kinship caregiver appointments.

R. Computer/tablets may be purchased for the kinship caregiver when necessary for tele-med appointments, mental/behavioral health appointments and online support groups for the child and/or caregiver. Expenditures for computers/tablets may not exceed $800.00 per household. All other resources for obtaining computers/tablets must be exhausted prior to purchase.

* If a caregiver is receiving a child only TANF grant, they may be eligible for the DSHS Economic Services AREN (Additional Requirements for Emergent Needs) program to cover one-time shelter costs.

**Although the KCSP policies do not restrict what types of foods/beverages can be purchased with KCSP funds, ALTSA encourages kinship providers to encourage healthy food/beverage purchases. Policies can be developed at the AAA level to restrict certain food and/or beverage purchases.

INAPPROPRIATE USES OF KCSP FUNDS

KCSP funds cannot be used for ongoing benefits to meet basic needs such as: continued rent or utility payments, or children's medical or dental services.

Other examples of inappropriate uses of these funds include the purchase of:

A. clothes for household members other than the relative children.

B. tobacco products.

C. food/drink items, e.g., alcohol, not appropriate for children's consumption; and

D. electronic items, e.g., video games, gaming systems.

Computer/tablets may be purchased for the kinship caregiver when necessary for tele-med appointments, mental/behavioral health appointments and online support groups for the child and/or caregiver. Expenditures for computers/tablets may not exceed $800.00 per household. All other resources for obtaining computers/tablets must be exhausted prior to purchase.

Exceptions can be made by ETPs for items needed for educational purposes, medical, mental health, or support group purposes and not available through other avenues.

SERVICE PROVIDER REQUIREMENTS

Service providers (e.g., legal providers, mental health counselors, interpreters) who receive KCSP payment must be certified or licensed through Washington State, with the exception of persons who only supervise the child(ren) during caregiver appointments or providing tutoring services.

Any person who will provide a service(s) for children without supervision (e.g., counselors, care providers or tutors) must pass and have documentation of a WA State Patrol background check before providing services and before payment can be authorized. The contracted KCSP provider is responsible to ensure background checks are in place.

DETERMINING INDIVIDUAL KINSHIP CAREGIVER FUNDING LEVELS

A. AAAs or their designated subcontractors will screen kinship caregivers according to standardized procedures developed by the AAA to determine if and how much financial support may be available to meet specific needs of kinship caregivers.

B. The AAAs are responsible for handling and approving the KCSP Exception to Policy (ETP) cases. The AAAs must send copies (by email) of the approved and denied ETP requests to the ALTSA KCSP Program Manager who can also be consulted on individual cases.

C. Kinship caregivers may apply to the AAA or its subcontractor(s) for financial assistance up to two times per year. More than one need may be addressed by the KCSP funds during a three-month period; however, caregivers may utilize the funds for additional needs up to 2 times every 12 months. The window of time begins when the first service is provided.

D. If the child(ren's) needs in a kinship care family exceed $1,500 during a 12-month period, an ETP must be approved by the AAA.

Each AAA will establish limits as to how much financial support may be available to meet specific needs of kinship caregivers.

E. KCSP funds must be used for eligible expenses incurred after being approved for the program. The only exceptions are eligible expenses incurred prior to approval for things such as rent, utilities or overdue payments.

F. The AAA or its subcontractor(s) will manage the authorizations and have in place or develop a payment system for approved goods and services, which can include: 1) vouchers 2) purchase orders, and/or 3) credit cards for approved staff; and/or 4) food and gas cards which exclude other items from being purchased. Only a check may be provided to a third-party service provider accompanied by a receipt, invoice, or other valid documentation.

G. Direct payments to kinship caregivers are not allowed.

H. AAAs are responsible to ensure that when purchasing goods/services or one-time set-up fees/deposits on behalf of an eligible kinship caregiver, documentation within the client file must include:

1. Kinship caregiver's name.
2. Eligible relative children's first and last names, their birthdates, gender, and last four digits of their social security numbers (if available).
3. A description of the approved goods and/or services including authorized amount.

4. Confirmation that the purchase is consistent with needs identified by the caregiver for the benefit of the kinship child(ren) and is consistent with program requirements; and
5. Proof (e.g., receipt, invoice, etc.) that the goods or services were purchased, and received by the kinship caregiver and are within the program costs limitations and guidelines.

I. AAAs will decide the process that works best for their service area; however, agencies must be able to produce all back-up documentation upon request, e.g., copies of invoices, receipts, cancelled checks, and client case notes.

J. Kinship caregivers must sign an agreement acknowledging that funding may only be used for authorized items and or services and their responsibilities (e.g., returning purchase documentation). Local AAA policies will determine the consequences for purchases over the authorized amount or for any unqualified expenditures.

K. The KCSP funds will not affect the TANF grant eligibility for the kinship caregivers.

Telephonic or Video Conferencing Screening Process

Eligibility standards do not change because the screening is occurring by telephone or video conferencing. Staff will complete all screening questions.

1. If possible, obtain the documents from the client or collateral agency (e.g., other state agencies such as DSHS or DCYF etc...) electronically.

2. Send a copy of screening/intake, consent, and declaration form by mail for signature with a postage-paid return envelope. Do not delay the services because these forms are not signed and returned.

3. If the family has ability to send and respond by email confirming the declaration of relationship, consent and understanding their responsibility of services this may be accepted as their signature.

4. A digital picture of signature is also allowed.

5. Document the person's name, and date the screening took place on the screening/intake form and other necessary information in case notes.

REFERRALS TO THE KINSHIP NAVIGATOR PROGRAM

If an AAA operates a separate Kinship Navigator Program (KNP), KCSP recipients must be offered a referral to the local Kinship Navigator to discuss their other needs.

REPORTING REQUIREMENTS FOR THE KCSP

Financial Reporting

To allow for accurate tracking of KCSP funds, ALTSA requires that AAAs account for expenditures separate from other programs.

The KCSP expenditures are reported in three categories:

- Program Administration: (up to 10% of the AAA allocation may be used for general administration). AAAs can choose to pass on their allocation for program administration to their subcontractor,
- Service Delivery: (up to 15% of the AAA allocation may be used for costs associated with outreach, payment authorization, screening, background checks); and,
- Goods and Services: Payment for goods or services needed by the children of eligible kinship caregiver families.

Program Reporting

The AAAs/KCSP subcontractors must utilize the Community Living Connections (CLC) reporting system to enroll caregivers, record KCSP caregiver services and complete the Kinship Intake for each participating kinship caregiver family.

Narrative Reporting

Annually, and no later than October 1st of each year, AAAs are required to submit the following information to the ALTSA Kinship Care Program Manager:

1) At least two case examples describing the circumstances and the needs of a participating caregiver, what assistance was provided to the caregiver through KCSP, and the impact the intervention had on the kinship caregiver and their family to help or continue stability for the children in their care. This information is used to explain to the legislature and other interested parties the effectiveness of and need for support for the KCSP.

2) Copies of any new public relations material(s) developed for the KCSP (including brochures, newspaper articles, flyers, etc.).

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
3/24/2020		COVID Temporary Revision	
5/21/2020		COVID Temporary Revision	
12/15/2022		Revised	

Kinship Navigator Program

Chapter 17c describes Kinship Navigator Program available to kinship caregivers. Information collected from caregivers is stored in the GetCare data management system.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Rosalyn Alber Kinship & Lifespan Respite Program Manager
360.584.2450 rosalyn.alber@dshs.wa.gov

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BACKGROUND

Kinship caregivers are resource families that have a prior relationship with a child or youth, either as relatives or suitable persons. Relatives have a relationship through blood, marriage, or custom. Suitable persons, sometimes called "fictive kin" have a preexisting relationship with the child. They can be neighbors, godparents, schoolteachers, coaches, family friends, or non-relative "aunties."

DEFINITIONS AND EXAMPLES

Caregiver Eligibility

Persons eligible to receive services from KNP may include a kinship caregiver as defined in the Background Section above, raising a child(ren) aged 18 or younger, not theirs by birth, unless the youth who is older than 18 attends high school.

Role of the Kinship Navigator

The role of the Kinship Navigator is to connect kinship caregivers with community resources, such as health, financial, legal services, support groups, training, and emergency funds, federal and state benefits.

HISTORY OF WASHINGTON STATE'S KINSHIP NAVIGATOR PROGRAM

The Kinship Navigator Program began in Washington State in July of 2004 when Casey Family Programs (a member of the Washington State Kinship Oversight Committee/KCOC) funded and piloted two programs. As a result of the pilot, the Legislature funded the program in 2005 and as of 2023 has expanded to all Area Agencies on Aging (AAAs) in WA state covering each county.

In 2016 the Legislature appropriated funding for the Tribal Kinship Navigator Program. As of 2023 there are seven participating Tribes (Lummi, Samish, Port Gamble S'Klallam, Colville, Yakama Nation, Makah, Quileute).

PRINCIPAL DUTIES AND RESPONSIBILITIES FOR THE KINSHIP NAVIGATOR

- The Kinship Navigator will provide information and assistance along with supportive listening to kinship caregivers of all ages who are raising children or planning to do so. Navigators need to be knowledgeable about relevant federal and state benefits, as well as local resources.

- The Kinship Navigator will provide outreach focusing on serving relatives from geographically isolated and historically marginalized communities.

- The Kinship Navigator will provide follow-up with kinship caregivers as needed.

- The Kinship Navigator must develop strong collaborative working relationships with groups and agencies that work with kinship caregivers.

- The Kinship Navigator will help educate the community about the needs of kinship families and available resources.
- The Kinship Navigator will support the caregivers while mediating with state agency staff and/or service providers to ensure the caregivers receive services for which they are eligible.

- The Kinship Navigator will participate in available training and statewide Kinship Navigator meetings. Attendance in Kinship Care Oversight Committee (KCOC) meetings is encouraged.

- The Kinship Navigator must record and report information as outlined below.

REPORTING REQUIREMENTS FOR THE KNP

Data Collection/Program Reporting

All client data is entered into the GetCare database. (Tribal Navigator Programs will either use GetCare or excel spreadsheet).

Data collection steps include:

1: Demographic data service report (GetCare)

2: Kinship Program Intake Assessment (annually-GetCare)

3: Time spent on client support (Case Coordination units in GetCare)

Program reporting includes:

- Case examples (semi-annually to ALTSA Kinship Program Manager)
- Client satisfaction (conducted annually at the program level)

If Kinship Care Support Program (KCSP) disbursement is applicable, please consult chapter 17b of the Long Term Care Manual (LCM) for required support documentation.

BUDGET/ALLOWABLE COSTS

Funds are available starting in FY 2024 to support at least one Kinship Navigator FTE at each Area Agency on Aging (AAA). Allowable costs include staff, travel, translation and interpreter services, data collection support, supplies and administration (not to exceed 10%) and equipment only when directly necessary to provide Kinship Navigator services.

FOR MORE INFORMATION

Please see find the website under related links or contact Rosalyn Alber.

RESOURCES

Related Administrative Policies

- Kinship Navigator Program MB

Related Links and Websites

- https://www.dshs.wa.gov/altsa/home-and-community-services-kinship-care/kinship-care

CONTACTS

Rosalyn Alber, Kinship & Lifespan Respite Program Manager
rosalyn.alber@dshs.wa.gov
Phone # 360-584-2450
Address ALTSA HQ Blake East

ACRONYMS

- ALTSA-Aging and LONG-TERM Support Administration
- KNP-Kinship Navigator Program
- KCOC-Kinship Caregiver oversight committee
- KCSP- Kinship Caregiver Support Program
- AAA- Area Agencies on Aging
- RCW- Revised Code of Washington

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #

Home Delivered Nutrition

The home delivered nutrition services program provides nutritious meals and other nutrition services to older persons who are homebound by reason of illness, incapacitating disability, or otherwise isolated. Services are intended to maintain or improve the health status of these individuals, support their independence, prevent premature institutionalization and allow earlier discharge from hospitals, nursing homes, or other residential care facilities. Each meal served contains at least one third of the current recommended dietary allowances as established by the Food and Nutrition Board of the National Academy of Sciences - National Research Council.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Cameron Akita Program Manager
360.867.8861 cameron.akita@dshs.wa.gov

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PROCEDURES

Target Population

A. The target population for the home-delivered nutrition services program is persons who:
   1. Are age 60 and over , and
   2. Are unable to prepare meals for themselves because of:
      a. Limited physical mobility; or
      b. Psychological or mental impairment; or
      c. Lack of knowledge or skills to select and prepare nourishing and well balanced meals; and
      d. Are homebound.
   3. All persons served must be members of the target population, or spouse.

Eligibility

1. SCSA Eligibility requirements: Age 60 or over.
2. OAA Eligibility requirements: Age 60 or over OR spouse of person age 60 or over.

Vulnerability Criteria

To the degree feasible, persons served should meet the following vulnerability criteria:

A. Is unable to perform one or more of the activities of daily listed below without assistance due to physical, cognitive, emotional, psychological or social impairment:
   a. Ambulation
   b. Bathing
   c. Cooking
   d. Dressing or undressing
   e. Eating
   f. Housework
   g. Laundry
   h. Manage medical treatments (prescribed exercises, change of dressings, injections, etc.)
   i. Manage medications (what to take, when to take, how to store properly, etc.)
   j. Manage money (budgeting, check writing, etc.)
   k. Personal hygiene and grooming
   l. Shopping
   m. Telephoning
   n. Toileting
   o. Transfer (getting in and out of bed/wheelchair)
   p. Transportation

OR

B. Has behavioral or mental health problems that could result in premature institutionalization, or is unable to perform the activities of daily living listed in #1, or is unable to provide for his/her own health and safety primarily due to cognitive,

behavioral, psychological/emotional conditions which inhibit decision-making and threaten the ability to remain independent.

AND

C. Lacks an informal support system. Has no family, friends, neighbors or others who are both willing and able to perform the service(s) needed or the informal support system needs to be temporarily or permanently supplemented.

SERVICE PROVISION

A. Nutrition education is a service by which individuals gain the understanding, skills, and motivation necessary to promote and protect their nutritional well-being through their food choices.

B. Nutrition outreach is a services designed to seek out and identify, on an ongoing basis, the maximum number of the hard-to-reach, isolated, and vulnerable target group eligible individuals throughout the program area.

C. Each home-delivered nutrition program service provider must provide each older person with the opportunity to make a voluntary and confidential donation to the cost of the meal.

D. In no way may a program operated by specific groups, such as churches, social organizations, senior centers or senior housing developments, restrict participation in the program to their own membership or otherwise show discriminating preference for such membership.

E. Subject to participant consent, all participants will be referred to the I&A component of the I&A/CM program for screening to determine the need for case management. Consult with the local area agency on aging for additional referral information.

F. Each day's menu must meet one-third of the current Recommended Dietary Allowances.

G. Each service provider must provide for home-delivered meals at least once a day, five or more days a week. Meals may be hot, cold, frozen, dried, canned or supplemental foods with a satisfactory storage life. Service providers should consider, where feasible and appropriate, serving two or more meals per day, seven days a week, and providing meals on holidays.

H. The service provider should document or have immediate access to the following information about each participant by the delivery of the first meal.

1. Name, home address, and phone number of participant.

2. Name and phone number of participant's physician and/or person to contact in case of an emergency.
3. Special diet requirements, restrictions, or nutritional problems and concerns expressed by the participant.
4. Any physical disabilities, handicaps, or other problems which may influence the type and schedule of food service delivery or meals offered to the participant.

NOTE: Home Delivered Meals may also be provided through the COPES Program. See Personal Care Services in Chapter 7 of the Long-Term Care Manual for more information.

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Related WACs and RCWs

WAC 388-17-100(F)	Nutrition Services are not Means Tested
OAA Title III Sec. 336-339	Hot Meals to be Provided in by Home Delivery at Least Five Days Per Week.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #

Congregate Nutrition

The congregate nutrition services program helps meet the complex nutritional needs of older persons who do not have adequate nutrition by providing sound and satisfying meals and other services such as nutrition outreach and education, in a group setting. Federal Standards require each meal served to contain at least one-third of the current Recommended Dietary Allowances as established by the Food and Nutrition Board of the National Academy of Sciences - National Research Council.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Cameron Akita Program Manager
360.867.8861 cameron.akita@dshs.wa.gov

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PROCEDURES

Target Population

A. The target population for the congregate nutrition services program is persons age 60 and over who:

1. Are unable to prepare meals for themselves because of:
   a. Limited physical mobility; or
   b. psychological or mental impairment; or
   c. Lack of knowledge or skills to select and prepare nourishing and well balanced meals; or
   d. Lack of incentive to prepare and eat a meal alone.

2. All persons served should be members of the target population.

B. To the degree feasible, persons served should meet the following vulnerability criteria:

1. Is unable to perform one or more of the activities of daily listed below without assistance due to physical, cognitive, emotional, psychological or social impairment.

   a. Ambulation
   b. Bathing
   c. Cooking
   d. Dressing or undressing
   e. Eating
   f. Housework
   g. Laundry
   h. Manage medical treatments (prescribed exercises, change of dressings, injections, etc.)
   i. Manage medications (what to take, when to take, how to store properly, etc.)
   j. Manage money (budgeting, check writing, etc.)
   k. Personal hygiene and grooming
   l. Shopping
   m. Telephoning
   n. Toileting
   o. Transfer (getting in and out of bed/wheelchair)

p. Transportation

OR

2. Has behavioral or mental health problems that could result in premature institutionalization, or is unable to perform the activities of daily living listed in #1, or is unable to provide for his/her own health and safety primarily due to cognitive, behavioral, psychological/emotional conditions which inhibit decision-making and threaten the ability to remain independent.

AND

3. Lacks an informal support system: Has no family, friends, neighbors or others who are both willing and able to perform the service(s) needed or the informal support system needs to be temporarily or permanently supplemented.

Eligibility

A. SCSA Eligibility requirements: Age 60 or over.

B. OAA Eligibility requirements: Age 60 or over OR spouse of person age 60 or over.

C. Individuals providing volunteer services during meal hours.

NUTRITION PROVIDERS

Congregate nutrition sites located in communities where there are significant numbers of minorities should make special efforts to serve these minorities.

In no way may a program operated by specific groups, such as churches, social organizations, senior centers or senior housing developments, restrict participation in the program to their own membership or otherwise show discriminating preference for such membership.

SERVICE PROVISION

A. Referral to Information and Assistance/Case Management (I&A/CM). Subject to participant consent, all participants who appear to meet the vulnerability criteria listed above should be referred to the I&A component of the I&A/CM program for screening to determine the need for case management services.

B. The service provider should document or have immediate access to the following information about each participant no later than his/her fifth meal at the congregate nutrition site:

1. Name, home address, and phone number of participant.
2. Name and phone number of participant's physician and/or person to contact in case of an emergency.

3. Special diet requirements, restrictions, or nutritional problems and concerns expressed by the participant.

C. Each congregate nutrition program service provider must provide each older person with the opportunity to make a voluntary and confidential donation to the cost of the meal.

D. Each congregate nutrition site must seek to be authorized to accept food coupons (food stamps) in lieu of cash from participants who are eligible to purchase food coupons and who wish to use the coupons for congregate meals. Food coupons can be accepted by the congregate nutrition site for meals served at congregate nutrition sites in accordance with the Food Stamp Act.

E. The service provider must provide special menus, where feasible and appropriate, to meet the particular dietary needs arising from the health requirements, religious requirements, or ethnic backgrounds of eligible persons.

F. Each day's menu must meet one-third of the current Recommended Dietary Allowances.

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Related WACs and RCWs

WAC 388-17-100(F)	Nutrition Services are not Means Tested
OAA Title III C Sec. 331	Hot Meals to be Provided in Congregate Settings, Nutrition Education and Other Nutritional Services May be Included

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #

Transportation

Chapter 20 explains the types of transportation services available to ALTSA clients under the Older American's Act, Senior Citizens Services Act, Waiver programs, Medicaid Personal Care (MPC), Assistive Technology, Adult Day Services, Adult Day Health, and Medicaid Transportation Broker Services administered through the Health Care Authority.

ALTSA will coordinate services with other agencies that are safe, efficient, cost effective, and appropriate to our clients.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Linda Garcia Language & Disability Program Manager
360.968.9745 linda.garcia1@dshs.wa.gov

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WHAT ARE TRANSPORTATION SERVICES?

Transportation services assist eligible clients with getting to and from social services, medical services and health care services, meal programs, senior centers, essential shopping, and some recreational activities. Personal assistance for those with limited physical mobility is provided during transport. Always look first to local public transportation services and demand-responsive public transportation service for individuals with disabilities who, because of their disability, cannot use accessible, regular fixed-route bus service.

*Funding may be limited for some transportation services. For 1099 Providers refer to MB 14-075.

PROVIDING TRANSPORTATION SERVICES FOR WAIVER CLIENTS AND ROADS TO COMMUNITY LIVING CLIENTS

Clients may be eligible for waiver-funded (e.g. COPES, Medicaid Transformation Project (MTP), and New Freedom transportation services) and RCL transportation services when the service:

- Provides client access to community services and resources to meet their therapeutic goal, as determined in their care plan;
- Cannot be provided by the client's family, friends, neighbors, or community agencies;
- Is not diversional in nature; and
- Is in addition to and does not replace the Medicaid-brokered transportation (available through use of the Medical ID card) or transportation services available in the community.

Additional Considerations:

- Do not authorize this service for essential shopping scored in CARE.
- The client's personal care attendant can accompany the client at no extra cost if the client needs assistance during the trip or at the destination.
- This service is limited to two round trips per week to a destination within a fifteen-mile radius from the client's residence and provided by the lowest cost and most appropriate mode of transportation. Compensation for automobile transportation shall be limited to 120 miles per month. These limits do not apply to transportation services available under MTPD program.
- Use the AAA contractor list to identify contracted, qualified service providers and service rates. Qualified providers include volunteers, taxis, and public transit.
- Payment of this service will generate a 1099 document if the provider's 1099 earnings are $600 or more for the tax year.

If the client is eligible, you may authorize this service with 1099 vendors in ProviderOne, using these codes:

COPES	S0215 - U2
RCL	S0215 – U2

New Freedom	S0215 – U2

COMMUNITY CHOICE GUIDES (CCG) WHO PROVIDE TRANSPORTATION SERVICES FOR ROADS TO COMMUNITY LIVING (RCL) AND WASHINGTON ROADS CLIENTS

Not every CCG can provide transportation to eligible RCL and WA Roads clients. CCGs who provide transportation services must meet specific transportation requirements in their Community Transition and Training Specialist contract. This service does not replace nor be a substitute to the Medicaid Transportation Broker available to the eligible client. This service is in addition to the Medicaid Transportation Broker.
CCGs meeting all requirements to provide transportation may provide clients with transportation to essential community services and resources in accordance with the client's care plan.
Examples include, but are not limited to

- Visiting community settings to help a client locate and arrange accessible housing.
- Taking a client to various offices necessary to facilitate community living (e.g. to change address with SSA and US Postal Service or obtain an ID card from the Dept. of Licensing).
- Showing a client where community resources are located (pharmacy, local grocery store, etc.) and how to access them (bus stops, etc.).
- Taking a client to shop for transitional household goods (not for essential shopping scored in CARE).
- Transporting the client from the skilled nursing facility to their new community setting. The CCG may transport small personal items (e.g. a suitcase or walker) along with the client but they are not to provide "moving" services.

CCGs providing transportation must:

- Allow the client's personal care attendant to accompany the client with no additional payment if the client requires assistance during the trip or at the destination.
- Be responsible for the entire performance of the transportation services in accordance with federal, state, and local ordinances, statutes, and regulations.
- Maintain transportation records to document the dates, times, destinations, and distances of each client's transportation service.
- Only be compensated for the time they are with the client.

To authorize a CCG to provide transportation for an eligible RCL and WA Roads client:

- For Washington Roads, obtain prior approval from supervisor, assign WA Roads RAC. *(See LTC Manual Chapter 5a.docx for additional information)*.
- For RCL, send an email to DSHSALTSARCLReferrals@dshs.wa.gov. *(see LTC Manual Chapter 29 for additional information).*
- Document the need by selecting Community Integration on the Treatment Screen in CARE. Use the Sustainability Goals screen to communicate authorization for the specific transportation

service. Assign the transportation task to a CCG who meets all transportation requirements in their contract.
- Authorize the transportation rate at the regular CCG rate using service code SA263.

FUNDING TRANSPORTATION SERVICES FOR ADULT DAY SERVICE CLIENTS

Individuals may receive services through an adult day care or adult day health program.

Adult Day Care:
WAC 388-71-0724 (15) "Transportation to and from the program site is not reimbursed under the adult day care rate. Transportation arrangements are made with locally available transportation companies or informal resources."
Transportation for Adult Day Care (as Respite or Social Day Care) may be financed with Older American's Act or Senior Citizens Services Act (SCSA) funding. Refer to AAA Policies and Procedures Manual, Chapter 3, for criteria.

Adult Day Health:
WAC 388-71-0724 (16)" Transportation to and from the program site is reimbursed under adult day health daily rate. Adult day health is required to assist clients in arranging or providing transportation to and from the program sites".
In referring the client to an adult day health center, the case manager may consider: the frailty and endurance of the client, the clients skilled nursing or rehabilitative needs, and a reasonable round-trip travel time that may not exceed two hours, unless there is a no closer center that can meet the clients skilled care needs.

USING THE ASSISTIVE TECHNOLOGY (AT) PROJECT TO MEET TRANSPORTATION NEEDS

If a client has access to a vehicle, consider using the Assistive Technology Project to solve the client's special transportation need. AT devices refer to any item, piece of equipment, or product system, whether acquired commercially off-the-shelf, modified, or customized, that help to increase, maintain, or improve the functional capabilities of individuals with disabilities.

Examples of transportation devices include automatic or manual lifts for vans or other vehicles; hand controls; etc. The client must own the vehicle to receive modifications. Check into other resources for vehicle modifications such as:
- The Division of Vocational Rehabilitation (DVR) (individual must be in a vocational plan);
- The Veteran's Administration (VA) for a service-connected disability;
- New Freedom Waiver (if there are denials from other sources);
- Other waivers in DDA or HCS that may offer assistive technology;
- CFC program offered by DDA and HCS that offers assistive technology;
- The Northwest Access Fund that offers a low-interest loan program for vehicle modification or vehicle purchase. NW Access Fund website: http://www.nwaccessfund.org/

This is state funded only program with limited funds and services will not be paid out of ProviderOne.
Refer to LTC Manual, Chapter 16, for additional information on Assistive Technology.

Roads to Community Living (RCL) Assistive Technology and Vehicle Adaptations

Purchase of assistive technology or vehicle modifications that help to increase, maintain, or improve the functional capabilities of participants.

RCL	SA 390

NOTE: The purchase or lease of vehicles is not covered by any State or Federal program administered through ALTSA.

FUNDING TRANSPORTATION SERVICES FOR DDA CLIENTS

For more information on transportation funding through DDA programs please refer to the DDA Policy Manual regarding Waiver Services, CFC, Community Residential Services, Community Protection Program, and Family Support Services.

MEDICAL MILEAGE REIMBURSEMENT FOR ADULT FAMILY HOME PROVIDERS

Reimbursement is available to an Adult Family Home Provider who transports a resident to medical providers as outlined in the Department's service plan generated by CARE. Reimbursement is available for up to 50 miles per month when brokerage transportation will not meet the resident's needs.

The AFH resident must have an assessed need for medical transportation as documented in the CARE service plan. Compensation will be on a per-mile-driven basis at the standard IRS mileage rate, up to a maximum of fifty (50) miles per month per resident.
Mileage reimbursement for travel to medical appointments is not available to AFH providers in the PACE program.

Mileage reimbursement for travel to medical appointments is different from Mileage reimbursement for community integration. Authorization for one does not preclude authorization for the other. When authorizing medical transportation, use the comment section on the Transportation screen in CARE, to document why Medicaid brokerage transportation will not meet the client's needs.

Authorize up to 50 miles per month using service code:

S0215	U4

USING NON-EMERGENCY MEDICAL TRANSPORTATION BROKER SERVICES – WAC 182-546

The Washington State Health Care Authority (HCA) may pay for transportation services to get clients to and from needed non-emergency healthcare appointments. These appointments must be for services allowed by the client's current Medicaid enrolled program.

Non-emergency medical transportation is provided through businesses called Regional Brokers. Clients may use Medicaid Transportation Broker Services for medical appointments regardless of what program or waiver service they are receiving. This service is covered under the client's ProviderOne services card

To receive this service:

1. The medical destination must be covered by the client's medical program;
2. The medical provider must be the closest provider of that type. Documentation of language barriers may be considered on an exception to rule basis by the case manager;
3. It must be pre-authorized by a Regional Broker. The Broker:
   - Will screen to look at prior transport resources;
   - Will choose the mode (bus/transit, reimbursement, etc.) and the company/provider;
   - May need private information to make a decision. This is covered and allowed by HIPAA. If client refuses to provide information, the Broker will deny transportation.

Regional Broker List – Non-Emergency Medicaid Transportation – https://www.hca.wa.gov/assets/billers-and-providers/ContractedBrokers.pdf

If the client already has a way to get to their healthcare appointment, HCA may be able to help client by paying for gas or paying for client's mileage.

USING STATE FUNDED ALTERNATIVE BENEFIT PLAN (ABP) SERVICES

Transportation can be provided under ABP services when the non-emergency medical transportation service cannot. This program will convert individuals who were on the previous MCS/GAU/GAX programs. This program can include transportation to assessment centers for chemical dependency evaluations to determine treatment requirements or to establish the need for a protective payee.

ABP	Service code T2003

ABP In-home	Service code T1019

PROVIDING TRANSPORTATION SERVICE THROUGH OLDER AMERICANS ACT, TITLE III (B), AND SENIOR CITIZENS SERVICES ACT (SCSA) FUNDING

The target population for transportation services is persons aged 60 and over who need transportation to medical and health services, social services, meal programs or for shopping assistance and cannot:

- Manage their own transportation because they do not have a car;
- Drive;
- Afford to drive; or
- Use public transportation or public transportation is not available or accessible.

Prioritize clients for transportation funded through the Older Americans Act, using the following criteria:

4. Clients:
    a) Are unable to perform one or more of the activities of daily living listed below without assistance due to physical, cognitive, emotional, psychological, or social impairment:
        - Ambulation;
        - Bathing;
        - Meal Preparation;
        - Dressing;
        - Eating;
        - Housework (e.g. laundry);
        - Personal Hygiene;
        - Shopping;
        - Using the telephone;
        - Toileting;
        - Transportation;
        - Transfer (getting in and out of bed/wheelchair);
        - Managing money (budgeting, check writing, etc.); and/or
        - Managing medical treatments (prescribed exercises, change of dressing, injections, etc.)

        OR

    b) Have cognitive, behavioral, or mental health problems that could:
        - Result in premature institutionalization;
        - Keep them from performing the activities of daily living listed above;
        - Prevent them from providing for their own health and safety.
    c) Lack an informal support system (i.e. have no family, friends, neighbors, or others who are both willing and able to perform the service(s) needed.)

Transportation may be provided through Regular Specialized Transportation or Volunteer Transportation. Please refer to the Transportation Guidelines: https://www.dshs.wa.gov/altsa/home-

and-community-services/transportation-program-guidance in the Information for AAAand AAA Contracts (for programs such as COPES, CFC, MAC, TSOA, etc.)

If you identify a client who meets the above criteria, refer them to the Senior Information and Assistance (I&A) case management program for intake into transportation programs. Consult with the local Area Agency on Aging (AAA) for additional referral information.

NOTE: Clients receiving funds through Title III of the Older Americans Act and non-means tested SCSA services must be given a free and voluntary opportunity to contribute to the cost of the services provided. Transportation providers may develop a suggested contribution schedule. If a schedule is developed, providers must consider the income ranges of older adults in the community. No eligible person may be denied service because he or she is unable or unwilling to contribute to the cost of service. The service provider must protect the person's privacy with respect to contributions, establish procedures to safeguard and account for all contributions made by users and use all such contributions to expand the service.

RESOURCES

Related WACs and RCWs

WAC 388-71-0724 (15) How do I apply for an adult day program state contract (adult day care)
WAC 388-71-0724 (16) How do I apply for an adult day program state contract (adult day health)
WAC 182-546 Transportation Services

Acronyms

AAA	Area Agency on Aging
ABP	Alternative Benefit Plan
ADC	Adult Day Care
ADH	Adult Day Health
AFH	Adult Family Home
APS	Adult Protective Services
AT	Assistive Technology
CARE	Comprehensive Assessment Reporting Evaluation
CCG	Community Choice Guide
CFC	Community First Choice
COPES	Community Options Program Entry System
DDA	Developmental Disability Administration
DVR	Department of Vocational Rehabilitation
GA-U	General Assistance - Unemployable
GA-X	General Assistance – Expedited Medicaid
HCA	Health Care Authority

HCS	Home and Community Services
MAC	Medicaid Alternative Care
MCS	Medical Care Services
MPC	Medicaid Personal Care
MTP	Medicaid Transformation Program
RCL	Roads to Community Living
SCSA	Senior Citizens Service Act
TSOA	Tailored Supports for Older Adults
VA	Veterans Administration
WAC	Washington Administrative Code

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
5/22/2025	Linda Garcia	• Moved chapter info to template with new DSHS logo and made general formatting changes • Updated table of contents • Changed MTPD to MTP • Updated language re: WA Roads, added link to WA Rds LTC manual chapter 5a. • Updated language re: RCL, added RCL Referral email address, added link to Chapter 29. • Under "Funding Transportation Services for DDA Client", added link to DDA Policy Manual • Made correction to service code for medical mileage • Under Non-Emergency Medical Transportation Broker section - replaced link to Regional Broker list and added clarifying language. • Added Resource section - Added WACs section and acronyms section	

Volunteer Chore Service

Through the use of volunteers, this program provides assistance with housework, laundry, shopping, cooking, moving, minor home repair, yard care, limited personal care, and transportation to eligible elderly and disabled persons. The program does not provide assistance with bill paying or to people living in residential care facilities, with the exception of assistance to persons moving back to the community from residential care.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Cameron Akita Program Manager
360.867.8861 cameron.akita@dshs.wa.gov

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PROCEDURES

Eligibility

A person is eligible for Volunteer Chore Services (VCS) if he or she is:

1. Eighteen years of age or older; and,

2. Living at home, unless the person is moving from a residential facility to home and needs assistance moving; and,

3. Unable to perform certain household or personal care tasks due to functional or cognitive impairment; and,

4. Financially unable to purchase services from a private provider or to have his or her needs met using other resources.

Referral Process

A. VCS is required to give priority to referrals from HCS, DDD, I&A and case management staff. Make referrals to VCS when an applicant or client:

   1. Does not meet the eligibility requirements for department paid services; or

   2. Is on the waiting list for Chore Personal Care Services; or

   3. Is eligible for five or less hours of Chore Personal Care Services per month; or

   4. Declines Medicaid Personal Care, COPES or Chore Personal Care Services because of income participation or estate recovery; or

   5. Needs assistance with tasks not available in the Medicaid Personal Care, COPES or Chore Personal Care Services Program.

B. Complete Section I of the DSHS form 15-184, Referral to Volunteer Chore Service Program, following the instructions on the back of the form. If services are needed on an emergency basis (within 7 days), make a referral to VCS by telephone and send a completed DSHS form 15-184 by mail.

C. Tear out the goldenrod copy of the form and place it in the client's service record. Mail the rest of the form to the local VCS office with a self-addressed envelope. For the phone number or mailing address of the local VCS office refer to the VCS directory, or call the VCS administrative office at (206) 467-5344 for all counties but Whatcom, Skagit, Island, San Juan, and Snohomish. For these counties, call the local Area Agency on Aging.

D. The VCS staff will search for a volunteer and complete Section II on the referral form. VCS will retain the pink copy and return the completed original to the referring office. This will serve as notice of whether a volunteer has been found for the client.

E. If more than two weeks are needed to find a volunteer, VCS will send a photocopy of the form back to the referring office marked "pending". Follow up with VCS directly if you have not heard within two weeks whether a volunteer was found.

F. After VCS has completed Section II and returned the form to the referring office, file the white original form 15-184 in the service record, replacing the incomplete goldenrod copy, and send the yellow copy to Attn: Volunteer Chore, AASA, PO Box 45600, Olympia, WA 98504-5600.

RESOURCES

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Related WACs and RCWs

WAC 388-15-206	Volunteer Chore Services
RCW 74.38.050	Availability of Services for Persons Other Than Those of Low Income—Utilization of Volunteers and Public Assistance Recipients-0Private Agencies—Well Adult Clinics—Fee Schedule, Exceptions
RCW 74.08.541(4)(c)	Definitions—Chore Services--Eligibility

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #

Apple Health Managed Care (MCO) and Apple Health Medicare Connect (DSNP)

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Kelli Emans — Senior Strategic Integration Advisor
360.725.3213 Kelli.emans@dshs.wa.gov

Brendy Visintainer — Duals Integration Unit Manager
360.725.2640 Brendy.Visintainer@dshs.wa.gov

Ethan Leon — Managed Care Data and Policy Analyst
360.725.3566 Ethan.Leon@dshs.wa.gov

Vanessa Sherrill — Advancing Medicare-Medicaid Integration (AMMI) Program Manager
360.725.3477 Vanessa.Sherrill@dshs.wa.gov

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OVERVIEW OF MANAGED CARE

The purpose of the managed care service delivery model is to integrate services an individual may need in one delivery system with one payment called a capitated payment. The managed care plan must furnish all of an individual's services included in the managed care contract using this capitated payment. This puts the managed care plan at risk for high cost services as well as creates incentives to use prevention and pro-active techniques to keep a person well.

The Health Care Authority (HCA), the Department of Social and Health Services (DSHS), and the Centers for Medicare and Medicaid Services (CMS) have contracts with managed care entities. The contract between HCA, DSHS and/or CMS and the Managed Care entity details what services are covered in the contract and what the Managed Care Organization (MCO) is responsible for. Contract examples include:

- Apple Health (Medicaid)
- Program for all Inclusive care for the Elderly (PACE) (DSHS & CMS)
- Medicare Advantage and Dual eligible – Special Needs Plan (DSNP) (CMS)

APPLE HEALTH (AH) MANAGED CARE AND APPLE HEALTH MEDICARE CONNECT (AHMC)

Apple Health (AH) Managed Care

See WAC 182-538 Washington State Health Care Authority Managed Care for full details.

HCA is the single state Medicaid agency and is responsible for managing Medicaid medical benefits for eligible recipients. HCA also manages the medical benefits of state employees known as the Public Employees Benefits Board (PEBB) program.

HCA has transitioned to mostly contracting with plans to administer the Medicaid benefits, some of the most relevant programs for our clients are:

1. **Fully Integrated Managed Care (FIMC)**
   HCA contracts with MCOs who are responsible for the full scope of Medicaid physical, mental and substance use disorder services. For more information, please see the HCA publication: "Welcome to Washington Apple Health: Managed Care" benefits book.

2. **Behavioral Health Services Only (BHSO)**
   HCA contracts with MCOs who are responsible for mental and substance use disorder services. Clients who are eligible for BHSO benefits are not eligible for FIMC due to having another Third Party Liability (TPL) for their physical health benefits. This is most commonly Medicare and are referred to as Dual Eligible clients. For more information, please see the HCA publication: "Welcome to Washington Apple Health: Behavioral Health Services Only" benefits book.

3. **Fee for Service (FFS) (See Special Populations for more information)**
   Provider is paid directly by HCA for services provided. All dual eligible (those on both Medicare & Medicaid) are FFS for their medical but enrolled in managed care for behavioral health services only. For more information, please see the HCA publication: "Welcome to Washington Apple Health: Coverage without a managed care plan" benefits book**.**

4. **Apple Health Managed Foster Care (AHFC) (See Special Populations for more information)**
   HCA contracts with Coordinated Care (an MCO) to provide medical services and coordination to foster children, foster care alumni and individuals who receive adoption support services.

5. **Primary Care Case Management (PCCM) (See Special Populations for more information)**
   Mostly tribal clinics. Providers are paid FFS, clinic is given a monthly per member per month payment to fund care coordination activities.

Apple Health Medicare Connect (AHMC), seen as a D-SNP segment in CARE and ProviderOne, is not an Apple Health (Medicaid) service. For more information see the section "What is a D-SNP".

Identifying clients who are enrolled in managed care via ACES Online, Provider One, and CARE:

Staff may need to explore further with a client to determine the client's actual coverage. Here are the ways staff can find a client's managed care plan and eligibility:

ACES Online:

First pull up a client by entering name or ACES ID. Hover over the Details drop down and select Medical Information.

ProviderOne:

First hover over the Client dropdown and select Benefit Inquiry. Search the client by their ProviderOne ID number. Click the Ok button. You will now be on the screen that shows Managed Care information.

CARE:

First open the client's file in CARE. Expand the Client Details section. Click on the ProviderOne option. Click the View ProviderOne Details. This will open a web browser and click on the Managed Care hyperlink. This will display their managed care plan.

If the client is enrolled in managed care, the health plan name, program and start and end dates will be visible. You can view managed care information, Primary Care Case Management, Health Home, and PACE enrollments on this screen. Clients who are Fee-For-Service (FFS) will not show any managed care enrollment plan but will be active on a Medicaid program in ACES.

Please see the Resources section for screenshots.

Integrated Managed Care

Additional web resources for benefits and eligibility can be found in the Resources section at the end of this manual.

Benefits:

Please see the HCA Benefit Matrix for more detail. Coverage includes:

- Outpatient care such as: Wellness exams, immunizations, maternity care
- Pharmacy, including over the counter (OTC) and prescription medications
- Laboratory services
- Inpatient Hospital/Emergency Room
- Nursing facility for rehab/skilled nursing services
- Outpatient Mental Health

Eligibility:

Eligibility for Apple Health Medical coverage is handled through:

- The Health Benefit Exchange www.WAHealthPlanFinder.org
- The local DSHS community service office for SSI-eligible aged, blind, and disabled clients.
- www.washingtonconnection.org

Mandatory AH Integrated Managed Care enrollees include:

- Parents, children & pregnant women
- SSI Categorically Needy Blind and Disabled
- CFC, CFC+COPES & institutional clients
- Medicaid Expansion adults without children (MAGI)
- Foster Care (if they do not elect Fee-For-Service [FFS] coverage)
- Clients with Third Party Liability

Enrollment

Medicaid clients will be enrolled into an MCO in the month they are determined eligible for Medicaid. This means they will be enrolled back to the first of the month in which they are determined eligible. This reduces gaps in managed care coverage and increases care coordination for individuals who are newly eligible or have lost eligibility and are reestablishing their Medicaid eligibility.

Fully Integrated Managed Care (AH-FIMC)

FIMC for **Medicaid Only** includes the full scope of Medicaid physical plus mental health and substance use disorder services. Clients with physical health and pharmacy coverage will be enrolled in FIMC Apple Health.

- Apple Health Family (Healthy Options)
- Apple Health Blind Disabled
- Apple Health Adult Coverage
- State Children's Health Insurance Program

Dual eligible clients will not be enrolled in FIMC.

Benefits:

- Medicaid clients have a choice of at least two managed care organizations in an IMC region.
- Medicaid State Plan services will remain the same and clients will continue to a have access to block grant or state-funded behavioral health services that complement the Medicaid benefits.
- Clients will now have one point of contact for medical and behavioral health services instead of navigating up to three systems.

Services covered include:

- Outpatient care such as: Wellness exams, immunizations, maternity care
- Pharmacy, including OTC and prescription medications
- Laboratory services
- Inpatient Hospital/Emergency Room
- Nursing facility for rehab/skilled nursing services
- Mental Health services with the exception of crisis services
- Substance Use Disorder treatment

Behavioral Health Services Only (BHSO)

The **BHSO** program for **Dual Eligible clients** provides specialty mental health and substance use disorder services ONLY and is a separate product than FIMC that is offered by the same MCOs.

Clients who are typical FFS populations can access behavioral health services through the BHSO program (For example: Medicare coverage or someone exempt from managed care). They will get physical health services through the FFS system.

Apple Health – BHSO = FFS Medical and Managed Care for behavioral health services.

- Medicare/Medicaid duals
- PCCM
- Foster Care clients that elect to have FFS benefits

Exceptions

- Dually eligible and otherwise managed care exempt individuals will not be enrolled in FIMC but will be required to be enrolled in a managed care plan for BHSO
- An undocumented person (as defined by WAC 182-503-0535 (1)(e) will not be enrolled in either program and will remain in FFS medical except undocumented pregnant women, during their pregnancy will be enrolled in BHSO.

Special Populations

There are clients who can be enrolled in programs outside of the five managed care programs or may not be enrolled in a managed care plan at all, known as Fee-For-Service (FFS). These special populations are:

- American Indian/Alaskan Native (AI/AN)
  - Eligible for Primary Care Case Management (PCCM)
  - Eligible for FFS
- Foster Care
  - Eligible for Apple Health Foster Care
  - Eligible for FFS
- Non-Citizen Clients, specifically:
  - Qualified aliens who have not met the five-year bar
    - Only eligible for FFS
  - Non-Qualified aliens
    - Only eligible for FFS
  - Undocumented person
    - Only eligible for FFS

American Indian/Alaskan Native and Foster Care clients may elect to be part of the FFS program.

Per WAC 182-503-0535 Non-Citizen Clients as defined in the above section are not eligible for Managed Care Plans and are only eligible for FFS benefits if found eligible for a State Funded Medicaid Program.

Click to return to Apple Health Managed Care

My client should be enrolled in managed care but isn't?

There are several reasons a client should be enrolled in a managed care plan but they are not. For example, the exemptions section shows groups of clients that are eligible Fee-For-Service (FFS) program. However, there are clients that can be approved on a program in ACES, but not be eligible for FIMC or BHSO. These programs are:

- Unmet Spenddowns (Any program that ends in 95 or 99)
- QMB (S03)
- SLMB (S05)
- QI-1 (S06)

Also there can be situations when a client has been determined functionally and financially eligible for a LTSS program (L-Program in ACES) but due to being in an Acute or State Hospital setting they are still pending in ACES due to the client's residence needing to be in a Long-Term Care facility before the program can be made active in ACES.

Finally, per WAC 182-503-0535, there are clients that may have State-Funded FFS Medicaid eligibility due to their Citizenship or Immigration status. Those individuals are:

- Qualified aliens who have not met the five-year bar
- Non-Qualified aliens
- Undocumented person

Health Plan Service Areas & Network

For the most up to date service area map detailing what plans are available in each county and RSA please visit HCA's website.

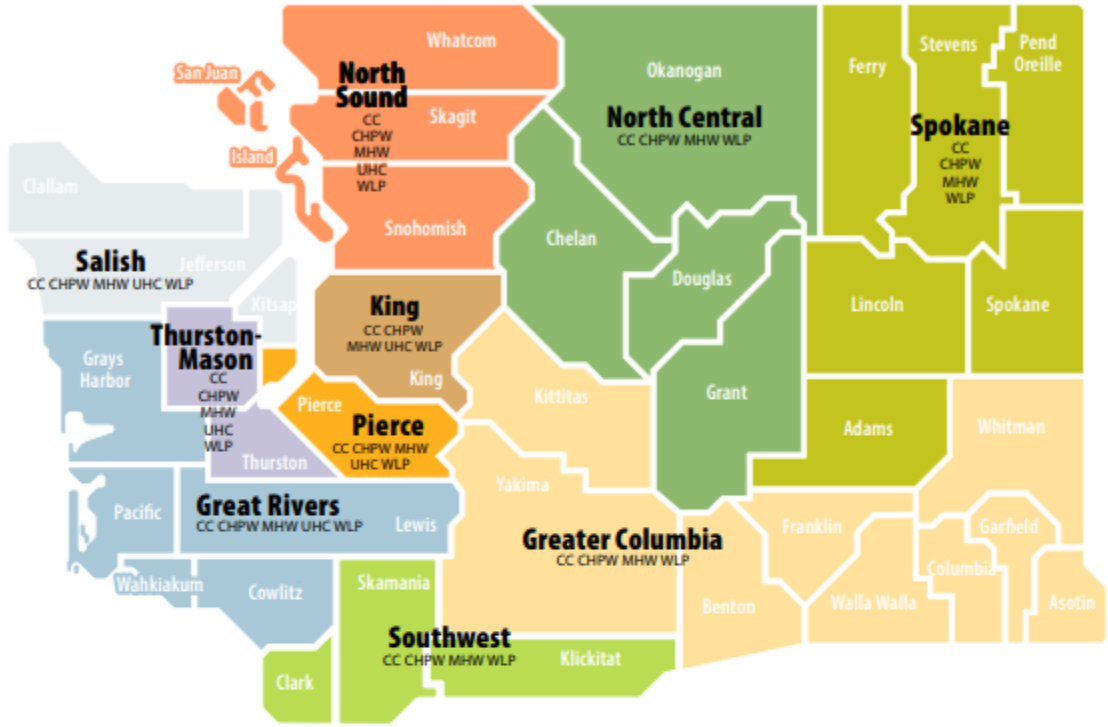
Regional Service Areas (RSA):

RSAs are the new geographical boundaries or service areas for Medicaid purchasing of physical and behavioral health care through managed care contracts.

- Authorized by legislation in 2014
- Regions on a map, not an organization that oversees services

Apple Health managed care

Service area map - January 2024



Integrated managed care regions

Greater Columbia	Pierce	Salish	North Central
King	Spokane	Great Rivers	
North Sound	Thurston-Mason	Southwest Washington	

Apple Health Foster Care (statewide)†

† Apple Health Foster Care is a statewide program. Integrated managed care is provided through Apple Health Core Connections (Coordinated Care of Washington - CC).

Health plans offered

CC	–	Coordinated Care
CHPW	–	Community Health Plan of Washington
MHW	–	Molina Healthcare of Washington
UHC	–	UnitedHealthcare Community Plan of Washington
WLP	–	Wellpoint Washington (previously Amerigroup)

HCA 19-0036 (10/23)

Washington Apple Health

Health Plan Contact Information (for Clients/Providers)

Wellpoint	Customer Service Website Provider Line Provider Website	1-800-600-4441 www.wellpoint.com 1-800-454-9790 https://www.provider.wellpoint.com/washington-provider/home
COMMUNITY HEALTH PLAN of Washington	Customer Service Website Provider Line Provider Website	1-800-440-1561 www.chpw.org 1-800-440-1561 www.chpw.org/for-providers
coordinated care	Customer Service Website Provider Line Provider Website	1-877-644-4613 www.coordinatedcarehealth.com 1-877-644-4613 https://www.coordinatedcarehealth.com/providers.html
MOLINA HEALTHCARE	Customer Service Website Provider Line Provider Website	1-800-869-7165 www.molinahealthcare.com 1-800-869-7165 https://www.molinahealthcare.com/providers/wa/medicaid/pages/home.aspx
UnitedHealthcare Community Plan	Customer Service Website Provider Line Provider Website	1-877-542-8997 www.uhccommunityplan.com 1-877-542-9231 www.uhcprovider.com/en/health-plans-by-state/washington-health-plans/wa-comm-plan-home.html

Changing Plans

Apple Health enrollees may change plans every month (effective the 1st of the following month):

- Via telephone at 1-800-562-3022. Clients may either wait for a customer services representative or use automated telephone Individual Voice Recognition
- Online at www.waproviderone.org/client
- Via paper enrollment form mailed to HCA
- The Health Benefit Exchange www.WAHealthPlanFinder.org (MAGI and Family medical-not SSI [S-programs] or Long-Term Care [L-programs])

Community Behavioral Health Support (CBHS) Services formerly Behavioral Health Personal Care (BHPC) Residential

In 2021, Legislation directed the Health Care Authority (HCA) and ALTSA to work with Center for Medicare/Medicaid (CMS) on creating a Medicaid benefit under the HCA behavioral health benefit that would more fully support BHPC (Behavioral Health Personal Care) under Medicaid. The title of this new program is Community Behavioral health Support Services (CBHS) under 1915(i) State Plan Home & Community Based Services 1915(i)

Beginning July 1st, 2024, a Health Care Authority (HCA) or Managed Care Organization (MCO) will only fund Community Behavioral Health Support (CHBS) services (formerly Behavioral Health Personal Care [BHPC]) clients in a residential facility for additional personal care rate reflected in an increase beyond the CARE generated rate. The HCA or MCO will now be funding this directly to providers and HCS will no longer be adding SA389, U1 service lines into CARE for these services. This includes Behavioral Health Specialty contracts. You can find more information on the HCA website Community Behavioral Health Support (CBHS) services and on the HCA billing guide.

Service provided under CBHS

CBHS provides Supportive Supervision and Oversight. Supportive supervision is direct monitoring, redirection, diversion, and cueing of the client to prevent at risk behavior that may result in harm to the client or to others. This is similar to what has been provided under BHPC. Services are individually tailored to meet each person's needs. This provides individuals with additional staff and assistance to build skills and resiliency to support stabilized living and integration. It is important to note, these interventions are not related to the provision of personal care. These interventions are coordinated as appropriate with other support services, to include behavioral health services provided by a behavioral health agency and/or behavior support services or other community supports as appropriate. Services should include integration of behavior support and/or crisis plans to help ensure community stability and an escalation process for collaborative care.

Allowable provider types

- Adult Family Homes (AFH)
- Assisted Living Facilities (ALF)
- Enhanced Adult Residential Care Facility (EARC)
- Adult Residential Care Facility (ARC)
- Enhanced Service Facilities (ESF)

Functional Eligibility

Individuals may be eligible for CBHS if they:

- Are 18 years or older
- Are eligible for Apple Health (Medicaid)
- Are eligible for or are receiving Home & Community Services (HCS), as defined in WAC 388-106-0010:

  - Assistance with three or more activities of daily living (ADLs), one of which may be body care
  - Hands-on assistance with one or more ADLs, one of which may be body care
- Have a qualifying diagnosis

An individual must meet one or more of the following risk criteria, within the past year:

- Assaultive history
- Self-endangering behavior
- Intrusiveness related to behavioral health condition (rummaging, unawareness of personal boundaries)
- Chronic psychiatric symptoms that cause distress or escalate individual or other residents to crisis
- Sexual inappropriateness
- A history of the behaviors above.
- History of being unsuccessful in community living settings, evidenced by one of the following:
  - Multiple failed community settings or imminent risk of losing long-term care setting
  - Frequent care giver turnover due to behavioral health condition(s)
- Past psychiatric history with no functional improvement without CBHS services, as evidenced by at least of the following in the past 12 months:
  - 2+ inpatient psychiatric hospitalization in the last 12 months
  - An inpatient stay in a community hospital or E&T facility for 30 days or more
  - Discharge from a state psychiatric hospital or long-term 90/180 day inpatient psychiatric setting

Financial Eligibility

Clients who are receiving LTSS with income up to 300% of the Federal Benefit Rate (FBR) or Special Income Level (SIL) are financially eligible for 1915i services. However, those with income between 150% of the Federal Poverty Level (FPL) and 300% (FBR) will need an income disregard.

The Health Care Authority (HCA) will determine which clients are over income for CBHS and will deny those clients. For non-MAGI clients who are financially eligible but need an income disregard, HCA will send a Barcode communication (13-0108) to the assigned Public Benefits Specialist (PBS) to let them know that a disregard is needed. The PBS will enter the 1915i services on the Institutional Care Screen with the services start date and document in the case record. ACES will apply the disregard for approval of the 1915i services. For non-MAGI clients who are financially eligible and do not need an income disregard, HCA will approve CBHS services. The PBS staff will not need to enter a 1915i coding on these clients and will not receive a communication from HCA regarding these clients.

CBHS Referral Process

When to submit a new CBHS referral

- Annual Renewals and Significant Changes

  - Referrals will be submitted annually and when a significant change is completed.
  - Case Managers will need to set CARE ticklers or have a tracking mechanism to ensure renewal referrals are submitted timely
- Mid-year tiering
  - For additional Supportive Supervision Hours only: If a provider has a request to review the clients tier mid-approval year, they will request this directly to the MCO or HCA via Supportive supervision re-tiering request form (CBHS) (HCA Form 13-0125). No new referral is needed from CM if a significant change is not required.

Clients new to CBHS

1. *During the CARE assessment while providing the client with Home and Community Based Services (HCBS) and options also provide the client with the CBHS brochure (HCA Form 19-0087).*

2. *If your client is interested in these services, the Case Manager will review the assessment for potential CBHS eligibility. If it seems the client is eligible on the Behavior Screen in CARE update the question "Was a referral made for CBHS/1915i eligibility?" to "Yes". If the client is enrolled in Medicaid complete section 1 and 2 of the CBHS Referral Form (HCA Form 13-0124). If Medicaid financial and/or functional eligibility is pending continue to Step 3. If your client has active Medicaid eligibility with a managed care plan (see How to identify Managed Care Plans PDF in the Apple Health & Managed Care section) skip to Step 4. If your client has active Medicaid eligibility without a managed care plan also known as Fee-For-Service skip to Step 5.*

3. *If your client is pending Medicaid eligibility:*
   a. *but has been assigned a managed care plan prior to their Medicaid financial and/or functional eligibility being determined (i.e. Your client is pending discharge from a State Hospital) then send the referral to the assigned managed care plan using the email identified on the referral form. Skip to Step 6*
   b. *but has not been assigned a managed care plan prior to their Medicaid financial and/or functional eligibility being determined send the referral to HCA using the email identified on the referral form. Skip to Step 6*

4. *If your client has a managed plan identified as Fully Integrated Managed Care (FIMC) or Behavioral Health Services Only (BHSO) send the referral to the managed care plan using the email identified on the referral form. Skip to Step 6*

5. *If your client has active Medicaid eligibility without a managed care plan send the referral to HCA using the email identified on the referral form. Continue to Step 6*

6. *The MCO or HCA will confirm receipt with the Case Manager in two business days. The MCO or HCA may ask or collect additional information.*

7. *The MCO or HCA will complete section 3 and recommend or not recommend CHBS services. When the MCO completes section 3 the MCO will send the form to HCA.*

8. *HCA will complete Section 4 determining functional and financial eligibility. If the form is returned where a client is not functionally or financially eligible continue to Step 9. If the client is functionally and financially eligible skip to Step 10*

9. *For clients not found functionally or financially eligible HCA will:*
    a. *mail the denied form to the HCS/AAA CM, MCO, and MCOBHOforms@dshs.wa.gov inbox.*
        i. When HCS/AAA CM receives the denied form, they will update the CARE assessment behavior screen question "Was the client found eligible?" to "No" and add a SER note. *The canned text can be found in the F1/help screen of the SER screen in CARE Web*
    b. *send a denial letter to the client.*

10. *When the client is found functionally and financially eligible for CBHS an income disregard may be applied*

11. *The MCO or HCA will complete section 5 of the referral form.*
    a. *If a provider is not identified the MCO will notify the HCS/AAA CM of the approval tier and partner with HCS/AAA to find a provider.*
    b. *If a provider is identified the HCA/MCO will send the completed form to the HCS/AAA CM and the MCOBHOforms@dshs.wa.gov inbox. If the client was approved by the MCO then the MCO will send the completed for to HCA.*

12. *The HCS/AAA CM will send the referral form to DMS dshs.altsadms@dshs.wa.gov*

13. *The HCS/AAA CM will update the CARE Assessment by:*
    a. *If the client will be in an Enhanced Service Facility (ESF) the client's 1020, U5 service code and reason code will need to be updated to match the client's approved tier. This is included in Chapter 7f.* ***If the client is at Unified Residential Care in Spokane please see 13b as they will need a different rate.***

Reason Code	T1020, U5
MCO Funded Tier 1	$ 559.80
MCO Funded Tier 2	$ 498.09
MCO Funded Tier 3	$ 401.29
MCO Funded Tier 4	$ 390.95
MCO Funded Tier 5	$ 390.95
MCO Funded Tier 6	$ 390.95

b. If the client will be Unified Residential Care in Spokane the client will need a $24/day rate enhancement for additional services provided beyond the ESF contract and the CBHS services provided by the MCO. This is included in Chapter 7f. The client's T1020, U5 service code and reason code will need to be updated to match the client's approved tier using this chart for Unified Residential Care.

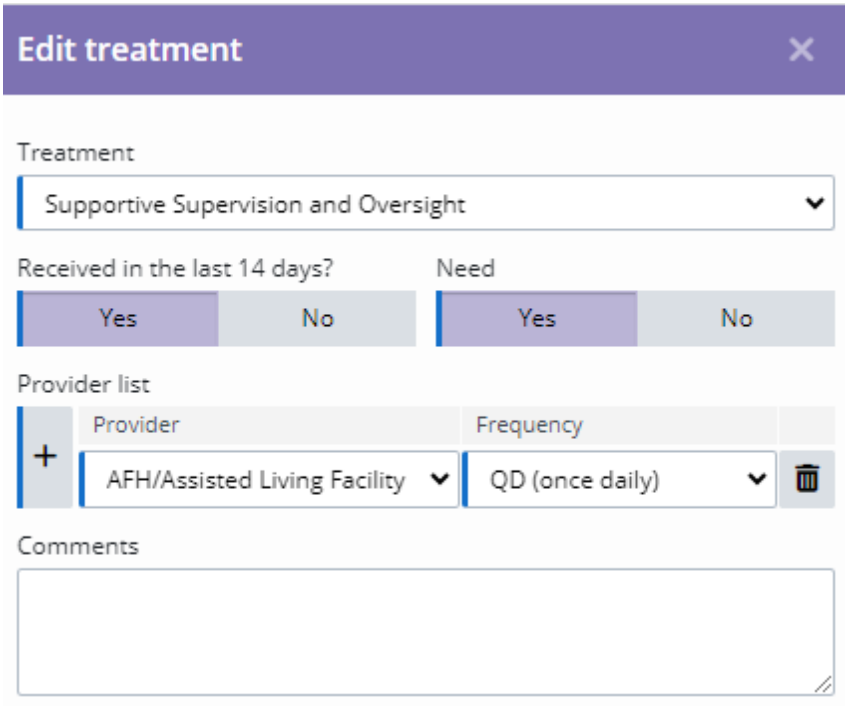
Unified Residential Care in Spokane	
Reason Code	T1020, U5
MCO Funded Tier 1	$ 583.80
MCO Funded Tier 2	$ 522.09
MCO Funded Tier 3	$ 425.29
MCO Funded Tier 4	$ 414.95
MCO Funded Tier 5	$ 414.95
MCO Funded Tier 6	$ 414.95

c. Updating the Behavioral Screen question "Was the client found eligible?" to Yes.

d. Updating the CARE Treatment screen with:

i. Treatment Supportive Supervision and Oversight
ii. Received in the last 14 days? Yes
iii. Need Yes
iv. Provider List Appropriate Provider
v. Frequency QD (once daily)

Example:



e. CARE SER Note which the canned text can be found in the F1/help screen of the SER screen in CARE Web

Required Notifications to MCOs and HCA

Notifications are required to the MCO when:

1. Client is planning on moving facilities. The MCO/HCA will need to confirm they are contracted with the facility where the client is planning on transitioning.
2. Client/AREP/Guardian is no longer interested in receiving a 1915i service.
3. Client's LTC services are closing.
4. Client passed away.

The HCS/AAA CM will communicate this with the Change of Circumstance: Community Behavioral Health Supports (CBHS) / 1915i (DSHS Form 16-275). After confirming closure:

1. Notify the Public Benefits Specialist (PBS) of the closure for CBHS services via 14-443 communication in Barcode.
2. Document the closure in a SER under the CBHS service code.
3. Update the assessment to remove Supportive Supervision treatment and send the provider updated assessment and service summary.

MCO Funded Behavioral Health Wraparound Support previously Behavioral Health Personal Care (BHPC) In-Home

Beginning July 1st, 2024, a Managed Care Organization (MCO) will only fund the following Behavioral Health Wraparound Support (BHWS) formerly, Behavioral Health Personal Care (BHPC)for additional personal care hours reflected in an increase beyond the CARE generated hours.

To be eligible for BHWS funding, a client must meet the criteria outlined in all three boxes.

> If a client does not meet the three criteria boxes, do **NOT** submit a BHWS request.

Criteria for BHWS funding

The client must meet criteria below for a request of BHWS funding to be made:

Box #1 – Psychiatric Disability Criteria:

1. The client has a primary diagnosis of a serious mental illness (schizophrenia, bi-polar disorder, major depressive disorder); and that psychiatric diagnosis is 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.

   However, if the client has these **diagnoses <u>but the mental health diagnosis/behaviors</u> are the primary reason the client needs personal care**, still submit the request.

OR

2. 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.

AND

Box #2 – Involvement with Mental Health Services Criteria:

In addition to the above criteria being met, the client should also engage with mental health services in **one** of the three ways below:

1. The client is currently receiving mental health services;
   OR
2. The client is transitioning from an inpatient setting and will be receiving mental health services in the community;

AND

Box #3 – Needs wraparound support beyond the CARE generated hours:

The client meets the criteria in both Box #1 and Box #2, **AND** needs wraparound support (additional personal care hours) beyond the CARE generated hours. Follow the instructions below for requesting MCO funding for wraparound support.

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 Medicaid and Medicare Managed Care Coordination Contacts Lists. Review the client's care plan, including diagnoses, treatments, behaviors, etc., and why you think this client's need for BHWS funding is because of behaviors or symptoms of a mental illness.

Is this a new request for BHWS funding?

If so, and the client is currently receiving mental health services covered under their medical benefit (i.e. Apple Health), 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.). If the client is receiving behavior support services through an ALTSA paid provider, and is not currently receiving mental health services through their medical benefit, then coordinate with the ALTSA paid behavior support provider to ensure accuracy of the assessment.

1. Fax client's signed/completed Consent form (DSHS 14-012) to the client's local mental health professional/agency or ALTSA paid behavior support provider.
2. Call the client's local mental health professional/agency (or ALTSA paid behavior support provider) and discuss the following information:
    a. An assessment has been completed and you are calling to discuss the case, review the care plan, and client's need for BHWS support.
    b. Inform them of client's planned living setting (in-home or residential).
    c. Review client's mental health diagnoses and treatment plan for accuracy.
    d. Review what services are being provided by the local mental health professional/agency (or ALTSA paid behavior support provider) 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.
    e. Incorporate any information from the local mental health professional/agency (or ALTSA paid behavior support provider) into the CARE assessment.
3. Add the contact information for the local mental health professional/agency or ALTSA paid behavior support provider on the BHWS Request to the MCO (DSHS form 13-712).

Request BHWS funding from the MCO

Within 2-5 days of completing a CARE assessment (moving it to current) in which the criteria in the boxes above are reflected and described, a BHWS request for funding should be submitted to the 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.

1. Complete the BHWS request form (DSHS form 13-712) to the MCO and include the CARE Assessment Details, CARE Service Summary.

   Detail the behaviors and caregiver interventions on this form, and what BHWS support is needed. This information helps the MCO quickly determine how the client's mental health is impacting their need for the BHWS request.

   Please note: if the additional support hours requested is unusually high, prior to submitting the request for funding, staff the case with your supervisor, your regional Managed Care Systems Consultant (MCSC), and consider a care conference with the designated Care Coordination Contact listed on the Medicaid and Medicare Managed Care Coordination Contacts Lists. This step allows the MCO to ask clarifying questions and ensures collaboration of the care plan.

2. Send DSHS form 13-712, CARE Assessment Details, and CARE Service Summary (also known as the packet) to the Funding Request Contact listed on the Medicaid and Medicare Managed Care Coordination Contacts Lists via secure email using the **template emails and subject line language provided**.

   Behavioral Health Wraparound Suppo

3. The MCO will review the packet and determine if the established criteria listed above has been met.
   i. The MCO should confirm receipt of request within 2 business 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 MCO representative will contact the Case Manager (CM). If you do not receive a response within 5 business days you should escalate the communication through the assigned escalation contact listed on the Medicaid and Medicare Managed Care Coordination Contacts Lists.

      The MCO may review additional information, as necessary, in deciding whether the above criteria are met, reviewing PRISM, conversation with the provider, conversation with the HCS/AAA worker, conversation with the Enrollee's Mental Health Provider and other involved providers.

   ii. 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 by the MCO to meet the client's need should be written on the form by the MCO representative.

      When the MCO denies BHWS funding based on the provision of other services, a plan (e.g., Individual Service Plan) must be developed by the MCO and implemented to meet the service needs identified.

4. Once the MCO signs, completes and returns the DSHS form 13-712:
   i. Document the approval or denial from the MCO in a SER.
      1. Approvals,
         a. notify the provider of the BHWS approval and document this conversation in a SER, including the name of the person you spoke with. Explain that this approved BHWS rate is a wraparound rate above the CARE generated rate/hours. Language to be used when notifying the client's provider:

            <CLIENT'S MCO> has approved a Behavioral Health Wraparound Support of <MCO APPROVED HOURS> for the dates of <Approved Funding Dates on 13-712>. This is only a portion of the client's funding and is in addition to the CARE generated hours. The Managed Care Organization (MCO) is the sole decision maker for ongoing funding beyond the approved funding dates. Future requests to the MCO for ongoing funding beyond the approval dates must include documentation supporting the need for ongoing services.

         b. In CARE Web, include the following approval information on the Comments screen, under the General Comments.

            <CLIENT'S MCO> has approved a BHWS for the dates of <Approved Funding Dates on 13-712>. The following supports will be provided: **COPY (Ctrl + C) and PASTE (Ctrl + V) the comments from the section that states what the caregiver does (or will do) as an intervention.**

      2. Denials,
         a. notify the provider of the BHWS denial. Document this conversation in a SER, including the name of the person you spoke with. Language to be used when notifying the client's provider:

            <CLIENT'S MCO> has denied the Behavioral Health Wraparound Support of <REQUESTED HOURS FROM MCO>. The Managed Care Organization (MCO) is the sole decision maker for determinations on these requests. Continue to staff any changes in the client's condition with the client's assigned case manager.

   ii. Scan and email a copy of the completed DSHS form 13-712 (approved or denied) to: MCOBHOforms@dshs.wa.gov. Please scan/email only ONE client's form per email.
   iii. Submit completed DSHS form 13-712 to the Document Management Systems (DMS) via HOTMAIL to be included in client's electronic case record (ECR).

      i. **For In-home clients**,

1. The wraparound support hours approved by the MCO will be incorporated into the personal care service code T1019.
2. Select reason code "MCO_BHO Client/ MCO_BHO Funded" for that service line.
3. The start and end date of the service code should be the same dates approved on DSHS form 13-712.

Example of in-home personal care with wraparound support:

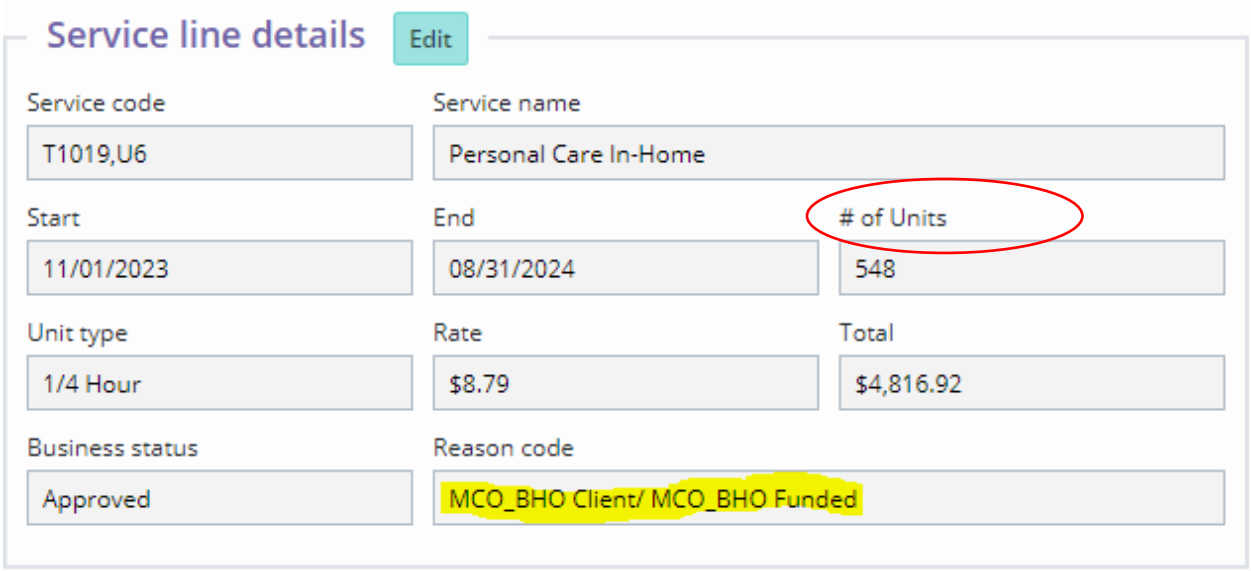
DSHS form 13-712 – approved amount by MCO:

For In-Home Clients

CARE generated hours per month:	**92**
Wraparound Support additional hours:	**45**
Total hours per month requested:	**137**
Monthly estimated cost of care:	**$ 4,816.92**

Authorization to in-home care provider (137 hours = 548 units):

#	Status	Service code	Service name	Start date	End date	# Units	Unit type	Rate
1.10	Approved	T1019,U6	Personal Care In-Home	11/01/2023	08/31/2024	548	1/4 Hour	$8.79



5. On the Behavior screen select the following options:

i. To the question, "Was a referral sent to the MCO or HCA?" Select "No"
ii. Select "other" for the reason no referral was made.
    i. Document the reason the CBHS referral was not made in the required comment box.
        1. Case manager will type "Client's Care Plan is for in-home."

6. Set a reminder for at least a week before the end of the MCO funded approval period (or CARE plan period) so that another request for BHWS support can be made to the MCO if the client continues to meet the criteria listed above.

7. If the client's case is transferred to another office/agency, ensure the next CM/agency is aware of the MCO's approval of BHWS support and when another BHWS request will be due if necessary.

8. At next assessment, if client meets the criteria in the boxes above, request funding from the MCO for BHWS support services following the same process noted above.

Another BHWS request to the MCO for funding 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 (e.g. informal support change, QA correction)
- Client changes from one MCO (for example Wellpoint) to another MCO (for example Molina)

Behavioral Health Administrative Services Organization (BH-ASO)

Some services, such as response services for individuals experiencing a mental health crisis, must be available to all individuals regardless of their insurance status or income level. For this reason, the HCA will have a contract with an organization known as a Behavioral Health Administrative Service Organization (BH-ASO) to provide these services in integrated regions.

BH-ASO

The BH-ASO is only responsible for a subset of crisis-related services for Medicaid clients in integrated region and is responsible for providing limited services to individuals who are not eligible for Medicaid, as well as managing certain administrative functions.

Services Provided – Regardless Insurance Status or Income

The following services may be provided by the BH-ASO to anyone in an integrated region who is experiencing a mental health or substance use disorder crisis:

- A 24/7/365 regional crisis hotline to triage, refer and dispatch calls for mental health and substance use disorder crises;
- Mental health crisis services, including the dispatch of mobile crisis outreach teams staffed by mental health professionals and certified peer counselors;
- Short-term substance use disorder crisis services for people intoxicated or incapacitated in public;
- Designated Mental Health Professionals (DMHPs) who can apply the Mental Health Involuntary Treatment Act, available 24/7 to conduct Involuntary Treatment Act assessments and file detention petitions;
- Chemical dependency specialist who can apply the substance use disorder involuntary commitment statute, including services to identify and evaluate alcohol and drug involved individuals who may need protective custody, detention, etc. The chemical dependency specialist will also manage case findings and legal proceedings for substance use disorder involuntary commitment cases.

Services Provided – Uninsured and Low-Income

The BH-ASO may provide certain mental health and substance use disorder services to people who are not enrolled in or otherwise eligible for Medicaid. For some services, like those funded through the federal Substance Abuse Prevention and Treatment (SAPT) block grant, individuals may need to meet other priority population requirements to be considered eligible.

The BH-ASO may provide the following services to individuals who are not eligible for Medicaid:

- Mental health evaluation and treatment services for individuals who are involuntarily detained or agree to a voluntary commitment;
- Residential substance use disorder treatment services for individuals involuntarily detained as described in state law;
- Outpatient mental health or substance use disorder treatment services, in accordance with a Less Restrictive Alternative court order;
- Within available resources, the BH-ASO may provide non-crisis behavioral health services, such as outpatient substance use disorder and/or mental health services or residential substance use disorder and/or mental health services, to low-income individuals who are not eligible for Medicaid and meet other eligibility criteria.

What is a D-SNP

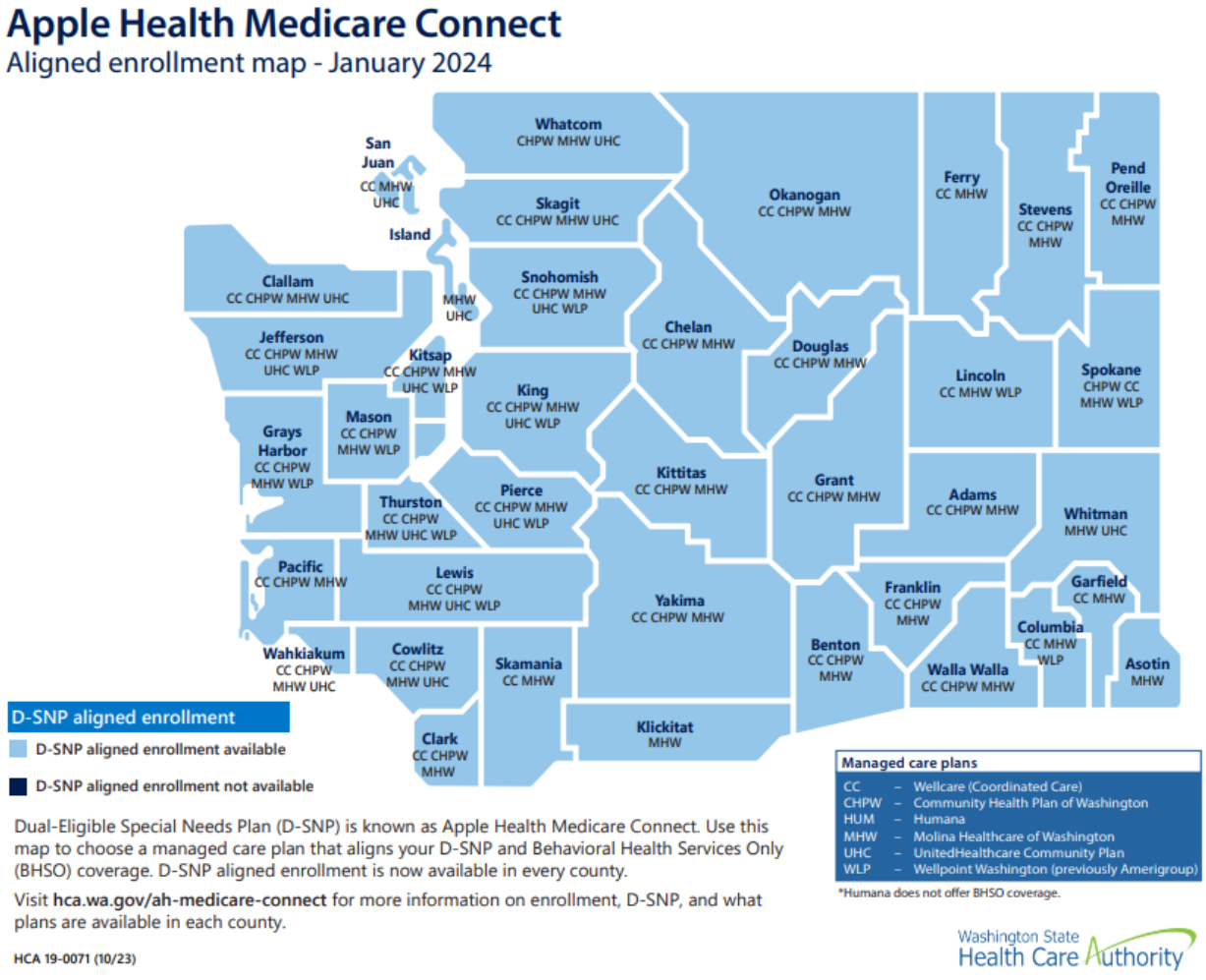
A Dual-Eligible Special Needs Plan (D-SNP) is a special kind of Medicare Advantage plan for dual-eligible individuals. A D-SNP combines Medicare and Apple Health (Medicaid) services under one managed care plan. In Washington, D-SNPs have been branded as Apple Health Medicare Connect (AHMC) to better communicate that AHMC is only available who are enrolled in Apple Health (Medicaid) and Medicare.

Who is a dual-eligible individual

A dual-eligible individual has both Medicare coverage and Apple Health coverage. This includes physical and behavioral health care coverage. If a client is a dual-eligible client, Medicare is the primary coverage for their physical health care needs. They also have Apple Health as secondary coverage. Dual-eligible clients also have behavioral health coverage through an Apple Health managed care plan. This is a Behavioral Health Services Only (BHSO) plan. Behavioral health includes mental health and substance use disorder treatment.

AHMC Health Plan Service Areas & Network

For the most up to date service area map detailing what plans are available in each county please visit HCA's website or use the service area guide found in the attachments.



Care Coordination

Apple Health Managed Care & Nursing Facilities

Managed care, like Medicare, covers a rehabilitative/skilled nursing benefit if the authorization criteria is met. When a managed care enrollee is hospitalized and needs to be discharged to a nursing facility, the plan must be contacted for nursing facility authorization.

MCOs have transitional care requirements for moves from the hospital to the nursing facility and home. Once it has been determined that the rehab/skilled stay will end or an enrollee does not meet authorization criteria, that enrollee should be referred to Home and Community Services (HCS) for a nursing facility level of care (NFLOC) assessment. HCS should also review available options with the client.

Contacted Regarding Discharges:

- If contacted by a hospital/facility for the NFLOC assessment or for discharge options
  - Staff must ask if the hospital stay is covered by an MCO ***and*** if the client is enrolled in Medicaid managed care.
- If the client is enrolled in Medicaid managed care (Apple Health):
  - The facility must have a denial from the MCO before the stay can be covered by HCS.

Assisting with Coordination (Case Managers)

- If you receive billing questions, refer the provider to the health plan the client is enrolled in.
- Assist clients who have Apple Health medical coverage by knowing the health plan contact phone numbers.
- Find out which plan(s) contract with doctors and specialists in their area. This will help you assist the client in choosing the right Apple Health managed care plan. It will also help when the client has a provider/plan coordination issue.
- If you need assistance with acute hospital or skilled nursing facility transitional care activities, please use the plan contacts in the Medicaid and Medicare Managed Care Coordination Contacts list.
- Report issues to the plan, the ALTSA HQ Managed Care Data and Policy Analyst Ethan Leon at Ethan.Leon@dshs.wa.gov
- For additional information regarding Nursing Facility coordination, see the Nursing Facility Case Management Chapter, Chapter 10.

For additional information on Nursing Facility billing see the HCA Nursing Facility Provider billing Guide

Managed Care Organization (MCO) Assistance with Transition of Care

MCOs, who are responsible for physical health benefits, should offer the following support to clients, HCS and/or the hospital when clients are discharging from inpatient hospital settings:

- Coordinate medically necessary services, supplies, and resources. For example:
  - Transition planning:
    - Arranging for DME (Durable Medical Equipment) approval and delivery
    - Assigning a PCP (Primary Care Provider) for the client to see post discharge
    - Assisting in community transition setting searches
    - Negotiating contracts with SNFs and paying for Enrollees' SNF stays that meet rehabilitative or skilled criteria
    - Completing a written discharge plan, including scheduled follow-up appointments, provided to the Enrollee and all treating providers; Formal or informal caregivers shall be included in this process when requested by the Enrollee to ensure timely access to follow-up care post discharge and to identify and re-engage Enrollees who do not receive post discharge care
  - Post Discharge care:
    - Organized post-discharge skilled and rehabilitative services, such as home health care services, after-treatment services, and occupational and physical therapy service
    - Telephonic reinforcement of the discharge plan and problem-solving two (2) to three (3) business days following discharge
    - For Enrollees at high risk of re-hospitalization, the Contractor shall ensure the Enrollee has an in-person assessment by the Enrollee's PCP or Care Coordinator for post-discharge support within seven (7) calendar days of hospital discharge. The assessment must include follow-up of: discharge instructions, assessment of environmental safety issues, medication reconciliation, an assessment of support network adequacy and services, and linkage to appropriate referrals
    - Scheduled outpatient Behavioral Health and/or primary care visits within seven (7) calendar days of discharge and/or physical or mental health home health care services delivered within seven (7) calendar days of discharge
    - Follow-up to ensure the Enrollee saw his/her provider
    - Planning that actively includes the patient and family caregivers and support network in assessing needs.
- Assist with facilitating authorizations for covered medical services and behavioral health services.
- Ensure continuity of care for enrollees transitioning to the MCO during an active course of treatment for an acute or chronic health condition

MCOs should offer the following care coordination to enrollees who meet criteria:

- Individual needs support coordinating access to service with their primary/private insurance provider
- Individual encounters difficulty accessing prescribed treatment, services, or supplies
- Individual has complex healthcare needs and could otherwise benefit from assistance in coordinating care. For example:
  - An individual receives a new diagnosis and they or their guardian feel like they "don't know where to start"
  - An individual has had frequent or long-term hospitalizations
  - An individual has had frequent emergency department use

All HCS and AAA case managers should use the MCO Transitions of Care Contact List found at http://intra.altsa.dshs.wa.gov/hcs/ on the right side of the webpage, under Contractors for the most current Transitions of Care contacts. When corresponding please use the Transitions of Care (discharge) email attachment found at the end of this chapter to frame HCS and AAA emails to the MCO for Initial Contacts, Follow Up, and Day of Discharge coordination.

If you experience any issues with this process, please contact to HQ Managed Care Data and Policy Analyst.

Managed Care Assistance with Care Coordination

When an HCS/AAA client enrolled in managed care needs assistance to coordinate their health care services and access to appropriate treatment, the CM must assist the client and their guardian, if applicable, to request "care coordination" from the client's Apple Health MCO or Medicare Advantage (MA) Health Plan (including clients who have managed care only for behavioral health services).

We have a document in the Apple Health & Managed Care section titled MCO Care Coordination at a Glance which will help answer questions about the role of Managed Care Organizations in Care Coordination, why it can be helpful to coordinate with the MCOs and how to coordinate with the MCOs. We also have a Care Coordination contact list can be found on the HCS/AAA intranet website at http://intra.altsa.dshs.wa.gov/hcs/ on the right side of the webpage, under Contractors. For D-SNP Coordination please use the Medicaid and Medicare Managed Care Coordination Contacts Lists on the D-SNP CM-TOC tab. (Please see the Attachment section at the end of this chapter.)

1. To request care coordination, the CM may send a secure email* to the client's MCO to request care coordination and assistance to address barriers the client is experiencing to access medically necessary care covered by Apple Health. Email addresses for the five Apple Health plans are:
   a. Molina Healthcare of Washington, Inc. (MHW)
   b. Community Health Plan of Washington (CHPW)
   c. Coordinated Care of Washington (CCW)
   d. Wellcare (for Dual Special Needs Population [D-SNP] operated by CCW)
   e. United Healthcare Community Plan/Care Improvement Plus South Central Insurance Company (UHC) (for Dual Special Needs Population [D-SNP])

f. Amerigroup (AMG)/Wellpoint (WLP) (for Dual Special Needs Population [D-SNP])
g. Humana/Arcadian Health Plan (for Dual Special Needs Population [D-SNP])

*Emails from the DSHS URL (@dshs.wa.gov) identifies the requestor as a DSHS employee and meets HIPAA requirements to request care coordination on behalf of an HCS/AAA client.

2. When making a care coordination request include the following in your email:
   a. In the Email "Subject" line, provide the reason for care coordination request. For example:
      i. Mental health treatment
      ii. Durable medical equipment
      iii. Needs Primary Care Provider
   b. In the body of the email, provide the following information:
      i. Client Name
      ii. Client ProviderOne ID: (9-digit number ending in WA)
      iii. Date of Birth
      iv. Residence Type
      v. CM Name and Contact Information
      vi. Summary of client barrier/issue/need

3. If you do not receive a response or assistance with your request timely, the CM should discuss the case with their supervisor to determine if escalation is needed. Sent a second email to the MCO with 'escalation' in the title of the email.

4. If the CM and supervisor do not receive a response, they may determine escalation to HCS HQ is needed when issues are not resolved.

   a. If the CM supervisor determines that escalation to HQ is appropriate, the CM supervisor will submit the original email communication and escalation with the MCO to Ethan.Leon@dshs.wa.gov

Once the request for escalation is received, HCS HQ will outreach with HCA to discuss the identified barrier to access. Based upon the type of request, the case manager and supervisor will be notified regarding next steps.

If you experience any issues with this process, please contact the HQ Managed Care Data and Policy Analyst Ethan.Leon@dshs.wa.gov.

RESOURCES

Related WACs & eCFRs

WAC 182-526-0155	HCA & Appellant's Representation
WAC 182-538	Washington State Health Care Authority Managed Care

WAC 182-538-130 Exemption

CFR 42-438 Managed Care

Acronyms

AAA	Area Agency on Aging
ACES	Automated Client Eligibility System
AHFC	Apple Health Foster Care
AHMC	Apple Health Medicare Connect
CC	Care Coordinator
CCW	Coordinated Care of Washington
CFC	Community First Choice
CMS	Centers for Medicare and Medicaid Services
COPES	Community Options Program Entry System
DDA	Developmental Disability Administration
DSHS	Department of Social and Health Services
D-SNP	Dual Special Needs Plan
FFS	Fee-for-Service
FIMC	Fully Integrated Managed Care
HCA	Health Care Authority
HCS	Home and Community Services
HH	Health Home
LTSS	Long-Term Services and Supports
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
NFLOC	Nursing Facility Level of Care
PCCM	Primary Care Case Management
PCM	Primary Case Manager
RSA	Regional Service Area
SSI	Supplemental Security Income
TPL	Third Party Liability

Glossary

Care Coordination	An approach to healthcare in which all of a patient's needs are coordinated with the assistance of a primary point of contact. The point of contact provides information to the patient and the patient's caregivers and works with the patient to make sure that the patient gets the most appropriate treatment, while ensuring that health care is not duplicated.
Disenrollment	The process by which an enrollee's participation in a managed care program is terminated. Reasons for disenrollment include death, loss of eligibility, or choice not to participate, if applicable.

Fee-For-Service	A service delivery system where health care providers are paid for each service separately (e.g. an office visit, test, or procedure).
Long-Term Services and Supports	A wide variety of services and supports that help people with functional impairments meet their daily needs for assistance in qualified settings and attain the highest level of independence possible. LTSS includes both Home and Community-Based Waiver Services and Medicaid Personal Care Services.
Managed Care	A prepaid, comprehensive system of medical and health care delivery. - *Medical*: Includes preventive, primary, specialty care and ancillary health services - *Integrated***:** Includes Medical services PLUS behavioral health and long term services and supports.
Third Party Liability	Refers to the legal obligation of third parties (e.g., entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a state plan. By law, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the state plan.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
8/2/19	Integration Unit	Updated into new template	
5/9/23	Office of Policy and Integration	Split Chapter 22 into three parts: Chapter 22a, 22b, and 22c	

Web Resources

Return to Identifying clients who are enrolled in managed care via ACES Online, Provider One, and CARE
Return to Integrated Managed Care
Return to AHMC Health Plan Service Areas & Network

Apple Health & Managed Care

How to identify Managed Care Plans

MCO care coordination at a gl

Behavioral Health Wraparound Suppo

Medicaid and Medicare Managed Care Coordination Contacts

HCA Managed Care webpage

Regional Information Spreadsheet

Fee-For-Service (FFS)/Apple Health Coverage without managed care

ProviderOne Find a Provider List for FFS

Washington Healthplanfinder

"Welcome to Washington Apple Health: Managed Care" benefits book

"Welcome to Washington Apple Health: Behavioral Health Services Only" benefits book

"Welcome to Washington Apple Health: Coverage without a managed care plan" benefits book

Apple Health Enrollment Form

HCA Apple Health Medicare Connect (Dual-Eligible Special Needs Plan [D-SNP]) Website

D-SNP Service Area Guide

CBHS/1915i SharePoint

HCA Community Behavioral Health Support website

Health Homes

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Anthony Foster — Health Home Training Specialist
360.725.2640 Anthony.foster@dshs.wa.gov

Kerri Hummel — Health Home Quality Assurance Specialist
360.725.2278 Kerri.Hummel@dshs.wa.gov

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HEALTH HOME PROGRAM

Overview

The Health Home (HH) program was created out of the Affordable Care Act, section 2703, which allowed states to provide specific services to Medicaid and Medicare/Medicaid (Duals) eligible clients. This program is a collaboration between ALTSA and HCA.

Integrated Care Coordination

The HH program promotes person-centered health action planning to empower clients to take charge of their own health care. This is accomplished through better coordination between the client and all their health care providers.

HH services are a set of optional Medicaid benefits available to eligible clients. Participation is voluntary, at no cost to clients, and does not change or duplicate services currently being delivered. A Care Coordinator (CC) steps in when a service is needed and is not already being provided, to bridge gaps in care. The HH program is designed to:

- Ensure cross systems coordination and care transition;
- Increase confidence and skills for self-management of health goals; and
- Create a single point of contact responsible for bridging all systems of care.

Client Advocacy

Clients receiving HH services will be assigned a CC who will partner with them, their families, caregivers, representatives, doctors, and other agencies providing services to ensure coordination across these systems of care. The CC will:

- Work with their client to develop a Health Action Plan (HAP) that is person-centered;
- Make in-person visits and provide support by telephone to help the client, their families and service providers;
- Assist the client in accessing the right care at the right time, at right place and with the right provider; and
- Provide at least one of the HH services each month.

The client and CC meet at a location of the client's choice: their home, clinic, or other community location to receive services. Care Coordinators, sometimes work with a team for the delivery of HH services.

Health Action Plan (HAP)

The HH program emphasizes person-centered care with the development of the HAP. The HAP includes routine screenings such as the Patient Activation Measure (PAM®), an assessment that gauges the knowledge, skills, and confidence level essential to managing one's own health and healthcare.

Other tools CCs use include screenings for body mass index, depression, level of independence in accomplishing activities of daily living, fall risk, anxiety, substance use, and pain. The HAP and the assessment screens are updated periodically. The centerpiece of the HAP is identifying the client's self-

identified short and long-term health related goals, including action steps that the client and others plan to do to improve their health.

HAP Form DSHS 10-481 and Instructions

10-481.pdf 10-481ins.pdf

Structure – who provides these services?

HCA contracts with both community-based organizations and managed care plans to provide HH services. These designated "Health Home Leads" contract with Care Coordination Organizations (CCOs) to provide the services. Some HH Leads hire internal CCs as well. The HH program is structured as a community-based delivery system and focuses on matching clients with a CCO that has a preexisting relationship or has expertise that would enhance their ability to provide HH services to that particular client.

Enrollment

Clients are passively enrolled into the HH program by HCA. Enrollment into the HH program is voluntary and clients may disenroll at any time by their CC or by signing an Opt Out form.

Eligibility

To be eligible for Health Home Services clients must:

- Be on Medicaid or have both Medicaid and Medicare (Dual Eligible); and
- Have an identified chronic condition; and
- Be at risk for a second chronic condition
    - **P**redictive **R**isk **I**ntelligence **S**yste**M (PRISM)** score of 1.5 or higher (indicates risk for a second chronic condition).

PRISM is used to determine which clients are eligible. Specifically, the client must have a chronic condition and be at risk of another as determined by a PRISM risk score of 1.5 or more. A risk score of 1.5 means a client's expected future medical expenditures to be 50% greater than the average for Washington's Supplemental Security Income disabled population.

Not all clients are eligible. For example, clients on spend down or enrolled in PACE, are not eligible.

For those with limited PRISM data, there is a Clinical Eligibility Tool that may be used to determine a risk score and can be found at https://www.hca.wa.gov/billers-providers-partners/program-information-providers/health-home-resources#clinical-eligibility-tool

Payment – how do Leads get paid?

Health Home services are Medicaid covered benefits and paid for by the state through its contracts with managed care organizations providing HH services to their members and community based HH Lead entities. HCA pays the HH Leads through ProviderOne. Case Managers never authorize HH services.

Dual Special Needs Plan (DSNP)

In January 2023, the Health Home program was extended to Dual Special Needs Plan (DSNP) enrollees as a Medicare benefit for those who were engaged in Health Home services at the time of DSNP enrollment. Health Home has further expanded to DSNP enrollees and effective January 2025, each MA Health Plan includes a Health Home program available to all full-dual DSNP enrollees who meet eligibility criteria for the Health Home program.

The service structure remains consistent where Health Home Leads and Care Coordination Organizations (CCO) continue to provide Health Home services to DSNP beneficiaries. Once clients transition to Health Home through the DSNP, the Medicare Advantage Plan pays the Health Home Lead directly.

Services Provided

As defined by CMS, the HH program provides the following six services beyond the traditional Medicaid or Medicare benefits.

Comprehensive Care Management

The initial and ongoing assessment and care management services aimed at the integration of primary, specialty, behavioral health, long-term services and supports, and community support services, using a comprehensive person-centered HAP which addresses all clinical and non-clinical needs. Examples include:

- Conduct outreach and engagement activities
- Complete required and optional screenings
- Develop the HAP
- Develop goals and action steps to achieve those goals
- Prepare crisis intervention and resiliency plans

Care Coordination

Facilitating access to, and the monitoring of, services identified in the HAP to manage chronic conditions. Includes updates to the HAP, monitoring service delivery, and progress toward goals. Care coordination is accomplished through face-to-face and collateral contacts with the client, family, caregivers, medical, and other providers. Examples include:

- Implement the HAP
- Monitor progress towards short and long term goals

- Coordinate with service providers, case managers, and health plans as appropriate to secure necessary care and supports
- Conduct or participate with multidisciplinary teams
- Assist and support the client with scheduling health related appointments and accompany if needed
- Communicate and consult with providers and the client as appropriate

Health Promotion

Providing information for optimal health outcomes and promoting wellness. Examples include:

- Provide individualized wellness and prevention information specific to the needs and goals of the client
- Provide links to health care resources that support the client's HAP goals
- Promote participation in community educational and support groups
- Act as a health coach to support the client in initiating and sustaining behavioral change

Comprehensive Transitional Care

Facilitating services for the client and family/caregiver when the client is transitioning, between levels of care. Examples include:

- Participate on multidisciplinary planning teams such as nursing facility discharge planning
- Review post discharge with client/family to ensure discharge orders are understood and acted upon including medication reconciliation
- Assist with access to needed services or equipment and ensure it is received
- Providing education to the client and providers that are located at the setting from which the person is transitioning

Individual and Family Supports

Coordinating information and services to support clients and their families or caregivers to maintain and promote the quality of life, with particular focus on community living options. Examples include:

- Provide education and support of self-advocacy
- Identify and access resources to assist client and family supports in finding, retaining, and improving self-management, socialization, and adaptive skills
- Educate client, family or caregiver regarding Advance Directives, client rights, and health care issues

Referral to Community and Social Services Supports

Providing information and assistance for the purpose of referring clients and their families or caregivers to community-based resources that can meet the needs identified on the client's HAP. Examples include:

- Identify, refer, and facilitate access to relevant community and social services
- Assist clients to apply for or maintain eligibility for health care services, disability benefits, housing and legal services not provided though other case management systems
- Monitor and follow-up with referral sources to confirm appointments and other activities were established and clients were engaged in services

Working with Care Coordinators

Care Coordinators do not duplicate or replace services or case management provided by HCS, DDA, or AAA. Clients who participate in the HH program will continue receiving their primary medical, specialist, behavioral health, and long-term services and supports from their current providers. Participation will not change the way a client's other services are currently managed, authorized, or paid.

The CCs complement the work of HCS/AAA/DDA Case Managers. A CC may contact you to inform or share information about one of your clients to help support them in reaching one of their health-related goals, to work together on an issue that needs resolution, or provide advocacy in the work you do.

HCS/AAA/DDA Case Manager Roles

Once a client is participating in the HH program, staff should:

- Coordinate with the CC to facilitate resources and referrals. In some cases, the CC may request a copy of a client's CARE assessment. If requested, a consent form (HCA 22-852) will be shared.
- Include the CC as a collateral contact in CARE
- Collaborate and communicate with the CC
- Know that the CC is considered a member of the client's health care team. In some instances, they may attend the CARE assessment visit.

Table: HCS v CC Case Management

SERVICE DESCRIPTION	HH CC	HCS/AAA/DDA
Determine eligibility for LTC services and supports.		**X**
Perform a face-to-face CARE assessment with the client in their residence to determine service needs and program eligibility at least annually.		**X**
Assist the client to develop a plan of care to enable them to reside in the setting of their choice and monitor that plan.		**X**
Authorize services with the client's choice of qualified provider according to their plan of care.		**X**
Termination Planning for personal care services/LTSS.		**X**

SERVICE DESCRIPTION	HH CC	HCS/AAA/DDA
Report abuse, abandonment, neglect, self-neglect, or financial exploitation to Adult Protective Services or the Complaint Resolution Unit.	**X**	**X**
Report Suicide Ideation	**X**	**X**
Make referrals for services identified by the client to improve health and prevent additional disease or disability.	**X**	**X**
Provide comprehensive care management including review of PRISM risk scores to Health Home high needs and utilization patterns.	**X**	
Assist to develop and implement a person-centered Health Action Plan	**X**	
Provide transitional care services following a discharge from institutions into the community.	**X**	
Administer the Patient Activation, Caregiver Activation, or Parent Activation Measure used for Health Action Planning and self-management skill development.	**X**	
Provide care coordination and comprehensive care management across the client's team of health care professionals.	**X**	
Provide health promotion services/information to the client including health education, development of a self-management plan and improving social and community networks promoting healthy lifestyles (smoking cessation, weight loss, and physical activity).	**X**	
Identify resources for the client and their family in the community to allow the client to attain their highest level of health and functioning.	**X**	
Educate family members about disease processes, what to expect, and caregiving skills necessary to assist the client in achieving their HAP goals.	**X**	

Determining if a client is enrolled for HH services

There is no notification system to let the HCS/AAA/DDA Case Manager know when a client is part of the HH program. Case managers will need to:

- Check CARE ProviderOne screen
  - Click on Managed Care and it may indicate HH program and the Lead organization
- Check ProviderOne
  - Select client search with ProviderOne ID

  - Check if the Health Home Clinical Indicator is populated with current dates
  - Check Managed Care Enrolled screen which may indicate HH and the Lead organization
- Contact the clients Apple Health managed care organization, HH Community Lead in your area, or HCA at HealthHomes@HCA.WA.GOV regarding questions of enrollment or how to refer a client
- Find the contact information for Health Home Leads at https://www.hca.wa.gov/assets/billers-and-providers/hh-leads-contacts.pdf

RESOURCES

Related WAC

WAC 182-557-0100 Health Home

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
8/2/19	Integration Unit	Updated into new template	

Health Home Print Resources

10-481.pdf

10-481ins.pdf

HH Fact Sheet. Community - FINAL.p

Health Home

Health Home | Department of Social and Health Services
Health Home | Washington State Health Care Authority
Health Home – Washington's State Plan Amendment

wamffsfdaamendment6 December 2024.d

Program of All-Inclusive Care for the Elderly (PACE)

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Kathryn Pittelkau PACE Policy Program Manager
360.725.2366 Kathryn.Pittelkau@dshs.wa.gov

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OVERVIEW OF MANAGED CARE

The purpose of the managed care service delivery model is to integrate services an individual may need in one delivery system with one payment called a capitated payment. The managed care plan must furnish all of an individual's services included in the managed care contract using this capitated payment. This puts the managed care plan at risk for high-cost services as well as creates incentives to use prevention and pro-active techniques to keep a person well.

HCA, DSHS, and CMS have contracts with managed care entities. The contract between HCA, DSHS and/or CMS and the Managed Care entity details what services are covered in the contract and what the MCO is responsible for. Contract examples include:

- Apple Health (Medicaid)
- Program for all Inclusive care for the Elderly (DSHS & CMS)
- Medicare Advantage and D-SNP (CMS)

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

PACE stands for Program of All-inclusive Care for the Elderly. It is an innovative Medicaid/Medicare program that provides frail individuals age 55 and older comprehensive medical and social services coordinated and provided by an interdisciplinary team of professionals in a community-based center and in their homes, helping program participants delay or avoid long-term nursing home care.

Each PACE participant receives customized care that is planned and delivered by a coordinated, interdisciplinary team of professionals working at the center. The team meets regularly with each participant and his or her representative in order to assess the participant's needs. A participant's care plan usually integrates some home care services from the team or residential placement with several visits each week to the PACE center, which serves as the hub for medical care, rehabilitation, social activities, and dining.

The PACE model was developed in San Francisco in the 1970s as ON LOK, the Chinese American community's alternative to nursing home placement. It was formally established by CMS as a permanent Medicare Advantage option in 1997.

Offering PACE as a Choice

The following elements are directed and required by legislation (SBH 1499) to ensure that PACE is provided as an option for possibly eligible clients living within a PACE available service area. At each assessment, AAA and HCS staff within the PACE service area will see a required question on Care Plan screen in CARE related to PACE. The question is:

"PACE is available in certain zip codes in the county the client resides, would the client like to receive more information about the PACE integrated managed care program?" Yes/No/Already enrolled.

Assessor is to ask client and respond to question accordingly. If response is "yes" and client resides in King County, it will ask an additional question if client has a preference as to which PACE program:

"If yes, are you interested in a particular PACE program?"

- **Providence Elderplace**
- **International Community Health Services**
- **PNW PACE**
- **No preference**

For clients whose response is "yes", PACE organizations will contact them to provide more information on PACE managed care.

Staff will no longer complete nor submit form 17-218 "PACE Request for More Information".

A report that has the "yes" responses compiled will be generated weekly to the PACE Organization (PO) of clients who indicated they would like more information about the PACE program. The PO will coordinate with the client and inform HCS/AAA should client choose to enroll and be accepted.

Staff Training

Training is set up and offered through the PACE Organization (PO) at regular intervals for both HCS and AAA staff. Trainings are meant to be interactive and jointly held. The PACE training link is provided below as an ongoing resource for HCS and AAA staff.

Please use Chrome for the below link:
http://intra.altsa.dshs.wa.gov/videos/PACE/story.html

Private Pay

HCS/AAA is also responsible for assessing individuals not eligible for Medicaid or Medicare who are interested in enrolling in PACE to determine initial functional eligibility as well as ongoing functional eligibility. These referrals generally come directly from PACE organization.

Service Providers

DSHS currently contracts with the PACE organizations (PO) Providence Elderplace (PEP), International Community Health Services (ICHS) and PNW PACE Partners (PNW PACE) to administer the PACE program.

To be enrolled in PACE the client must live in a zip code in the PO's service area.
Please see below the embedded spreadsheet which notes PACE available Zip codes per County per PO:

Zip codes per County per PACE organizatior

There are nine PACE centers in Washington State.

Providence ElderPlace - Seattle
4515 Martin Luther King Way South
Seattle, WA 98108
(206) 320-5325

Providence ElderPlace - West Seattle
4831 35th Ave. SW
Seattle, WA 98126
(206) 320-5325

Providence ElderPlace - Redmond
8632 160th Ave. NE
Redmond, WA 98052
(206) 320-5325

Providence Elderplace Spokane
6018 N Astor
Spokane, WA 98208
(509) 482-2475

Providence ElderPlace - Kent
7829 S 180th St.
Kent, WA 98023
(206) 320-5325

Providence Elderplace - Alder
1404 Central Ave S
Kent, WA 98032
(206) 320-5325

Providence Elderplace Everett
1615 75th Street SW
Everett, WA 98203
(206) 320-5325

International Community Health Services (ICHS)
803 S. Lane St.
Seattle, WA 98104
Phone: (425) 755-1100

Pacific Northwest PACE Partners (PNW PACE)
6442 Yakima Ave
Tacoma, WA
Phone: (253) 459-7270

Services

PACE provides its participants with all services covered by Medicare and Medicaid, without the limitations normally imposed by these programs. It also provides any other services deemed necessary by the interdisciplinary team that would allow program participants to remain in the community.

Services provided by PACE include, but are not limited to:

- Primary care (including doctor, dental and nursing services)
- Prescription drugs
- Adult day health care
- Home and personal care services
- Nutrition services,
- Case management
- Hospital and nursing home care if and when needed.
- Transportation to and from the center and all off-site medical appointments

Eligibility

To participate in PACE, an individual must be 55 years of age or older, require NFLOC but be able to live `safely in the community at time of enrollment with the services of PACE, and reside in the service area of a PO. PACE participants may disenroll from the program for any reason and those with Medicare or Medicaid who disenroll will be assisted in returning to their former or preferred health care coverage.

Both the PO and the client agree to the PACE enrollment by signing an enrollment agreement. This agreement means the client agrees to receive services exclusively through the PO and its contracted network.

This may mean that the participant will need to change providers including PCP.

Determining Eligibility

HCS/AAA will assess clients and determine whether they:

- Are age 55 or older;
- Meet nursing facility level of care (NFLOC) as defined in WAC 388-106-0355;
- Reside in the PACE service area/or will at the time of enrollment; ***and***
- Are financially eligible per WAC 182-515-1505. (MAGI clients are financially eligible); Remain functionally eligible by Reassessing Clients (Annual or Significant Change)

In Spokane, Pierce and Snohomish Counties, the breakdown of which entity handles ongoing PACE assessments is as follows:
AAA – in home PACE clients
HCS – residential PACE clients

The PO is responsible for notifying HCS/AAA of any significant changes in the client's condition:

1. Collaborate with the PACE social worker prior to each assessment. Review the previous assessment/SERs and information given by the PO before the visit.

2. Communicate with collateral contacts as needed to obtain information and include relevant parties to complete an accurate assessment.
3. Complete the face-to-face assessment. Be sure that you have:
    - Assigned the PO as the paid provider
    - Assigned relevant tasks to the PO. No provider schedule is necessary.
4. Verify financial eligibility at least annually, document on the Financial Screen in CARE and document in the file.
5. Once complete, move the assessment to current per procedures in Chapter 3 of the LTC Manual, send the CARE Assessment Details and Service Summary to the PO. Send Service Summary and CARE Results (when necessary) to client.
6. Extend PACE RAC, if applicable, for the new plan period (only available and needed if care plan is in-home).

Continued Functional Eligibility

PACE services can continue even though a PACE participant no longer meets State Medicaid NFLOC *if* the HCS case manager reasonably expects that the participant would again meet NFLOC in the next 6 months should PACE services end. This is called "deeming". "Deemed eligible for PACE" is what will display in care plan as the desired program choice in this situation.

State Staff Responsibilities:

1. HCS/AAA staff will continue to complete annual reassessments of all PACE participants. If the assessment results in the client not meeting NFLOC, staff will review the assessment and consider whether the:
    a. Participant's health status is maintained or benefited, at least partially, because of the services PACE currently provides; *and*
    b. Participant's health and/or functional status are likely to decline over the next six (6) months without PACE services.

    Examples of information that would support deeming of continued eligibility could include, but are not limited to:
    - Physician and/or nursing progress notes documenting the treatment and impact of a chronic/disabling condition;
    - List of services currently provided to the participant (OT, PT, dietary management, blood glucose/blood pressure checks, diabetic foot care, etc.);
    - Frequency of medical appointments and/or frequency of medical treatments/ interventions that point to an unstable medical condition that must be treated/ monitored regularly to avoid complications;
    - Decline or loss of mobility combined with cognitive decline or progression; etc.

2. If HCS/AAA case managers deem continued eligibility, they will continue to conduct full annual reassessments (and any significant change assessments) and determine NFLOC and/or that deeming criteria continues to be met.

3. If the client meets deeming criteria, staff will choose "Deemed Eligible for PACE" in the program drop down in CARE.
4. HCS/AAA staff will note in a CARE SER the decision to deem eligibility in the PACE program.
5. If HCS/AAA staff determine that a previously deemed participant no longer meets NFLOC or deemed continued eligibility or the client is not financially eligible for Medicaid a denial notice and appeal rights will be issued to the participant with a copy sent to the PO.
6. If the participant requests a Department administrative hearing to dispute the State's denial of continued eligibility, PACE services may continue until the appeal is heard and a decision is rendered. If the denial is upheld, the participant may be required to pay the cost of PACE services rendered after the initial denial effective date.
7. If a request for administrative hearing is not received, PACE enrollment will be terminated at the end of the month in which the PAN was issued if the PAN was issued at least 10 days prior to the end of the month; if PAN was issued less than 10 days prior to the end of the month, PACE enrollment will be terminated at the end of the following month.

Forms

AAA/HCS Case Managers are required to complete the following forms:

- **PAN** – Once you assess the client in CARE, you must send the client the Planned Action Notice. The Planned Action Notice for PACE clients must include information that tells the client:
  - They are eligible for services;
  - That PACE is the program of choice;
  - The number of personal care hours or daily rate they are eligible for.
- **Rights and Responsibilities**
- **Consent Form** – Complete when working with collateral contacts to gather/share information. The PO is an "ALTSA paid provider".

Roles

Note: Clients are eligible for PACE services on the first of the month in which they are enrolled following the date the client is financially/functionally eligible. Clients can only be enrolled effective the first of the month.

HCS/AAA ASSESSOR	**Determine Eligibility** Complete the CARE assessment to determine functional eligibility (specifically nursing facility level of care) for long-term care services. If the client is functionally eligible for nursing facility level of care, offer PACE as an option for receiving services. **Client Seeks Enrollment**

	Once you receive confirmation from the client that they wish to enroll, provide a copy of the CARE Assessment Details and Service Summary to the PO for review. **Enrollment Confirmed** Once you received notification from PO that client will enroll in PACE: • Send a copy of the Service Summary and Assessment Details in "current" status to the PO (if not already done). The Service Summary does not have to be signed by the client or PO. • Send a Planned Action Notice (DSHS 14-405)* to the client or their representative stating the effective enrollment date along with Service Summary (and CARE Results if necessary) • *Below are current instructions for PAN per PACE enrollment: 1) Send PAN indicating PACE approval with the following PACE specific details a. Effective date is the first day of the month of PACE enrollment. b. Select PACE as the 'Program. c. Enter CARE rate in the new amount field. d. PACE WACs will auto-populate when 'functionally eligible' is chosen related to PACE approval: 388-106-0700, 388-106-0705 e. Note: A termination line on the PAN related to the program that is ending, in conjunction with PACE approval, is not required and should not be completed. • Send DSHS 14-443 to Financial with enrollment start date, and ProviderOne ID of PACE provider*, and indicate if it will be in-home or residential care. For the latter include the CARE daily rate. • * ProviderOne IDs of PACE providers: Providence ElderPlace ProviderOne #: **105011001** ICHS ProviderOne #: **209579901** PNW PACE ProviderOne # **217922601** • Add PACE RAC in CARE. This will only be available if the setting is in-home. • End all ProviderOne authorizations for end of month prior to enrollment. • ProviderOne payment authorizations are not done by HCS. • Add PO as the "formal caregiver" in collateral contacts. • Assign all unmet and partially met tasks to the PO as paid provider on care plan support screen. • If client is receiving wellness education service under COPES complete interim to remove this treatment. This service is not available to clients in PACE. • If client is receiving ADH service under COPES and any ADLs are partially met and informally assigned to ADH provider, complete interim to make these ADLs unmet.

PUBLIC BENEFIT SPECIALIST	If not already established, determine financial eligibility for long-term care (PACE). Upon confirmed enrollment: **enter P1 ID of PO in ACES so award letters and all correspondence gets sent to the PO**.
PACE ORGANIZATION (PO)	**Prior to Enrollment** • Contact interested clients to discuss program • Schedule site visit and evaluation • Review CARE assessment **Enrollment Denied** • PO informs client and sends information to HQ with reason as to why **Enrollment Confirmed** • Notify HCS/AAA of enrollment decision including enrollment start date. • Send a monthly electronic enrollment file by the 23rd of the month for enrollment the following month that contains client enrollment effective dates to the PACE Program Manager with a cc to the HCS/AAA field supervisor. Enrollments only occur at the start of a given month. • Send disenrollment letters for enrollees with other coverage.
PACE HQ PROGRAM MANAGER	• Enroll the client into PACE via the ProviderOne system if eligible. • Review and evaluate any enrollment denials submitted by the PO.

Ongoing Client Management / Roles & Responsibilities

Case Management for PACE Clients

Once a client is enrolled in the PACE program, the PO assumes case management responsibilities.

Ongoing HCS/AAA SW Responsibilities	Ongoing PO Responsibilities
• Annual functional assessments • Significant change assessments • Verify financial eligibility for each face-to-face assessment • Coordination with PO case managers • Obtain medical records from PO • Process disenrollments • Communicate necessary info to financial as needed • Notify financial of SNF stays that go beyond 30 days	• Implement and oversee care plan • Day to day case management • Enlist, contract, and pay providers (including IPs) • Communicate changes to HCS (address, telephone #, milieu of care (including SNF placements) • Request significant change assessments (vetting request/reviewing current CARE first) • Staff cases with PO interdisciplinary team as needed • Distribute CARE assessment and plan of care to providers • Assist clients with eligibility reviews

HCS/AAA and PO Coordination

HCS/AAA and the PO must report the following client changes to one another when they occur:

- Admit or discharge from a nursing facility. HCS must notify financial if over 30 days;
- Need for home maintenance allowance (HMA). Requested by PO, HCS processes.
- Change in address or phone number;
- Change in plan of care which includes:
- Change in care setting (in home, residential, SNF)
- Disenrollment from plan (including expedited disenrollment);
- Move out of the service area;
- Changes in or termination of Medicaid eligibility;
- Change from Medicaid to private pay and vice versa. PO makes HCS aware.
- Financial reports changes in cost of care to the PO via award letter.
- Client passes away

PO Responsibilities

- Must maintain services for the enrollee while enrolled, regardless of how much service needs increase or decrease;
- Is responsible for admitting and/or discharging PACE enrollees from the various living environments.
- Must collect participation from the enrollee.
- Will contract providers for all PACE services).
- Must have an internal "exception to rule" policy as it relates to needed services above what CARE assessment indicates. (HCS ETR is N/A for PACE)
- Review current CARE assessment prior to requesting significant change
- Must notify HCS of any:
  - Address changes;
  - Changes in income or resources; *or*
  - Changes in living situations (in-home, residential, nursing facility);

HCS/AAA Field Manager/Supervisor Responsibilities

- Point person for HQ PACE PM as it relates to PACE programs' field-level operations
- Point person for other HQ PACE PMs as needed (ProviderOne, contracts, FLSA, etc.)
- Point person for PO management related to day-to-day operations of PACE programs
- Troubleshoot and address enrollment issues including lapses in enrollment
- Point person to provide assistance to PO (or their subcontractor) navigating ProviderOne as it relates to payment authorizations for individual providers
- Point person for PO intake and management staff related to enrollments and disenrollments
- Point person for work with RCS as needed related to PACE clients in residential settings
- Oversee and receive new enrollments monthly and assign to HCS workers

- Assist HQ PACE PM reconciling payment issues with PO on a monthly basis
- Meet with PO and their subcontractors as needed or requested

CARE Rules & PACE Enrollees

- All CARE minimum standards are applicable to PACE enrollee assessments.
- When determining "status" for PACE enrollee, the PO is considered the ALTSA paid provider, not the IP, Homecare Agency, Residential or other provider. The actual providers are not to be considered "informal" supports because they are being paid by the PO.
- On the Support Screen, assign the PO as the paid provider for all applicable "unmet" and "partially met" needs. As well, tasks that would otherwise be assigned to PCP/MD should generally be assigned to PO.
- Potential referrals triggered from the CARE assessment are the responsibility of the HCS/AAA worker prior to enrollment into PACE, including the assessment that determines functional eligibility. Once the client is enrolled, the PO assumes all case management for the client.

The PO may request and be granted view access in CARE for clients enrolled in the contractor's PACE program. The PO should contact the HQ program manager to request access to CARE.

Payment

POs receive a set amount of Medicare and Medicaid funds each month to ensure participant care, whether services are provided in the home, community or in a nursing home setting. This capitated funding arrangement rewards providers who are flexible and creative in providing high quality care and gives them the ability to coordinate care across settings and medical disciplines.

The program also accepts participants who pay privately.

Provider Payments

- The PO contracts & enlists their own providers for all PACE services. This includes homecare agencies, AFH's, AL's and all other covered services.
- The PO is responsible for directly paying all their providers.
- IPs are paid via ProviderOne though the PO is billed back for the costs.
  - The PO inputs IP payment authorizations directly into ProviderOne using their own RU.
  - No other payment authorizations will be visible in CARE for PACE clients.

Disenrollment

Disenrollment is effective the last day of the month.

Voluntarily

- Request disenrollment;
- Are no longer Medicaid eligible; i.e. client is not financially or functionally NFLOC;

Involuntarily

- Move out of the PACE service area or leave for more than 30 days (unless an arrangement has been made or client is receiving referred treatment from the PO); *or*
- Engage in disruptive or threatening behavior and involuntary disenrollment is reviewed and approved by the HCS Headquarters Program Manager; *or*
- Fail to pay or to make satisfactory arrangements to pay any amount due to the provider after a 30-day grace period; *or*
- Are enrolled with a PO that loses its contract and/or license and is no longer able to offer services.

Process

1. The PO must send a written notice to the HQ PACE PM that fully documents that one of or more of the conditions exist to justify involuntary disenrollment.
2. The HQ PACE PM will consult with the regional supervisor regarding any concerns with the disenrollment or timeframes. Once approved/denied the HQ Program Manager will notify the regional supervisor and the PO of approval/denial within 15 days of receipt.

Roles

HCS/AAA Case Manager

1. Send the client a Planned Action Notice (DSHS 14-405), stating effective disenrollment date.
2. Follow procedures for setting up other long-term care program/services and supports, if desired by client. This would include enlisting a new formal/paid caregiver and, if it's an IP, work with CDWA to get IP in place to provide services for the client.
3. Coordinate with HQ and the PO.

PACE Organization

1. Send a monthly electronic disenrollment file by the 15th of the month to HQ PACE PM with a cc to the regional supervisor with the effective dates of participant disenrollments.
2. Coordinate with HCS (field and HQ) and AAA on any disenrollments. Timely notification to HCS/AAA field is critical; HCS/AAA field should be notified at the time PACE becomes aware of a disenrollment to allow time for HCS to implement new plan of care.
3. Determine and communicate safe, ongoing plan of care to HCS/AAA for implementation.
4. Assist client in establishing new PCP.
5. Assist client in signing up for new Medicare Part D plan.

HCS HQ Program Manager

1. Process disenrollments in the ProviderOne payment system.
2. Approve/deny any involuntary disenrollment requests.

3. Coordinate with the field and the PO.

Grievance, Appeals and Hearing Rights

- The PO must report to the HQ PACE PM quarterly regarding all grievance and appeals filed.
- If the PO denies or reduces a previously authorized service, the participant may appeal the denial to the PO.
- If the PO upholds its denial or does not respond timely to a request, the participant may request an administrative hearing.
- The participant must exhaust the appeal process before requesting an admin hearing on a PO determination.

Grievance

The client has the right to file a grievance either verbally or in writing to the PO any time they are dissatisfied with a service, the quality of care received or an interaction with PO staff.

Appeal

The client has the right to appeal any decision made by the PO to reduce, deny or terminate a service or an enrollment. This includes the right to appeal an involuntary disenrollment by the PO. The client should contact the PO to file an appeal.

Administrative Hearing

A client has a right to an administrative hearing only when entitled by the law and when aggrieved by a Department or PO decision or action. Clients have a right to a hearing:

1. For any action taken by the Department and indicated on the Planned Action Notice (PAN) including approval, denial, reduction or termination of services or eligibility.
2. When the department determined a client received more benefit than they were eligible for an overpayment was issued; *and*
3. When they have exhausted the appeal process regarding a PO determination or the PO did not respond timely to the request.

Administrative hearings are coordinated through the admin hearing coordinator for the service area. The department may be a witness.

Per WAC 182-526-0155, an appellant may represent themselves or may be represented by a lawyer, paralegal, relative, friend or any other person of his or her choice. **The appellant cannot be represented by an employee of the Department or the PO.**

RESOURCES

Related WACs & eCFRs

WAC 182-526-0155	HCA & Appellant's Representation
WAC 182-538	Washington State Health Care Authority Managed Care
WAC 182-513-1230	PACE (HCA website)

CFR 42-438	Managed Care
CFR 42-460	PACE

Acronyms

AAA	Area Agency on Aging
ACES	Automated Client Eligibility System
AHC	Apple Health Foster Care
CC	Care Coordinator
CCW	Coordinated Care of Washington
CFC	Community First Choice
CMS	Centers for Medicare and Medicaid Services
COPES	Community Options Program Entry System
DDA	Developmental Disability Administration
DSHS	Department of Social and Health Services
D-SNP	Dual Special Needs Plan
FFS	Fee-for-Service
FIMC	Fully Integrated Managed Care
HAP	Health Action Plan
HCA	Health Care Authority
HCS	Home and Community Services
HH	Health Home
LTSS	Long-Term Services and Supports
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
NFLOC	Nursing Facility Level of Care
PACE	Program for All Inclusive Care for the Elderly
PCCM	Primary Care Case Management
PO	PACE Organization
RSA	Regional Service Area
SSI	Supplemental Security Income
TPL	Third Party Liability

Glossary

Care Coordination	An approach to healthcare in which all of a patient's needs are coordinated with the assistance of a primary point of contact. The point of contact provides information to the patient and the patient's caregivers and works with the patient to make sure that the patient gets the most appropriate treatment, while ensuring that health care is not duplicated.
Disenrollment	The process by which an enrollee's participation in a managed care program is terminated. Reasons for disenrollment include death, loss of eligibility, or choice not to participate, if applicable.
Fee-For-Service	A service delivery system where health care providers are paid for each service separately (e.g. an office visit, test, or procedure).
Long-Term Services and Supports	A wide variety of services and supports that help people with functional impairments meet their daily needs for assistance in qualified settings and attain the highest level of independence possible. LTSS includes both Home and Community-Based Waiver Services and Medicaid Personal Care Services.
Managed Care	A prepaid, comprehensive system of medical and health care delivery. - *Medical*: Includes preventive, primary, specialty care and ancillary health services - *Integrated***:** Includes Medical services PLUS behavioral health and long term services and supports.
Third Party Liability	Refers to the legal obligation of third parties (e.g., entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a state plan. By law, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the state plan.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
8/2/19	Integration Unit	Updated into new template	
5/9/23	Office of Policy and Integration	Split Chapter 22 into three parts: Chapter 22a, 22b, and 22c	

Web Resources

PACE

DSHS – PACE webpage
HCA – PACE webpage

Quality Assurance and Improvement

The purpose of this chapter is to explain quality assurance and quality improvement (QA and QI) activities, processes, and expectations.

Ask the Expert

If you have questions about Social Services QA/QI, please contact:

Bill McBride QA Unit Manager
360.725.2604 william.mcbride@dshs.wa.gov
OR
Kristian Rodriguez QA Policy Program Manager
360.725.2623 kristian.rodriguez@dshs.wa.gov

If you have questions about Financial QA/QI, please contact:

Bill McBride QA Unit Manager
360.725.2604 william.mcbride@dshs.wa.gov

If you have questions about Adult Protective Services quality assurance, please contact:

APS Quality Assurance Unit
APSQAUnit@dshs.wa.gov

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BACKGROUND

The purpose of this chapter is to outline QA/QI activities and responsibilities for Aging and Long-Term Support Administration (ALTSA), Home and Community Services (HCS) Division.

To provide quality, well-planned, efficient, and accountable home and community-based care is one of the central missions of ALTSA. The development of a Quality Assurance (QA) system is critical in accomplishing this mission. This QA system encompasses both financial and social services quality assurance/improvement and includes activities such as:

1. Quality assurance procedures that will enable ALTSA to evaluate and ensure its ongoing compliance with Federal Funding Participation (FFP) thus ensuring federal match for ALTSA programs, Centers for Medicaid and Medicare Services (CMS) protocols, Home and Community Based Service waiver requirements, and State and Federal law;

2. Gathering a consistent broad range of information to identify trends, strengths and areas for improvement across all programs;

3. Identifying training needs for quality improvement. Development of training is necessary to address trends at all levels – individual, local unit, regional/Area Agency on Aging (AAA), and statewide;

4. Identifying best practices within HCS and AAA operations with the purpose of sharing strategies across the state;

5. Collecting client feedback to determine satisfaction with the services;

6. Within the electronic QA Monitor Tool, assessing compliance with existing regulations, policies and standards;

7. Reviewing the overall quality of client cases, focusing on the quality and accuracy of the assessment, care plan, and determining whether issues identified in the case regarding quality of care are responded to in a timely manner;

8. Reviewing the level of care determinations to assure that clients require the care and services for which they have been authorized;

9. Confirming provider qualifications;

10. Verifying that mandatory referrals are being made;

11. Assuring that client services and payments for those services are appropriately authorized and paid; and

12. Assuring that clients are financially eligible for Long-Term Care (LTC) services.

WHY IS QUALITY ASSURANCE AND QUALITY IMPROVEMENT IMPORTANT

All staff are invested in ensuring that quality services are being provided to the clients served by the department. Looking at quality from a global perspective, the reasons we do quality work are to:

- Ensure that all services promote the health, safety, and self-determination of the people we serve; and
- Make sure that the department is accountable to the state and federal stakeholders who provide funding for the services provided to our clients.

So much of what HCS does is to help the client obtain appropriate quality services to maximize their independence, dignity, and quality of life. The client is the ultimate beneficiary of our quality assurance and quality improvement activities.

In addition, we are accountable to the state and federal governments. About half of every dollar that is spent on our state's long-term services and supports programs is "matched" by the federal government. But, in order to get that match, ALTSA has to provide information to the federal government (CMS) to show that we are accountable for the funds we receive and that we are meeting their quality standards. CMS establishes quality standards for all states with regard to:

- waiver oversight
- client level of care assessments
- independence and choice
- person-centered client service plans
- client health and welfare
- provider qualifications, and
- financial accountability for the funds spent

In fact, if ALTSA cannot provide the evidence to CMS to show that we are meeting their quality standards, they could:

- Not approve of our waiver or state plan programs
- Not renew our existing programs
- Put a moratorium on waiver enrollments
- Withhold the federal match for services until compliance is achieved
- Impose financial penalties
- Require the state to hire an outside technical contractor to help develop compliance protocols and activities

- Take other actions as determined by the CMS Secretary

In addition to the federal compliance requirements, our state has developed additional quality standards based on important issues and priorities such as Skin Observation Protocol, nursing referrals, and client treatment questions.

PHILOSOPHY

Everyone is invested in quality – the goal of HCS has always been for HCS Headquarters (HQ), the Regions, and AAAs to work collaboratively toward quality assurance and improvement. Though a compliance review will always be required, the focus is moving to a more collaborative quality improvement process. The quality approaches and processes within this chapter support these goals and meet the state and federal monitoring requirements.

CMS REQUIREMENTS

Much of the work that we do has a federal overlay. The Centers for Medicare and Medicaid Services (CMS) requires states to provide evidence of discovery, remediation, and continuous quality improvement by developing and reporting on one or more performance measures for each CMS prescribed assurance and sub-assurance. States work with CMS to define their own performance measures based on the CMS requirements.

CMS defines four functions of a quality improvement cycle. These functions are Design, Discovery, Remediation, and Improvement. In order to maintain our waivers, CMS requires evidence that these functions are being implemented in a quality improvement strategy.

Design

Design is the process for describing how monitoring will occur and how issues will be addressed when detected. It is the plan for how the state will proactively strive for quality by identifying and addressing areas for improvement.

Discovery

Discovery is the process of gathering data and information on service participants to determine if there is adequate access to services and supports; the services and supports are delivered as indicated in their plan of care; that health and welfare is achieved; only qualified providers are used; and payments are accurate. Both positive and negative issues are identified.

Remediation

Remediation is the process of correcting individual problems that are discovered during the discovery process. The federal standard of compliance is 100%. This means that to reach the 100% required remediation, ALL identified QA findings must be addressed and resolved. The evidence report must include how many problems were identified (i.e., those issues with less than 100% compliance), how and when each problem was corrected, and the outcome of each issue.

Improvement

Quality Improvement includes changes at a systemic level to increase proficiency and improve the outcome of issues that were identified.

CMS FEDERAL ASSURANCES

To see how this all ties in together, the CMS Assurances, Sub-Assurances, and Performance Measures document is located at: http://adsaweb.dshs.wa.gov/hcs/QA/.

RESOURCES

Related WACs and RCWs

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #

Quality Assurance and Improvement – Social Services Monitoring

Chapter 23A describes the Quality Assurance process reviews mandated by the Centers for Medicare and Medicaid (CMS). This chapter includes the sampling methodology, timeframes, and requirements from field staff.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

William McBride Quality Assurance Unit Manager
360.725.2604 william.mcbride@dshs.wa.gov

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QUALITY ASSURANCE UNIT MONITORING PROCESS OVERVIEW

- All HCS and AAA case manager who have completed a CARE assessment are eligible to have a QA process review completed.

- A statistically valid sample of clients is pulled statewide.
  - Samples are pulled for waiver programs, CFC, and other state plan programs, and per focused review type.

- Each area's sample is pulled based on the percent of population for each program in each geographical area (see sampling below).

- The updated 12-month QA Monitoring Schedule is available on the QA intranet site. If dates or number of reviews change from the original release at the beginning of the monitoring year, which is distributed in a Management Bulletin (MB), the updated information can be found on the QA intranet site.

- Initial QA Process Review Notice will go out to each area prior to the start of each area's process review cycle.

- Monitoring occurs at headquarters; therefore, all required documents must be in the Document Management System (DMS) prior to QA process review.

- Areas have 3 working days to address high priority issues (client safety, payment, and financial eligibility errors) identified during the review.

- An Exit Conference is optional and conducted via video conferencing using TEAMs at the completion of the review.

- Areas have 30 calendar days to make required corrections.

- QA conducts a 30-day review to document remediation.

- Issues identified in the 30-day QA Process Review as not fully remediated must be corrected within 30 calendar days for the 60-day QA Process Review.

- QA conducts a 60-day Process Review and documents remediation.

- QA completes the Regional/AAA Final Report which is a summary of all QA Unit findings for that Region/AAA.

- Questions below the expected proficiency level will need to be addressed in the area's Proficiency Improvement Plan (PIP).

- QA completes the statewide Final Report which is a summary of all QA Unit findings for the annual review for all Regions and AAAs.

Sampling

CMS requires compliance monitoring utilize a statistically valid sample. For determining population size for sampling, the state is allowed to combine waiver programs: CFC+COPES, Residential Service Waivers (RSW), and New Freedom into one population. This population must be stratified by waiver program when the distribution of the sample is determined.

The QA unit uses Raosoft to help determine the statistically valid sample size. The parameters used in Raosoft are to following: 5% Margin of Error, 95% Confidence Level, and 50% Response Distribution.

- **Margin of Error**: The margin of error is the amount of error that you can tolerate. If 90% of the respondents answer *yes*, while 10% answer *no*, you may be able to tolerate a larger amount of error than if the respondents are split 50-50 or 45-55.
- **Confidence Level**: The confidence level is the amount of uncertainty you can tolerate. Suppose that you have 20 yes-no questions in your survey. With a confidence level of 95%, you would expect that for one of the questions (1 in 20), the percentage of people who answer *yes* would be more than the margin of error away from the true answer. The true answer is the percentage you would get if you exhaustively interviewed everyone. Higher confidence level requires a larger sample.
- **Response Distribution:** For each question, what do you expect the results will be? If the sample is skewed highly one way or the other, the population probably is, too. If you don't know, use 50%, which give the largest sample.

Sampling example to determine statistical sample size:

- There are the following authorizations in the state:
  - COPES = 38,468
  - RSW = 2,046
  - New Freedom = 426
  - TOTAL POPULATION = 40,940
- Using Raosoft to determine a statistically valid sample size of the total population of 40,490 using a 5% margin of error, 95% confidence level, and 50% response distribution will yield a statewide sample size of 382 cases to be reviewed.

Increasing sample size while stratifying waiver programs:

Beginning in 2018, CMS required the statewide sample size to be stratified between the three waiver programs: COPES, RSW, and New Freedom. Further, the state has the discretion to increase the sample size over the minimum statistically valid amount. Using Raosoft and adjusting either the Margin of

Error, Response Distribution or both, a sample size for each waiver program is generated so that the total files to be reviewed are equal to or greater than the statewide sample size of 382.

Adjusting the formula to a 7% Margin of Error, 95% Confidence Level, and 70% Response Distribution and uniformly applying this formula to each individual program yields the following results:

- COPES (38,468 cases) = 164
- RSW (2,046 cases) = 153
- New Freedom (426) = 119
- TOTAL REVIEWS TO BE COMPLETED: 436.

Note: *Since the total files to be reviewed is greater than 382, this is an acceptable stratification of the waiver programs. The new statewide sample size is now 436*

Determining the number of files to review per HCS/AAA office

QA determines the number of cases to be reviewed per HCS and AAA based on how much that area contributes proportionally to the total statewide population (see sampling example below).

- Region X has 1,565 COPES cases which = 3% of the statewide total.
- 3% of 164 is 4.92 or 5.
- Region X will have 5 COPES cases reviewed.

This sampling process is repeated for each Regional and Area Agency on Aging (AAA) office.

Monitoring Schedule

A QA monitoring schedule will be distributed by MB prior to the annual monitoring cycle. The schedule will include the following activities:

1. Each Region's process review cycle and timelines (initial, 30-day and 60-day Reviews)
2. Exit Conference dates
3. Final Report due dates
4. Statewide activities such as New Freedom Financial Management Service Reviews, QA Consultations, and various client survey and service verification activities.

QA Process Review Notices

An Initial QA Process Review Notice will be emailed to each area prior to the start of each area's process review cycle. The QA Review Notice will identify the begin dates and end dates of the process review cycle; the number of regular file reviews; and the number of focus reviews to be completed.

Exit Conferences

1. Exit Conferences are optional. The QA lead will ask the Regional Administrators and/or the Area Directors if they wish to have a QA Exit Conference at the time the office is notified of their upcoming initial review. If a QA Exit Conference is requested, the conference will be conducted through MS Teams by the QA Lead and the QA Unit Manager with the following staff who may be attending via MS Teams or phone.
    a. HQ staff, including QA Policy Program Manager, AAA Liaison, SUA Office Chief, HCS Chief of Field Operations, and
    b. Regional/AAA Management and line staff at the discretion of the management team.

2. The QA Unit presents the following in power point format:
    a. What QA reviewed
    b. QA questions that met or exceeded proficiency.
    c. QA questions that did not meet expected proficiency.
    d. Why proficiency was not met.
    e. Remediation, Change Request, PIP process; and
    f. 30-day due dates.

Notification of 3-Day Response Time Issues

1. QA Lead will notify the Region/AAA contact of a 3-day response issue at the end of each monitoring day.

2. Action must be initiated and documented within 3 working days after notification.

3. QA staff will verify at the 30-day review if each 3-day remediation was initiated within the appropriate time frame.

30-Day and 60-Day QA Process Reviews

CMS requires full remediation on **all** QA findings at the individual level that do not meet 100% proficiency.

1. All QA findings that require remediation must be completed within 30 calendar days. All documents needed for remediation verification will need to be scanned and emailed to the QA Lead and a copy of the scanned document(s) should be made available in DMS by the 30-day due date. If the documentation is required in the client Service Episode Record (SER), add it directly into the SER. If the remediation requires an interim CARE assessment, it must be moved to current and synchronized for QA viewing online prior to the 30-day due date.

2. Remediation documentation completed by the field is analyzed by Quality Assurance Staff (QAS) at the 30-day review.

3. Any outstanding QA findings after the 30-day process review are identified on the "Cases Requiring Action" report and that remediation are expected to be completed by the 60-day due date. The QA Lead is available to the Region/AAA to help on any outstanding issues.

4. Remediation documentation completed by the field will be analyzed by QAS at the 60-day review.

5. All QA findings that are still outstanding after the 60-day review will be reviewed with the Region/AAA contact who will be expected to have the QA finding fully remediated. The Region/AAA contact will need to inform the QA Lead when the finding is fully remediated so that final analysis can be completed.

6. Remediation completed after the 60-day due date will be documented as to why the remediation was not made within the time frame allotted and how much time past the due date remediation occurred. Remediation time frames will be included in the Final Region/AAA Report.

7. All issues that cannot be resolved will be forwarded to the Executive Management team for action.

CHANGE REQUEST COMMITTEE

The intent of the Change Committee is to interpret policy, make decisions on change requests, and make recommendations if policy is not clear.

1. The Change Committee consists of the following members:

a. QA Policy Program Manager (facilitator and active member);
b. Standing Members: Case management unit manager or representative; Waiver Program Manager or representative; CFC Program Manager or representative.
c. QA Lead for the area.
d. SUA lead or representative.
e. The field monitoring contact (either in person or by telephone); and
f. Other managers depending on the policy under discussion (e.g., IP Program Manager, Nursing Program Manager, Representative from APS, etc.).

2. Change Committee Process:
   a. Prior to submitting a change request the field's representative must determine if the finding in question has been previously heard by the Change Committee and thus a precedent-setting decision was made.
   b. For change requests that may be taken to the Change Committee, the local office documents the requested change in the Review Cycle Notes (RCN), using "QA Change Request" drop down. The QA Lead will review the requests.
   c. QA reviews the issue and makes corrections if a QA process review error has been made. Consultation with a policy program manager may occur if needed for clarification.
   d. The QA team reviews prior decisions by the Change Committee. If the issue is the same, the QA Unit will make the change based on the Change Committee's prior decision. These issues are not forwarded to the committee.
   e. Issues not corrected by the QA Unit, or which have not had a previous decision are forwarded to the Change Committee and documented in the SharePoint database.
   f. The QA Lead sets up the Change Committee meetings with at least a three-day advanced notice of the meeting date according to the QA calendar. If possible, the QA lead will provide more notice. The meeting notice will include a write-up of the Change Request. The QA Lead invites the appropriate HQ program managers to the meeting.
   g. The Change Committee:
      i. Reviews the change request documentation
      ii. Hears the field's analysis
      iii. Hears the QA Lead's analysis; and
      iv. Consults with other managers if the issues relate to their program.
   h. If a decision cannot be made within the Change Committee, the QA Policy Program Manager will have it addressed at the Executive Management level whose decision is final.

i. If the Change Request is approved, QAS will change the "no" to a "yes" or "NA". If the change is not approved, the Region/AAA contact will ensure the corrections are made. QAS documents the decision in the RCN.
j. The QA Policy Program Manager documents the decision in the SharePoint database.
k. If changes to policy are recommended, the QA Policy Program Manager identifies who will be responsible for follow-up and response to, or completion of, the recommended policy change.
l. At the end of the process review cycle, the QA Policy and Unit Managers review the Change Requests for possible impact on the next review cycle.

FINAL LOCAL REPORT SUMMARY AND COVER LETTER

1. After the 60-day process review, the QA Lead prepares the "Final Report Summary" which includes:
   a. Attachments of the local reports; and
   b. The Proficiency Improvement Plan template.

2. PIPs from the AAA offices will be reviewed and signed by the State Unit on Aging Office Chief or representative. PIPs from HCS Regional Offices will be reviewed and signed by the Deputy Director of Field Operations or representative.

3. The Final Report is due to the AAA Directors/Regional Administrators within 30 calendar days after completion of the 60-day QA process review.

PROFICIENCY IMPROVEMENT PLAN (PIP) FOR SOCIAL SERVICES MONITORING

A PIP outlines a plan for increasing future proficiency. The threshold for when a PIP is required will be specified in the QA Exit Conference. Both HCS HQ and the Regions/AAAs are responsible for developing and implementing a PIP.

1. Regional/AAA action is required for PIP development (based on initial findings). A Regional/AAA PIP is not required for the current QA Unit review cycle:
   a. When the required proficiency is reached on all QA questions.
   b. When HCS HQ is conducting the PIP on a QA question that does not meet statewide proficiency.

2. Regions/AAA will use the PIP template provided for all questions below the expected proficiency level.

3. HQ will identify items that need to be addressed at a statewide level and develop a HQ PIP. Information/trainings in response to the HQ PIP will be maintained on the QA intranet site and should be utilized by the field offices.

4. Regions/AAAs are required to address all other items that did not meet proficiency, except those items being addressed in the HQ PIP. Items being addressed by HCS HQ may also be addressed on a local PIP if the Region/AAA wants to focus on improving local proficiency. The Region/AAAs will support and reinforce strategies to increase proficiency and supervisors will continue to work with individual staff to increase proficiency in identified areas.

5. AAA Specialist, designated delegate, and other HQ program managers are available to assist in development and revision of the PIP.

6. The Region/AAA must submit the PIP to the QA Lead within 30 calendar days from the date the Final Report summary was emailed. The QA Lead tracks the time frame, if the PIP has not been received within 30 calendar days, the QA Lead will notify the HCS Deputy Director of Field Operations or the SUA designated delegate for additional follow-up.

7. HQ Review and Approval
    a. **AAA** – When the PIP is received, the designated delegate and AAA specialist jointly review the plan. The field representative is contacted by email if there are recommended changes. If changes are needed, the revised document is reviewed with the SUA Office Chief, AAA Specialist, and SUA designated delegate; and approved.

       The State Unit on Aging Office Chief or delegate by the State Unit on Aging Office Chief will be responsible for signing the PIP.

    b. **HCS** – When the PIP is received, the HCS Deputy Director of Field Operations reviews the plan. The field representative is contacted by email if there are recommended changes. If changes are needed, the revised document is reviewed with the HCS Deputy Director of Field Operations and approved.

The HCS Deputy Director of Field Operations or delegate by the HCS Chief of Field Operations will be responsible for signing the PIP.

8. Reporting Progress
    a. Regions/AAAs
        i. Progress reporting is unique to each item within the PIP and unique to each Region/AAA.
        ii. The Region/AAA completes the "Progress Reporting Section" and sends it to the SUA designated delegate or HCS Deputy Director of Field Operations, when due. If the progress report is not received on time, the SUA designated delegate or HCS Chief of Field Operations will follow up with the field and notify Executive Management, if necessary.
    b. HQ
        i. Upon review of the progress report the SUA designated delegate, AAA specialist or other management staff may share other ideas or strategies for quality improvement.
        ii. The QA Unit Manager reports the HQ PIP status on an "as needed" basis and at least quarterly to Executive Management at a regularly scheduled
        iii. Office Chief meeting.

ALTSA HCS Statewide PIP Process

1. The QA Policy Program Manager will develop a statewide PIP in collaboration with the QA Unit Manager, Wellness, Improvement, and Nursing Unit, and other program managers based on data in the review cycle Final Report and analysis/experiences/feedback/data, etc., provided by the QA Unit. Any QA question which has a statewide proficiency (for the previous process review cycle) of less than the approved threshold (86%) will require a HQ PIP. Prioritization of PIP timelines may be based on existing PIPs in process and workload impacts. Prioritization is given to those QA questions reported to CMS as part of the federal assurances and sub-assurances and where the client could be negatively impacted.

2. Implementation time frames are individually determined by items identified.

3. The HQ PIP will be reviewed and approved for implementation by Executive Management.

STATEWIDE FINAL REPORT

1. After the statewide review is completed, the QA team prepares the "Home and Community Services Quality Assurance Final Report" which includes:
    a. Questions monitored
    b. Changes to the QA review process, if applicable
    c. Compliance results

2. The Aging and Long-Term Support Administration (ALTSA) Quality Assurance Administrator has final approval of the Home and Community Services Quality Assurance Final Report. This report is distributed and presented to the Executive Management team, the Medicaid Agency Waiver Oversight Committee, the HCS Regional Administrators, the AAA Directors, and the regional HCS/AAA offices. The report is also distributed to the State Auditor's Office (SAO) and other stakeholders as requested. Once finalized the report is also posted on the QA intranet site.

SUPERVISOR MONITORING

The QA reviews completed by supervisors in the HCS and AAA offices are very important because they ensure that we are following CMS requirements, and that quality work is being completed by field staff. Supervisor QA reviews help identify training, staff performance, and policy issues. Supervisors review QA questions above and beyond the QA Unit process reviews, ensuring the health and welfare of the client. As a result, the supervisor's role is a critical part of the foundation for overall HCS quality compliance.

HCS/AAA supervisors have the following quality assurance and improvement responsibilities:

1. Training
    a. Annual Training Plan – Each Region/AAA will develop an annual training plan that outlines how mandatory and optional training will occur for new and experienced staff (employed one year or longer). This document is revised annually at the regional/AAA level. A separate plan does not need to be developed if these elements are included in the PIP.
    b. Training Documentation Form – Supervisors will use a method of their choice to document training completed for new and experienced staff.

c. Monthly Manual Chapter – Supervisors must train all case management staff on at least one chapter of the LTC manual each month.
d. Trends Identified through Required Monitoring – Supervisors must identify individual training needs for their staff and arrange for the provision of that training.

2. Monitoring Results – Supervisors will use the "Reviewed Cases with Questions Requiring Action" report to ensure that corrections identified by the QA Unit have been completed.

3. Supervisor QA Monitoring – Supervisors must inform their staff of the QA monitoring process and expectations. Supervisors monitor that their staff are:
    a. Creating an adequate need assessment.
    b. Authorizing, providing, and terminating services in a timely manner.
    c. Following department policies and procedures.
    d. Correctly determining eligibility and funding sources; and
    e. Completing required forms.

4. Supervisory Monitoring of New and Experienced staff:
    a. New staff without CARE experience
        i. Review of first five assessments –
            1. The goal is to provide training on correct assessment techniques and corrections can be made without having to create another assessment.
            2. Review must occur in a timely manner to meet the 30-day response time.
        ii. After the first five, review 50% of assessments for the next 3 months.
        iii. After 3 months, additional reviews are done at the supervisor's discretion based on performance.
        iv. Reviews must be completed using the QA Monitoring tool.

    b. New Staff transferring within the ALTSA system with CARE experience
        i. Evaluate skills by reviewing the first three assessments using local QA monitoring tools.
        ii. Additional reviews are done at the supervisor's discretion based on performance.

    c. Experienced staff (1 year or more of CARE experience)
        i. Random monitoring of three records per worker, over the course of a year.

ii. Use of the QA Monitor Tool is required, and reviews completed in the QA Monitor Tool will count toward the annual Supervisory reviews of three per year, per worker.
iii. The QA Unit will notify supervisors of their monitoring status mid-year.

HCS QUALITY ASSURANCE AND IMPROVEMENT INTRANET SITE

The HCS QA/QI Intranet Site (http://adsaweb.dshs.wa.gov/hcs/QA/) was developed for headquarters and field staff to learn more about quality assurance and quality improvement activities for HCS and the AAAs, and to share best practices.

The site contains information about and links to the:

- HCS QA monitoring schedules.
- List of the QA questions for the current process review cycle.
- Log of the QA Change Requests and Non-Concur requests submitted by field offices in response to QA Unit process review findings. (This has a searchable feature so offices can determine whether a same/similar finding was disputed in the past and the outcome of the disputed finding as determined by the Change and Non-Concur Committee.);
- Innovation center where social and financial workers, case managers, and supervisors can submit their ideas to the HCS QA Unit and program managers for improving and/or maintaining the quality of their work.
- Copies of the annual HCS QA process review reports.
- Updates about the statewide proficiency improvement projects in process by HCS Headquarters.
- State and Federal Audits of HCS; and
- Copies of Evidence Reports submitted to the Centers for Medicare and Medicaid Services for continued waiver renewal and approval.

Staff are encouraged to refer to this site at least quarterly for information and updates about HCS quality assurance and improvement.

AUTHORITY FOR POLICIES AND PROCEDURES

Section 1915 (k) of the Social Security Act #17: Authorizes the Community First Choice (CFC) State Plan Amendment and requires that the State of Washington have a formal system in place for monitoring the quality standards outlined in the SPA and that all problems identified by monitoring are addressed.

Section 1915 (c) of the Social Security Act #17: Authorizes the COPES Waiver and requires that the State of Washington have a formal system in place for monitoring the quality standards outlined in the waiver and that all problems identified by monitoring are addressed.

RCW 74.39A.050: Requires DSHS to implement a LTC care QI system that focuses on consumer satisfaction and positive outcomes for consumers. This statute outlines 15 QA principles consistent with federal laws and regulation.

RCW 74.39A.090: Requires DSHS to monitor the degree and quality of case management services provided to elderly and disabled clients by AAA.

RCW 74.39A.095: Specifies the minimum elements that must be included in AAA oversight of care being provided to clients.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
1/2025	Bill McBride	Revision and updated formatting	

Quality Assurance and Improvement – Financial Services Monitoring

Chapter 23B describes the Quality Assurance process reviews that are mandated by the Health Care Authority (HCA). This chapter includes sampling methodology, timeframes, and requirements from the staff.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

William McBide Quality Assurance Unit Manager
360.725.2604 william.mcbride@dshs.wa.gov

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FINANCIAL SERVICES MONITORING

Financial Quality Assurance Unit Monitoring QA Process Review

- A statistically valid sample is pulled for each regional area based on the combined number of completed financial applications and reviews that were processed for each region in an annual time period.
- The 12-month QA Monitoring Schedule is available on the QA intranet site. If dates or number of reviews change from original release at the beginning of the monitoring year, which is distributed in a MB, the updated information can be found on the QA intranet site;
- An Entrance Conference letter is sent at the start of an areas' QA Process Review period.
- Monitoring occurs at headquarters.
- An Exit Conference is conducted via MS TEAMS at the completion of the review.
- The region has 30 calendar days to make required corrections.
- ALTSA QA staff conducts a 30-day review to document remediation.
- Issues identified in the 30-day QA Review as not fully remediated must be corrected within 30 calendar days for the 60-day QA Review.
- ALTSA QA staff conduct a 60-day review and document remediation.
- ALTSA QA staff complete the Regional Final Report which is a summary of all QA Unit findings for that Region.
- Questions below the expected proficiency level will need to be addressed in the area's Proficiency Improvement Plan (PIP).
- QA Unit Manager completes the statewide Final Report which is a summary of all QA Unit findings for the annual review for all Regions.

Sampling

- A statistically valid sample will be used for each region.
- The number of QA reviews being completed will be based on the combined number of applications and reviews that were processed for each Region per year.

Sampling example:

- 292 applications + 1,427 reviews in Month Y for Region X = 1,719
- 1,719 applications/reviews x 12 months = 20,628
- Statistically valid sample for Region X = 378

This sampling process would be repeated for each region.

Monitoring Schedule

A QA monitoring schedule will be distributed by MB prior to the annual monitoring cycle. The schedule will include the following activities:

1. Each Region's QA Process Review cycle and timelines (initial, 30-day and 60-day Reviews)
2. Entrance and Exit Conference dates
3. Final Report due dates

Entrance Conferences

The Entrance Conference email is sent prior to monitoring each regional area and provides information about:

1. The monitoring processes
    a. Expectations
    b. Philosophy
    c. Changes to the QA process review, tool or questions from the previous year
2. Monitoring
    a. Schedule
    b. QA questions
3. Regional Reports
4. Exit Conference
5. 30-day Response QA questions
6. Remediation
7. Non-Concur Request Process
8. Proficiency Improvement Plan (PIP)

Exit Conferences for each Region

1. Exit Conferences are optional. The QA lead will ask the Regional Administrator if they wish to have a QA Exit Conference at the time the office is notified of their upcoming initial review. If a QA Exit Conference is requested, the conference will be conducted through MS Teams by the QA Lead and the QA Unit Manager with the following staff who may be attending via MS Teams or phone:
    a. HQ staff, including the Chief of Field Operations, Chief of LTC Financial Eligibility & Policy, and
    b. Regional Management and line staff at the discretion of the management team.

2. The QA Unit presents the following in power point format:
    a. The Proficiency Improvement Plan (PIP) activities from the previous year for the area being reviewed and for the current year for HQ.
    b. What QA reviewed.
    c. QA questions that met or exceeded proficiency.
    d. QA questions that did not meet expected proficiency.
    e. Why proficiency was not met.
    f. Remediation, Non-Concur Request, PIP process, and
    g. 30-day due dates.

30-Day and 60-Day Reviews

Full remediation is required on **all** QA findings at the individual level that do not meet 100% proficiency.

1. All QA findings that require remediation must be completed within 30 calendar days. Remediation documentation completed by the field is analyzed by the ALTSA QA staff at the 30-day review.

2. Any outstanding QA findings after the 30-day review are identified on the "Cases Requiring Action" report and remediation are expected to be completed by the 60-day due date. ALTSA QA staff are available to the Region to offer assistance on any outstanding issues.

3. Remediation documentation completed by the field will be analyzed by the ALTSA QA staff at the 60-day review.

4. All QA findings that are still outstanding after the 60-day review will be reviewed with the Social & Health Program Manager (SHPM) or Regional Representative who will be expected to have the QA finding fully remediated. The SHPM or Regional Representative will need to inform the

Financial QA Program Manager when the finding is fully remediated so that final analysis can be completed.

5. Remediation completed after the 60-day due date will be documented as to why the remediation was not made within the time frame allotted and how much time past the due date remediation occurred. Remediation time frames will be included in the Final Regional Report.

6. All issues that cannot be resolved will be forwarded to the Executive Management team for action.

NON-CONCUR REQUEST COMMITTEE

The intent of the Non-Concur Committee is to interpret policy, make decisions on non-concur requests, and make recommendations if policy is not clear.

1. The Non-Concur Committee consists of the following members:
    a. Chief of LTC Financial Eligibility & Policy.
    b. Financial QA Program Manager.
    c. Members of the LTC Financial Eligibility & Policy Unit; and
    d. The QA Regional contact representing the field

2. Non-Concur Committee Process
    a. Prior to submitting a non-concur request the SHPM/field representative would need to determine if the finding in question has been previously heard by the Non-Concur Committee and thus a precedent-setting decision was made.
    b. For Non-Concur requests that may be taken to the Non-Concur Committee, the regional office documents the requested change in the Review Cycle Notes (RCN), using "QA Non-Concur" drop down. The ALTSA QA staff will review the requests.
    c. The ALTSA QA staff review the issue and make corrections if a process review error has been made. Consultation with the LTC Financial Eligibility & Policy Unit may occur if needed for clarification.
    d. The ALTSA QA staff review prior decisions by the Non-Concur Committee. If the issue is the same, the ALTSA QA staff will make the change based on the Non-Concur Committee's prior decision. These issues are not forwarded to the committee.
    e. Issues not corrected by the ALTSA QA staff, or which have not had a previous decision are forwarded to the Non-Concur Committee and documented in the SharePoint database.
    f. The ALTSA QA staff sets up the non-Concur meetings with at least a one-week advanced notice of the meeting date according to the QA calendar. The meeting notice will

include a write-up of the Non-Concur Request. The ALTSA QA staff invites the appropriate HQ staff to the meetings.

g. The Non-Concur Committee:
   i. Reviews the non-concur request documentation.
   ii. Hears the field QA contact's analysis.
   iii. Hears the ALTSA QA staff's analysis; and
   iv. Makes a final decision based on policy

h. If a decision cannot be made within the Non-Concur Committee, the QA Unit Manager will have it addressed at the Executive Management level whose decision is final.

i. If the Non-Concur Request is approved, the ALTSA QA staff will change the "no" to a "yes" or "N/A". If the change is not approved, the field QA contact will ensure the corrections are made. The ALTSA QA staff documents the decision in the RCN.

j. The QA Unit Manager documents the decision in the SharePoint database.

k. If changes to policy are recommended, the Chief of LTC Financial Eligibility & Policy will identify who will be responsible for follow-up and response to, or completion of, the recommended policy change.

l. At the end of the review cycle, the QA Unit Manager, and the Chief of LTC Financial Eligibility & Policy review the Non-Concur Requests for possible impact on the next review cycle.

FINAL LOCAL REPORT SUMMARY AND COVER LETTER

1. After the 60-day review, the ALTSA QA staff prepares the "Final Report Summary" which includes:
   a. Attachments of the local reports, and
   b. The Proficiency Improvement Plan template

2. The Financial Policy unit Office Chief reviews the PIP and upon approving the PIP forwards the PIP to the Deputy Director of Field Operation for signature.

3. The Final Report is due to the Regional Administrators within 30 calendar days after completion of the 60-day review.

PROFICIENCY IMPROVEMENT PLAN (PIP) FOR FINANCIAL SERVICES MONITORING

A PIP outlines a plan for addressing items that do not meet proficiency. The proficiency threshold will be specified in the QA Exit Conference. Both HCS HQ and the Regions are responsible for developing and implementing a PIP.

1. Regional action is required for PIP development (based on initial findings). A Regional PIP is not required for the current QA Unit review cycle:
    a. When proficiency is reached on all QA questions.
    b. When HCS HQ is conducting the PIP on a QA question that does not meet statewide proficiency.

2. Regions will use the PIP template provided for all questions below the expected proficiency level.

3. HQ will identify items that need to be addressed at a statewide level and develop a HQ PIP if necessary. Information about the HQ PIP status will be maintained on the QA intranet site.

4. Regions are required to address all other items that did not meet proficiency except those items being addressed in the HQ PIP. Items being addressed by HCS HQ may also be addressed on a local PIP if the Region wants to focus on improving local proficiency. The Region will support and reinforce strategies to increase proficiency and supervisors will continue to work with individual staff to increase proficiency in identified areas.
5. QA Unit Manager, ALTSA QA staff, and other HQ staff are available to assist in development and revision of the PIP.

6. The PIP is due to the ALTSA QA staff within 30 calendar days from the date the Final Report summary was emailed. ALTSA QA staff tracks the time frame, follows up and offer assistance, if not received on time.

7. HQ Review and Approval
    a. When the PIP is received, the ALTSA QA staff, QA Unit Manager and HCS Chief of Financial Eligibility & Policy jointly review the plan. The field representative is contacted by email if there are recommended changes. If changes are needed, the revised document is reviewed and approved.

8. Reporting Progress

a. Regions
    i. Progress reporting is unique to each item within the PIP and unique to each Region.
    ii. The Region completes the "Progress Reporting Section" and sends it to the Financial QA Program Manager, when due, with a copy to the QA Unit Manager. If the progress report is not received on time, the ALTSA QA staff will follow-up with the field and notify Executive Management if necessary.

b. HQ
    i. Upon review of the progress report the ALTSA QA staff or other management staff may share other ideas or strategies for quality improvement.
    ii. The QA Unit Manager reports the HQ PIP status on an "as needed" basis and at least quarterly to Executive Management at a regularly scheduled Office Chief meeting.

PUBLIC BENEFIT SPECIALIST SUPERVISOR MONITORING

The Financial QA process reviews completed by Supervisors in the Regional HCS offices are very important because they ensure that we are following Financial Eligibility Requirements and that quality work is being completed by field staff. Public Benefit Specialist Supervisor QA process reviews help identify training, staff performance and policy issues. Financial QA process reviews completed by Supervisors are mandated to be completed in the QA Monitor Tool only.

Public Benefit Specialist Supervisors have the following quality assurance and improvement responsibilities:

1. Monitoring Results – Supervisors will use the "Reviewed Cases with Questions Requiring Action" report to ensure that corrections identified by the QA Unit have been completed.

2. Supervisor QA Monitoring – Supervisors must inform their staff of the QA monitoring process and expectations. Supervisors monitor that their staff are:
    a. Correctly determining benefits that are issued.
    b. Processing all case actions in a timely manner.
    c. Following department policies and procedures.
    d. Required verifications are received and/or documented.

3. Supervisory Monitoring of New and Experienced staff:
    a. New Public Benefit Specialists (PBS) staff and experienced PBS new to long-term care (LTC) eligibility:

i. After an initial mentoring period when the PBS is assisted with case actions as they occur, 25%-100% of all case actions will be reviewed based on their learning level until the new worker demonstrates the ability to accurately determine financial eligibility.

b. Experienced staff (processed Applications and/or Reviews):
   i. Experienced staff is defined as staff that are authorized to process applications and/or eligibility reviews issuing a Medicaid benefit.
   ii. Three (3) full case reviews per worker(s) per year when the worker(s) have completed at least 3 full case actions in a calendar year.
   iii. Use of the QA Monitor tool is required, and QA process reviews completed in the QA Monitor Tool will count toward the annual Supervisory reviews of three per year, per worker.

AUTHORITY FOR POLICIES AND PROCEDURES

Section 1915 (k) of the Social Security Act #17: Authorizes the Community First Choice (CFC) State Plan Amendment and requires that the State of Washington have a formal system in place for monitoring the quality standards outlined in the SPA and that all problems identified by monitoring are addressed.

Section 1915 (c) of the Social Security Act #17: Authorizes the COPES Waiver and requires that the State of Washington have a formal system in place for monitoring the quality standards outlined in the waiver and that all problems identified by monitoring are addressed.

RCW 74.39A.050: Requires DSHS to implement a LTC care QI system that focuses on consumer satisfaction and positive outcomes for consumers. This statute outlines 15 QA principles consistent with federal laws and regulation.

RCW 74.39A.090: Requires DSHS to monitor the degree and quality of case management services provided to elderly and disabled clients by AAA.

RCW 74.39A.095: Specifies the minimum elements that must be included in AAA oversight of care being provided to clients.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
5/23/2025	Bill McBride	Revision and updated formatting	

Adult Protective Services

The purpose of Chapter 23c is to outline Quality Assurance and Quality Improvement activities for the Adult Protective Services (APS) Division.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:
APS QA Unit Office of the Assistant Secretary QA Team for APS
APSQAUnit@dshs.wa.gov

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QUALITY ASSURANCE OVERVIEW

A Quality Management System (QMS) is a commonsense approach of organizing the business and support processes that affect the quality of regulatory and service delivery. While an individual is critical to the success of the system, they are only one component. The success of any QMS relies upon clearly documented policy and procedures, adequate training, review of the processes being used, and when necessary, a plan for improvement.

The Aging and Long-Term Services Administration (ALTSA) QA unit is located within the Office of the Assistant Secretary (OAS) and collaborates with the Quality Improvement (QI) Unit and Adult Protective Services (APS).

The QA Unit's purpose is to complete process reviews which provide data to show required standards are met, to work collaboratively with the divisions, to act as an internal control, and to help identify areas for improvement.

The APS QI Unit's purpose is to examine processes within APS and identify areas to address system gaps. The QI unit develops Proficiency Improvement Plans (PIPs) in response to the QA process reviews in partnership with APS staff. Additionally, the QI unit leads the APS division in the development and implementation of all statewide QI policies, processes, and procedures to assist in assuring division compliance with all state and federal requirements, as well as agency and administration policies.
APS must comply with the following federal regulations and Revised Code of Washington (RCW) chapters:
A. RCW 74.34
B. WAC 388-103
C. 42 U.S. CODE § 1396R (g)(1)(D)
D. 42 U.S. Code § 1395i-3 (g)(1)(D)
E. SOCIAL SECURITY ACT 1819(G)(2)(D)
F. SOCIAL SECURITY ACT 1919(G)(2)(D)
G. RCW 43.17.385 QUALITY MANAGEMENT, ACCOUNTABILITY, AND PERFORMANCE SYSTEM
H. RCW 74.39A.051 QUALITY IMPROVEMENT PRINCIPLES
I. CMS QUALITY MEASURES AND REPORTING MEMO:
1. SECTION 3 – 86% PROFICIENCY THRESHOLD AND PIP REQUIREMENT
2. SECTION 2 – INDIVIDUAL FINDING REMEDIATION REQUIREMENT
J. STRATEGIC PLAN
1. STRATEGIC GOAL #2: HONOR INDEPENDENCE, RIGHTS, HEALTH & SAFETY FOR VULNERABLE ADULTS LIVING IN
HOME- AND COMMUNITY-BASED SETTINGS.
2. STRATEGIC GOAL #4: IMPROVE QUALITY, ACCOUNTABILITY AND RESPONSIVENES

This document contains information about the QMS within APS related to QA process reviews and QI activities. The content is relevant to APS staff, external stakeholders, and anyone seeking to understand the APS QMS.

Starting January 2016, Adult Protective Services (APS) Headquarters (HQ) Program Managers (HQ PMs) began completing Quality Assurance (QA) process reviews and entering data into the QA Monitor Tool. Additionally, in 2017 Field Supervisors and Subject Matter Experts (SME) began completing QA reviews in the QA Monitor Tool. In 2024 Quality Improvement Coordinators (QICs) began the work of supporting the continuous improvement process in central intake and the regions.

Timely completion of quality assurance activities helps protect the health and safety of clients and provides oversight of operations. Activities include completing QA reviews to ensure compliance with quality measures; data analysis to identify gaps in the processes being used based on QA review results; developing proficiency improvement plans and creating solutions using feedback from staff at all levels. Identified findings are addressed and improvement plans are developed and monitored to ensure continuous quality improvement. Through these functions, APS will obtain more predictable outcomes that ensure protection of adults who are vulnerable with consistent and timely investigations while offering protective services, supports and referrals.

STATEWIDE QUALITY ASSURANCE OBJECTIVES

1. Analysis of external and internal issues that affect the quality of service delivery that is relevant to the division's purpose and its strategic plan;

2. Evaluating and ensuring ongoing compliance with State and Federal law;

3. Ensuring that policies and procedures are clearly documented, and information is available, useable, and updated when needed;

4. Identifying areas in the process that need improvement and developing appropriate counter measures to address areas of concern at all levels – individual, local unit, regional, and statewide;

5. Completing QA process reviews that will assess compliance with existing regulations, policies, and standards;

6. Gathering a consistent and broad range of information to identify trends, strengths, and areas for improvement across the division;

7. Identifying best practices within APS with the purpose of sharing strategies across the state;

8. Developing Proficiency Improvement Plans (PIP) with the objective of continuously improving current processes that affect the quality of service delivery and ensure the health and safety of vulnerable adults;

9. Ensuring a continuous flow of communication between all levels of APS.

HQ QUALITY ASSURANCE UNIT PROCESS OVERVIEW

• QA process review occurs at the Office of the Assistant Secretary QA Unit staff level.
• The 12-month QA Activities and Schedule is available on the OAS QA for APS SharePoint site.
• Statistically significant samples are pulled for each regional area based on the number of completed Investigations and Investigations Closed No APS that were processed for each region in an annual time period.
• Statistically significant samples are pulled for screened-in intakes and screened-out intakes that were processed by APS Central Intake within an annual time period.
• Statistically significant samples are pulled for all investigations closed statewide within an annual time period.
• QA Review Entrance letters are sent at the start of each process review cycle.
• APS Central Intake and the Regions have 30 business days from receiving the initial QA proficiency reports to complete the necessary remediations and to also submit change requests.
• APS Central Intake and the Regions then have 5 business days to complete remediation if necessary for findings that were upheld by the change committee.
• An Exit Conference may be conducted via Microsoft Teams at the completion of the review, following any decisions from the change committee.
• OAS QA Consultants(s) conduct a 30-day HQ QA review to document remediation.
• Issues identified in the 30-day HQ QA Review as not fully remediated must be completed immediately by APS Designated Staff.
• OAS QA Consultants(s) complete the Final Report which is a summary of all QA findings.
• A Proficiency Improvement Plan (PIP) will need to be developed for QA questions designated by APS Director and/or the Aging and Long-Term Support Administration (ALTSA) Assistant Secretary.

PART 1: QUALITY ASSURANCE PROCESS REVIEWS

A. GENERAL GUIDELINES

Background
QA was developed for APS as part of ALTSA's Quality Management System (QMS) to improve processes within APS and to ensure guidelines for participation in federal programs are maintained.
Starting January 2016, Adult Protective Services (APS) Headquarters (HQ) Program Managers (HQ PMs) began completing Quality Assurance (QA) process reviews and entering data into the QA Monitor Tool. Additionally, in 2017 Field Supervisors and Subject Matter Experts (SME) began completing QA reviews in the QA Monitor Tool. In 2020 the QA unit was transitioned to the Office of the Assistant Secretary (OAS) and continues to work with APS leadership and staff to complete QA activities. In 2024 Quality Improvement (QI) consultants began supporting APS in implementation of the QMS.

Timely completion of QA activities helps protect the health and safety of clients and provides oversight of operations. Through the QMS system APS will obtain more predictable outcomes that ensure protection of adults who are vulnerable with consistent and timely investigations while offering protective services, supports, and referrals.

For information about each setting or program area reviewed by QA, see Appendix D: Resources and Forms.

Procedure
1. QA Unit will:
a. Conduct required process reviews to determine compliance with standards, state law, APS policy, and federal regulations.
b. Follow all procedures to ensure consistent QA process reviews.
c. Complete process reviews in a timely manner.
d. Monitor the APSQAUnit@dshs.wa.gov email box and respond to inquiries within 2 working (business) days (WD).
e. Clearly communicate findings and trends.
Note: The purpose of findings is to demonstrate an identified gap between policy guidance and what was found during the process review.
f. Always maintain professional and respectful conduct.

2. QI Unit will:
a. Participate in any collaborative training sessions with the QA unit.
b. Assist with facilitating discussions with APS staff when process questions arise.
c. Monitor the ImproveAPS@dshs.wa.gov email box and respond to all inquiries within 2 WD.
d. Clearly communicate information.
e. Always maintain professional and respectful communication.

3. Region/central intake will:
a. Maintain one point of contact within the region or central intake for QA information and work directly with the QI team. This is known as the Designated Staff (DS).
b. Enter all new staff with appropriate area and permissions into the QA Monitor application (QAM).
c. Inactivate any staff within their respective area in QAM.
d. Notify Program Integrity (PI) Unit Manager of new hires and start dates.
e. Notify QA Unit Manager of any position changes requiring permissions changes to QAM.

Definition of Roles within the QA Unit
1. ALTSA QA Unit Manager
a. Recruits, hires, and ensures that new QA staff are trained.
b. Supervises and provides oversight to the QA Unit to ensures all processes and procedures are followed and QA reviews are completed as required.
c. Performs regular spot checks of QA Consultant work for quality, consistency, and interrater reliability.
d. Assists the unit in completion of tasks to ensure work is completed timely and efficiently.
e. Assures the statistical relevance for all sampling and sample methodology and determines samples sizes required.
f. Ensures QA staff maintain a working knowledge of all relevant policy.
g. Requests clarification from APS and ALTSA leadership as needed.
h. Maintains the QA SharePoint site.

i. Maintains the QA Monitor Tool.
i. Provides updates on QA Questions, No Responses, and review types based on changes to the review process.
ii. Ensures trainings are available related to use of the QA Monitor Tool.
iii. Coordinates with Management Services Division (MSD) to repair bugs, create reports, or work on issues as they arise.

2. Process Review Lead
a. The Process Review Lead (QA Lead) is the QA Consultant assigned to coordinate the process review and all associated tasks to ensure completion.
b. Creates and distributes statistically significant and accurate samples.
c. Ensures all information and files are available for the process review, including updated reports, updated question documents, information sheets, required files, and any other information needed for the review.
d. Coordinates information requests to or from the program to be sure all questions and data requests for the review are addressed. Tracks responses to ensure any required updates to documents and processes are complete.
e. Ensures all QA reviews are entered and closed correctly during reviews, at the end of the review, and at the end of the calendar year to validate reviews are completed in the QA Monitor Tool.
f. Creates or runs required reports to ensure historical records are available.

3. QA Consultant
a. Is a member of the QA Unit who coordinates and completes QA process reviews.
b. Completes process reviews in the manner prescribed in the instruction documents, in this chapter, and in documents produced through the question document review process.
c. Works within the unit to ensure all work is completed in a professional and collaborative manner.

4. ALTSA Management Analyst (MA)
a. Is a member of the ALTSA QMS who reports directly to the ALTSA Senior QA Administrator.
b. Provides QA and APS QI Coordinators (QICs) data analysis one WD prior to the exit conference and two WD after initial proficiency reports are finalized.
c. Collaborates and consults with QA and QI when reviewing data.
d. Provides Ad Hoc data analysis and reports as requested by agreed deadlines.
e. Documents potential enhancements to QA reports throughout the year.
f. Work with the QA Monitor Development Team to correct issues with QA reports, suggest improvements, and test changes to the QA tool or reports.

Definition of Roles within the QI Unit
1. APS Program Integrity Unit Manager
a. Supervises and provides oversight to the QI Unit to ensure all processes and procedures are followed and QI activities are completed as required.
b. Recruits, hires, and ensures that new QI staff are trained.
c. Ensures QI staff demonstrate a working knowledge of this policy.
d. Conducts supervisory reviews of QI staff work to ensure policies and procedures are followed.

e. Requests clarification from APS leadership as needed.
f. Performs regular spot checks of QIC work for quality, consistency, and accuracy.
g. Assists the unit in completion of tasks to ensure work is completed timely and efficiently.
h. Distributes QA Process Review result reports to the Regional Administrators (RAs) and Program Managers (PMs), following both the initial proficiency reports, as well as the final statewide exit conference.
i. Present overview of QA/QI in collaboration with the QA Unit Manager, coordinated with the training unit.
j. Maintains the QI SharePoint site.
k. Ensures all APS staff have access to QIC Central Resources.
l. Collaborates with APS leadership, policy, and statewide and regional trainers on QI activities.
m. Coordinates quarterly program meetings with the following units:
i. Policy – Send the invite to the Senior Policy Advisor.
ii. Training – Send the invite to the Training Unit Manager.

2. QI Program Lead
a. The Program Lead is the QIC assigned to coordinate all QI activities for the assigned program. This includes but is not limited to QA process reviews response, including data analysis, change requests, root cause analysis, and PIP development, as well as associated tasks to ensure completion and ongoing monitoring. The lead is responsible for the success of all QI activities.
b. Supports, coordinates creation, and delivery of any QI driven trainings related to PIP activities and form updates in cooperation with appropriate APS staff.
c. Presents QI Overview at program specific trainings, coordinated with the training unit.
d. Coordinates trainings for QI team members (i.e., needed QI checks, etc.).
e. Responds to all communications related to the assigned program received via the ImproveAPS@dshs.wa.gov email inbox.
f. Ensures all QI monitoring checks are entered and closed per the process defined in the section labelled 'Thirty Day Reviews.'
g. Lead will coordinate QI activities with their Co-Lead.

3. QI Program Co-Lead
a. Supports the QI Lead in completing program related QI activities.
b. If the QI Lead is unavailable, the Co-Lead will take additional Lead responsibilities as needed.
i. If what is needed is unclear, consult with the Unit Manager.
c. Provide technical support, including note taking, during any QI provided in-services and presentations.
d. Co-Lead will coordinate QI activities with the QI Program Lead.

4. QI Coordinator
a. Is a member of the QI Unit who coordinates and completes QI activities.
b. Works within the unit to ensure all work is completed in a professional and collaborative manner.

B. PROCESS REVIEW SCHEDULE

Background
ALTSA QA maintains a 12-month QA Process Review Schedule, which runs January through December. The schedule is available on the OAS QA for APS SharePoint site.
QA reviews are entered into the QA Monitor Tool or SharePoint Forms by QA or as a check by QI. Reviews in QA Monitor must be closed and completed before the system lock-out in December when updates are processed for the next review cycle. This includes adding necessary 30-Day reviews and overturning findings when required. When reviews are not fully closed by the end of the calendar year, they are locked in place and remain in the QA Monitor as open reviews with no way to close them. This creates a layer of complexity that interferes with the functionality and ease of use of the system.

Procedure
The QA Unit Manager will publish a Management Bulletin (MB) at the beginning of each year to update the process review schedule. If the dates or the number of reviews change after the original release, staff will be notified, and the OAS QA for APS SharePoint site will be updated.
The Process Review Schedule includes key information, such as:
1. Each process review area being completed for the year.
2. Review dates: QA team trainings, entrance dates, and file review dates.
3. Dates the initial proficiencies will be provided to QI.
4. Change request and remediation due dates.
5. Change Request Committee (CRC) dates.
6. Exit conference dates.
7. PIP due dates.

QA Unit Manager Responsibility
1. Creates QA schedule.
2. Creates and submits the annual MB to the APS Policy unit for publication to provide APS with the updated schedule and process review information.
3. Ensure training for new QA staff occurs.
4. Ensures QA staff demonstrate a working knowledge of this policy.
5. Conducts end of year review verifications to ensure staff are following the policy.
6. Assures that weekly updates are sent for posting when changes to the schedule are required.

PIP due dates

Program Integrity Unit Manager Responsibility
1. Review QA schedule.
2. Ensure appropriate staff are made aware of required dates and scheduled meetings.
3. Refer questions to QA Unit Manager as they arise.

Adult Protective Services Responsibility
4. Review QA schedule.
5. Ensure appropriate staff are made aware of required dates and scheduled meetings.
6. Refer questions to QA Unit Manager as they arise.

C. QA QUESTION DOCUMENT REVIEW

Background
QA is responsible to complete process reviews using specific questions developed to ensure we are meeting federal, state, and ALTSA leadership guidelines. The questions are reviewed and updated with input from APS Policy, Training, QI, and other subject matters experts. The questions are approved by the APS Director.

Questions are updated based on current policies, procedures, the DSHS and ALTSA Strategic Plans, federal legislation, federal requirements for State Plans, Waivers, and Home and Community-Based setting rules, state legislation, current issues the division is experiencing, or in response to external audits or litigation.

How QA reviews each of the questions is developed by the QA Unit with input from subject matter experts (SMEs) and feedback from staff. This process is key to providing the opportunity for all staff to provide input and ensure QA has as much information as possible to complete the review accurately and efficiently.

QA data is tracked and may be reported to federal partners to provide evidence of compliance with Medicare and Medicaid programs. The information gathered from QA process reviews is also intended to assist the division with process improvement activities, act as an internal control, as well as maintain compliance with applicable laws and policies

All current QA question documents are located on the QA SharePoint site and are available by contacting QA at APSQAUnit@dshs.wa.gov.

Procedure
1. Documents are reviewed, updated, and revised as changes are required.
2. The QA Unit Manager will facilitate communication with policy, training, area specific SMEs, and other designated staff to review and discuss QA questions. All sections of the documents may be reviewed and revised.
3. Once final drafts are completed, significant changes to questions or proficiency expectations are reviewed and approved by the APS Director.
4. When MBs or new policies are published, QA will conduct reviews to that standard on the date the MB or policy is effective.
5. QA question materials to be used for the year are published to the How to Review SharePoint Page. Documents and links are also provided in the QA Schedule MB.

QA Unit Manager Responsibility
1. Outlines required changes with the APS Director to obtain final approval.
2. Ensure training for new QA staff occurs.
3. Ensures QA staff demonstrate a working knowledge of this policy.
4. Researches and responds to inquiries from the QA Unit.
5. Conducts supervisory reviews of QA staff work to ensure policies and procedures are followed.
Program Integrity Unit Manager Responsibility

1. Participate in all QA question document review conversations.
2. Maintain a log of potential policy updates between process reviews for tracking purposes.

Adult Protective Services Responsibility

1. Notify QA and QI by email of process changes that may affect how QA Process Reviews are completed.
a. It is encouraged to notify QA as topics arise.

D. SAMPLE METHODOLOGY

Background

The QA Unit uses the statistically valid sampling methodology recommended by the Centers for The QA Unit uses the statistically valid sampling methodology recommended by the Centers for Medicare and Medicaid Services (CMS). Raosoft's Sample Size Calculator is used to determine statewide sample sizes using the recommended 5% margin of error and 95% confidence level.

There are reviews in which entire population subject to review is too small to use only a sample of the population. In these cases, the entire population is reviewed.

Procedure

Investigations

- o Samples from each region will be investigations closed inconclusive, substantiated, and unsubstantiated, and a sample of investigations closed No APS.
- o The sample will be pulled from the three months after the PIP interventions are completed if possible.
- o Regional sample is based on the percentage of cases closed by unit during the time frame.
- o The random sample of cases to be reviewed are then generated by usage of the RAND function in Microsoft within the DataMart tool.
- o This sampling process repeats for each Region and APS Central Intake.

Example of a sample calculation:

2,038 Investigations Closed No APS for Region X, during prior calendar year.
9,638 Investigations (inconclusive, substantiated, unsubstantiated) for Region X, during prior calendar year.
2,038 entered into RaoSoft = 324 (statistically significant sample)
9,638 entered into RaoSoft = 370 (statistically significant sample)
Total investigations in prior three months = 2,169
Total Closed No APS in prior three months = 500
Unit A closed 5% of 2,169 Investigations and 7% of 500 Closed No APS.
o Sample size calculation size for Unit A:
o 370 x .05 = 19 Investigations,
o 324 x .07 = 22 Closed No APS
Unit B closed 1% of 2,169 Investigations and 2% of 500 Closed No APS.
o Sample size calculation size for Unit B:
o 370 x .01 = 4 Investigations,
o 324 x .02 = 6 Closed No APS
Unit C closed 7% of 2,169 Investigations and 3% of 500 Closed No APS.

o Sample size calculation size for Unit C:
o 370 x .07 = 26 Investigations,
o 324 x .03 = 10 Closed No APS

Intake
o APS Central Intake data sample Intake Screen-Out and Intake Screen-In.
Example of a sample calculation:
9,525 total screen in intakes processed during prior calendar year.
4,752 total screen out intakes processed during prior calendar year.

9,525 entered into RaoSoft = 370 (statistically significant sample).
4,752 entered into RaoSoft = 356 (statistically significant sample).
During the three months prior to the QA review start date, Central Intake created 2,578 screen in intakes and 1,980 screen out intakes.
Intake Worker A created 3% of 2,578 screen in intakes and 2% of 1,980 screen out intakes created during the three months prior to the QA review start date.
• Sample size calculation size for Intake Worker A:
o 370 x .03 = 11 screen in intakes,
o 356 x .02 = 7 screen out intakes

Intake Worker B created 6% of 2,578 screen in intakes and 5% of 1,980 screen out intakes created during the three months prior to the QA review start date.
• Sample size calculation size for Intake Worker B:
o 370 x .06 = 22 screen in intakes,
o 356 x .05 = 18 screen out intakes

Statewide
o 90-day reason code review
o Safety and Risk review
o Documentation Timeliness
o Statewide sample is stratified by cases closed by region within the population

Example of a sample calculation:
Total statewide investigations closed during prior calendar year with a 90-day reason code other than No Good Cause = 9,959

9,959 entered into RaoSoft for a statistically significant sample of 370

During the 2-month period prior to the QA review start date 1,850 investigations were closed with a 90-day reason code other than No Good Cause.
o Region A closed 480 or 25.9%
o Region B closed 732 or 39.6%
o Region C closed 638 or 34.5%

Sample size calculation for Region

A: 370 X .259 = 95.83 Sample size calculation for Region
B: 370 X .396 = 146.52 Sample size calculation for Region
C: 370 X .345 = 127.65

Region A would round to 96, Region B would round to 146, and Region C would round to 128.

The entrance documents will be sent to the program's designees prior to the start of the process review as described in section labeled 'Process Reviews'. The timeframe for the entrance communication may be adjusted based on program need.

QA Unit Manager Responsibility
1. Ensures sample methodology meets required standards.
2. Ensure training for new QA staff occurs.
3. Ensures QA staff demonstrate a working knowledge of this policy.
4. Conducts supervisory reviews of QA staff work to ensure policies and procedures are followed.
5. Requests training or clarification from leadership as needed.

E. PROCESS REVIEWS

Background

The QA Unit is responsible for determining whether specific proficiencies were met based on a prescribed set of questions.

The process reviews discussed in this section are defined as: the entrance, the initial process review work completed by QA, and the preliminary reporting. Process reviews are conducted remotely by the ALTSA QA Unit and staff are not required to travel.

Each process review is assigned a QA Process Review Lead (QA Lead), who is responsible for ensuring process review activities are completed. The QA Lead is considered the liaison and the SME for QA activities for the areas to which they are assigned. For information about which QA Unit Member is assigned as QA Lead for a specific area, please email APSQAUnit@dshs.wa.gov.
Procedure

ENTRANCE:
1. QA will e-mail entrance correspondence to the Designated Staff (DS) for the area being reviewed. This will include pertinent information related to the process review, such as the name of the QA Lead and an information sheet with pertinent dates and information for the review.
2. QA receives all correspondence via APSQAUnit@dshs.wa.gov.
3. The QA Lead will contact the Designated Staff to communicate any questions, concerns, or needs of the unit prior to the start of the review.
4. The QA Lead is responsible for ensuring communication between the staff and QA occurs during the review, as questions arise.
5. The QA Unit Manager or their designee will communicate with Policy, Training, QI, and other SMEs,

as needed to ensure the review is as accurate as possible, and new policies and procedures are communicated to QA.
6. The QA Lead will track any issues with the review, with questions, or with question documents. This information is gathered so that any issues are addressed at the next question document review meeting to inform potential updates.

INITIAL PROCESS REVIEW WORK:
At the beginning of the review, the QA Lead will ensure the area subject to review is aware the review has begun.

THE QA LEAD WILL:
1. Establish an open line of communication for the process review, and act as the primary point of contact.
2. Notify the Central Intake or Regional Designated Staff (DS) and QI Lead of any immediate remediation work necessary. Examples of immediate remediation work include sending a law enforcement referral or updating person management with safety concerns.
3. Monitor the QA mailbox and respond to inquiries within 2 WD.

DURING THE PROCESS REVIEW, THE QA LEAD WILL:
1. Track all issues and work toward a resolution before QA begins the review.
2. Notify DS of any immediate remediation requests and the date they are due and follow up until all remediation requests are addressed.
3. Add an RCN when immediate remediation action is required including the date the field was notified.
4. Verify the action when the field notifies QA the immediate remediation action was taken and add corresponding RCN.
5. Pull reports on a regular basis and identify issues which must be resolved. The QA Lead will manage this process and ensure issues are found and corrected as soon as possible during the process review.

QA Unit Manager Responsibility
1. Work with QA Staff during the process review to complete the review and address any concerns or specific questions related to how to complete any part of the review.
2. Ensure training for new QA staff occurs.
3. Ensures QA staff demonstrate a working knowledge of this policy.
4. Requests training or clarification from leadership as needed.

Adult Protective Services Responsibility
1. Designate one specific contact person for information and actions related to the process review, known as Designated Staff (DS).
2. When notified of immediate remediation action, ensure action is taken the same or next business day.
3. Inform QA Lead when immediate remediation action is completed.

F. INITIAL PROFICIENCY REPORTS

Background
At the completion of the review of records, initial proficiencies are sent to the QI unit and the Designated Staff. These are the preliminary results prior to any changes made during the change request process or at the Change Request Committee (CRC) meetings (refer to section labelled 'Change Requests' for more information). These preliminary results are subject to change once change requests are finalized.

Finalization of results in the QA Monitor tool occurs after the 30-day process described in the section labeled 'Thirty-Day Reviews' is completed.

Procedure
1. The ALTSA QA MA will send preliminary reports by the date posted on the official QA Unit Schedule. Reports are sent to the QA Unit Manager and the Program Integrity Unit Manager.
2. The QA Unit Manager or designee will forward the preliminary reports to the APS Director, APS Deputy Director, APS Office Chiefs, and the ALTSA Senior QA Administrator.
3. The Program Integrity Unit Manager or designee will compile the results and provide a breakdown of the data by Region and Unit. Results will include overview graphs, the proficiency reports, and the

QA Analysis Comments. Reports will be distributed to the RAs, DRAs, and PMs for the region or to the Unit Manager for CI.
a. Email to RAs and PMs should include details of next steps, including when change requests are due. Sample email template can be found in Appendix C.
b. The QIC enters Change Requests into the QA Monitor Tool by the due date identified on the official QA Unit Schedule. To ensure timely receipt and review of all submitted change requests, any requests must be submitted by APS staff to QI 5 WD prior to the due date on the schedule.

G. REMEDIATION

Background
Remediation is the process of correcting an issue found during the QA review. Some findings relate to health and safety, some issues could result in litigation, and other issues may result in monetary penalties or federal payback of funds. These types of findings require the issue to be corrected. There are times when remediation is not possible. QA question documents identify these questions by using "Historical data, unable to remediate" as a remediation option.

Law enforcement referrals are required during intake and investigation activities. When there is a finding related to a missing law enforcement referral, remediation is required to be completed the same or next business day from the notification of the finding.

For any QA finding where an action was possible, QI staff will enter the appropriate remediation response for each finding during the 30-day review cycle or indicate that remediation was not possible.

This input is required to allow the QA Monitor Tool to function properly at the end of each review year.

Procedure
1. Upon receipt of the initial proficiencies, QI and the DS for the region or central intake will review the findings and determine remediation actions in cooperation with APS workers, supervisors, and program managers as necessary.
2. The DS in partnership with the QI lead for the region or central intake will track and coordinate remediation requests and ensure all remediation activities are completed as required.
3. QA will monitor APSQAUnit@dshs.wa.gov during the 30-day cycle.
4. QI will enter all remediations into QA Monitor during the 30-day review process.

QI Staff Responsibility
1. Review all QA findings and work with regional and central intake staff on potential remediation actions.
2. In the QA Monitor Tool, QI will add a Review Cycle Note (RCN) to the process review to explain what was done to remediate the finding, using the code "Action Taken" for the RCN type.
3. If a review requires multiple remediation actions, those actions may be documented within the same RCN. It is not necessary to enter multiple RCNs within the same review. This does not apply for RCNs with the code "Change Request".
4. Notify QA via email when all remediation actions have been completed.
5. Ensure all remediation actions are completed on or before the required due date.
6. Notify APS leadership if deadlines are not being met.

APS Staff Responsibility
1. When notification of a finding is received, review the finding documentation to determine what needs to be done. If you do not know what to do, contact QI for assistance.
2. Complete the appropriate remediation by the required due date.
3. E-mail QI that you have completed the remediation and what action you took to complete the remediation. Do not send personal or confidential information via email. If you are not sure what to say or what to send, contact QI.
4. If notified by QI staff that deadlines are not being met, APS leadership will work with regional or intake staff to ensure priority is taken to address all remediation actions and communicate with the QI staff.

QA Unit Manager Responsibility
1. Respond to inquiries and train staff on remediation processes and procedures.
2. Ensure training for new QA staff occurs.
3. Ensures QA staff demonstrate a working knowledge of this policy.
4. Request training or clarification from leadership as needed.

H. CHANGE REQUESTS

Background
The purpose of the change request process is to allow staff the opportunity to provide additional

explanation or information so that QA findings can be reconsidered. When QA receives a change request, the actions QA may take regarding the finding include:

- Overturn: When QA agrees with the information provided, they will overturn the finding.
- Uphold: When both QA and QI agree that the information provided does not support overturning the finding, they will uphold, and QI will follow up to determine any necessary next steps.
- Change Request Committee: When QA and QI do not have enough information to overturn or to uphold the finding or determines that leadership needs to make the final determination, the QA Unit Manager will forward the finding to the Change Request Committee (CRC) to be considered.

Change requests must be submitted by 5:00 PM on the due date provided on the QA schedule. All requests must be submitted as an RCN in the QA Monitor Tool using Contact Code "Change Request." Email submissions and RCNs which do not include a correct contact code will not be considered. For reviews completed in SharePoint forms, all requests will be entered into the specific form by the designated due date and time.

Procedure

Requesting Changes to QA findings:
Prior to sending the change request, APS Designated Staff and QI will:
1. Review applicable QA question documents and instructions.
2. Review the policy in place at the time the investigation or intake work was completed.
3. Review historical Change Request Committee (CRC) decisions located on the QA SharePoint site.
    a) If CRC has upheld a QA determination on the same issue, the request will not be forwarded to CRC and the QA finding will be upheld.
    b) If there has been a change to policy or a compelling reason exists for leadership to discuss the issue again, QA will forward the request to CRC.
4. For investigation reviews, discuss the request with the Regional Administrator for the area who will have the final say if the change request will be entered into the QA Monitor Tool.
5. For intake reviews, discuss the request with the Central Intake Unit Manager who will have the final say if the change request will be entered into the QA Monitor Tool.

After determining the Change Request should be sent to QA:
1. QI will enter the RCN into the QA Monitor Tool.
2. Use the contact code "Change Request". This code must be selected, or the request will not be visible to QA and will not be considered.
3. All change requests must appear on the 2309 Change Request Report in ALTSA Reporting to be considered. (Using the contact code "Change Request" accomplishes this).
4. The change request language should include the question and no response requested to be changed, the reason why the change is requested, and policy language that supports the requested change. The change request should not hold confidential information including AV or AP names, dates of birth, or other identifying information.
5. If multiple questions and/or no responses within a review require a change request, enter a

separate change request RCN for each item.
THE QI UNIT WILL:
1. Ensure APS staff are aware of change request due dates and dates for when requests must be received by the QI Unit for processing.
2. Review all change requests in collaboration with region or intake leadership in determining what will be forwarded to QA.
3. Collaborate with QA Unit Manager to determine what will be upheld or overturned and which requests will be sent to the CRC for consideration.
4. Report back to requestors to advise them of the outcome of their requests.

THE QA UNIT WILL:
1. Review and research each change request received considering the additional information.
2. Request additional information from appropriate SMEs (e.g., Training, Policy, Regional Staff, etc.) as needed to clarify the issue.
3. Collaborate with the Program Integrity Unit Manager to determine what will be sent to CRC.
4. Forward requests that require a CRC decision to the committee prior to the CRC meeting.
5. QA Consultants will update findings in the QA Monitor Tool as directed by the CRC within 5 WD after the CRC Meeting and will complete the 30-day reviews before the Final Exit Conference.
6. The ALTSA QA MA will e-mail updated reports to QA and QI within 2 WD when the proficiencies have changed from the initial proficiencies or when required.

Change Request Committee (CRC) Responsibility

Purpose
To make the final determination as to whether to overturn or uphold QA findings. Each topic area or finding will be discussed during the meeting and a determination will be made only by the voting members as to the outcome of the QA finding(s).

Due to time constraints, countermeasures are not determined or discussed in detail at these meetings.

CHANGE REQUEST COMMITTEE MEETINGS:
1. CRC meetings are scheduled by QA and dates are published on the QA Schedule.
    a. A scheduled CRC Meeting may only be changed with the approval of the APS Deputy Director.
    b. When a voting member is unable to attend, they have the option to send a designee who will stand in for them and act as a voting member.
    c. It is preferred, but not required that all voting members attend. If one or two members are unable to attend, the meeting may proceed without them.
2. CRC does not repeat change requests which have been decided in historical committee meetings unless there is a compelling reason for them to hear the request again.
3. CRC may not hear change requests that have clear internal, state, or federal policy guidance. In these cases, QA and QI will discuss these requests to determine the outcome.

THE CRC INCLUDES THE FOLLOWING VOTING MEMBERS:
1. APS Deputy Director
2. APS Office Chiefs who are not in charge of the area subject to review

3. Senior Policy Advisor
ALL NON-VOTING CRC ATTENDEES WILL SUPPORT THE CRC'S PURPOSE BY:
1. Allowing the process to flow without interruption.
2. Responding to questions from CRC voting members and others who require their expertise.
3. Responding to requests to provide evidence, policy guidance, best practice, or experience.
4. Refraining from voting or expressing a desired outcome.
5. Holding comments and questions about next steps, countermeasures, or follow-up.
6. Not forward invitations to CRC meetings.
a. For those whose attendance is required to provide expert opinion or information the CRC voting members need, they will e-mail the meeting organizer to add the individual.

THE CRC WILL:
1. Review all change requests submitted and all supporting documentation.
2. Discuss each issue and ask questions that enable them to make an appropriate determination based on the policies and procedures in place at the time the work was completed.
3. Vote to determine whether to uphold or overturn the QA finding.
    a. If the vote is a tie, the APS Director or their designee will make the final decision.
    b. When the CRC upholds the finding, APS must remediate the finding within 5 WD if remediation is possible.
    c. When the CRC overturns the finding, QA will correct the review within 5 WD.

QA Unit Manager Responsibility
1. Provide clarification for QA findings and collaborate with QI to determine which requests are overturned, which are upheld, and which are forwarded to CRC.
2. Only forward invitations to those whose attendance is required to provide expert opinion or information the CRC voting members need.
3. Facilitate CRC meetings, maintain professionalism, and ensure the meeting stays on task.
4. Ensure training for new QA staff occurs.
5. Ensures QA staff demonstrate a working knowledge of this policy.
6. Request training or clarification from leadership as needed.

Program Integrity Unit Manager Responsibility
1. Ensure training for new QI staff occurs.
2. Ensures QI staff demonstrate a working knowledge of this policy.
3. Collaborate with QA to determine which change requests will be overturned and which are forwarded to CRC.
4. Ensure staff are provided the opportunity to present their request through their program's representative, their PM, or appropriate SMEs.
5. Only forward invitations to those whose attendance is required to provide expert opinion or information the CRC voting members need.
6. Request training or clarification from leadership as needed.

I. THIRTY-DAY REVIEWS

Background

Within the APS System, 30-day reviews are completed after the initial review when the initial review included at least one finding (at least one question was answered with no). The purpose of the 30-day reviews is to show all work has been finalized, all required remediation is complete, and the review requires no further action.

Anyone entering QA reviews, including those individuals entering supervisory reviews or QI checks, must also enter all 30-day reviews within 45 calendar days after the initial review is entered or before the QA Monitor blackout period begins in December, whichever occurs first.

The QA Monitor blackout period occurs in December during which no reviews can be entered into the system. During the QA Monitor blackout, the prior year is closed out and frozen, so any open reviews create complications and unnecessary work for those using the system.

Procedure

THE QA UNIT WILL:
1. Complete 30-day reviews by the due date listed on the schedule.
    a. When remediation is not possible and considered to be historical, QA will answer with N/A and choose the remediation "Historical data-unable to remediate"
    b. When remediation has been completed, QA will answer Yes and choose the appropriate remediation option.
2. The QA Lead will verify all reviews entered by QA are closed at the end of each review.
3. The QA Unit Manager or their designee will verify all reviews entered by anyone other than QA are closed by the end of the year prior to the blackout period.

THE QI UNIT WILL:
1. Enter checks into the QA Monitor Tool periodically throughout the year to gauge impact and effectiveness of PIP countermeasures or systemic changes.
2. Verify that all reviews entered are closed within 45 calendar days of the date the review was entered, or before the QA Monitor Tool blackout dates, whichever comes first.

QA Unit Manager Responsibility
1. Ensure training for new QA staff occurs.
2. Ensures QA staff demonstrate a working knowledge of this policy.
3. Conducts supervisory reviews of QA staff work to ensure policies and procedures are followed.
4. Request training or clarification from leadership as needed.

Program Integrity Unit Manager Responsibility
1. Ensure training for new QI staff occurs.
2. Ensures QI staff demonstrate a working knowledge of this policy.
3. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
4. Request training or clarification from leadership as needed.

J. FINAL EXIT CONFERENCE AND PROFICIENCY REPORTS

Background
Once all change requests and 30-day reviews are completed, proficiencies are re-calculated, and a final Exit Conference is held by QA to disseminate final QA results.

This process was initiated at the beginning of the 2024 QA cycle in response to feedback from staff that initial results are not as helpful as final results.

Procedure

THE QA UNIT WILL:
1. The QA Lead will verify the review is completed and all reviews are closed in the QA Monitor Tool.
2. The ALTSA QA MA will send final proficiencies to the QA Unit Manager and Program Integrity Unit Manager at least one (1) WD prior to the exit conference.
3. The QA Lead will coordinate and facilitate a Final Exit Conference which will include the following information:
    a. Information related to how the sample is chosen.
    b. QA questions asked during the process review.
    c. Review of findings and proficiencies achieved.
    d. Highlights from the review, including how the change request process impacted proficiencies.
4. ALTSA QA will send an invitation to the Designated Staff and regional leadership. This meeting may be forwarded to allow anyone with an interest in attending. Meetings are held remotely and typically use Teams.

THE QI UNIT WILL:
1. Attend all Final Exit Conferences and will present information about upcoming Root Cause Analysis meetings and next steps, including PIP due dates if a PIP is required.
2. Once completed, the QI Unit Manager or designee will distribute any updated proficiency reports to RAs and PMs, if applicable.

QA Unit Manager Responsibility
1. Ensure training for new QA staff occurs.
2. Ensures QA staff demonstrate a working knowledge of this policy.
3. Request training or clarification from leadership as needed.

Program Integrity Unit Manager Responsibility
1. Ensure training for new QI staff occurs.
2. Ensures QI staff demonstrate a working knowledge of this policy.
3. Request training or clarification from leadership as needed.

Adult Protective Services Responsibility
1. Forward the exit conference meeting information to staff within the region or unit and encourage attendance.

2. Review provided reports to understand information presented.

K. PROFICIENCY IMPROVEMENT PLAN (PIP)

Background
Expected Proficiencies:
The expected proficiencies for each QA question take into consideration the minimum required proficiency levels for the Centers for Medicaid and Medicare Services (CMS) waivers, any areas outlined on the ALTSA strategic plan, and the required proficiencies required by external auditors. Some questions require a higher proficiency level because of expectations by CMS, an external auditor, or executive leadership. The APS Director makes the final determination as to APS expected proficiencies.

Proficiency Improvement Plans:
A Proficiency Improvement Plan (PIP) outlines a plan for addressing QA questions that did not meet the required proficiency.
The action required for PIP development is based on the findings of the process review once all change requests are considered and the final proficiency results are distributed.

Action is required for PIP development. A PIP is not required for the current QA Unit review cycle:

a. When required proficiency of 86% is reached on all QA questions.
b. When the APS Director has requested APS staff and the PIPA unit to develop a PIP on a QA question that does not meet required or expected proficiency at a statewide level.

Procedure
1. PIP development and completion is the responsibility of the QIC in partnership with APS staff.
    a. The QA Unit is not involved in PIP development activities and does not direct the work that needs to be accomplished to complete the PIP.
    b. The use of Lean and Continuous Improvement tools is encouraged. Information and tools for ALTSA's Lean program can be found here.
    c. Any units or staff assigned a task on the PIP must be notified of the assignment before the PIP is signed by the APS Deputy Director.
2. The completed PIP must be submitted to the APS Deputy Director for final approval within 30 WD after the regional final report. This due date is included on the published QA Schedule.
3. A copy of the approved PIP must be saved to QIC Central in both PDF and Word formats (Word is used as a working document) once it is signed by the APS Deputy Director.
4. PIP Monitoring:
    a. The QI Lead will send the final signed PIP to any staff assigned a task.
        i. The QI Lead tracks due dates on the final approved PIP to monitor for completion.
        ii. The QI Lead will notify the Program Integrity Unit Manager if there are any potential barriers to completing interventions within the defined timelines.
        iii. The QI Lead provides written monitoring updates to leadership staff on a quarterly basis.
    b. QI Unit Manager provides APS leadership with status reports as requested.
    c. If PIP interventions or due dates change, the QI Lead will update the working version.

d. There should only be one working PIP at any given time for a process review. If the previous PIP is not yet completed by the next process review, the PIP should be closed with notation that interventions can be found on current PIP.
e. QI will make every attempt to utilize the same Sample Methodology process when completing monitoring checks to determine if PIP interventions are working.

QA Unit Manager Responsibility
1. Train new staff and ensure they can demonstrate they understand this procedure.
2. Request training or clarification from leadership as needed.

Program Integrity Unit Manager Responsibility
1. Ensure training for new QI staff occurs.
2. Ensures QI staff demonstrate a working knowledge of this policy.
3. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
4. Request training or clarification from leadership as needed.

Adult Protective Services Responsibility
1. Ensure robust participation in the data gathering and root cause analysis process by regional leadership, supervisors, and workers.
2. Encourage curiosity in examining systems.
3. Actively demonstrate shifting attitudes from blame to accountability and encouraging examination of process within and outside of the individual's control.
4. Allow space within monthly regional leadership meetings to discuss root cause analysis process, interventions, and data from monitoring of the interventions.
5. Regional leadership/Central Intake Unit Manager approves and signs the written PIP before forwarding to APS Deputy Director.
6. Implement identified interventions.
7. Ensure information on the process, interventions, and monitoring are made available to APS staff by way of newsletters, staff meetings, and other appropriate communications.

L. RECORD RETENTION

Background
Records are retained for historical information, data, and public disclosure purposes. For APS records retention information, please visit Policy Tech.
This section will provide an overview of how the QA Unit retains records of process reviews completed.

Procedure
1. QA Reviews are performed in the QA Monitor application or in Microsoft Forms.
2. If desired, QA unit members may use paper checklists or electronic checklists while completing the process review to ensure all process review questions are answered and input into the QA Monitor Tool correctly.
3. Once the review is completed, the review must be entered into the QA Monitoring Tool or Microsoft Forms Review as soon as possible. All information pertinent to the findings must be included in the

analysis comments in the QA Monitoring Tool or Microsoft Forms Review.
4. QA unit members may retain paper or electronic checklists only until the 30-day reviews are completed and the full review process is closed.
5. All paper documents related to the QA process review must be shredded in confidential shredding to avoid the release of any alleged victim names or other protected information.
6. All electronic documents created on OneNote, on the computer's desktop, or using any other programs created by the QA Consultant will be deleted once the 30-day reviews are completed. The QA Monitor Tool is the final and complete record for all QA reviews.
7. Records will be retained in the QA Monitor tool for six (6) years, after which, the records will be purged, unless there is a reason for which the record must be retained.
    a. The QA Unit Manager will send a notification annually to Central Files prior to the scheduled record purge to determine which records may not be purged from the system and the reason the record may not be purged.
8. Reviews created utilizing Microsoft Forms will be downloaded to Excel and saved in the shared Q drive for six (6) years, after which, the records will be purged, unless there is a reason for which the record must be retained.

QA Unit Manager Responsibility

1. Request training or clarification from leadership as needed.

M. FINAL REPORTS

Background
The QA Lead creates a report for each region or central intake following the completion of their review cycle.

The QA Unit Manager develops an Annual Statewide Final Report to publish results of the cumulative QA process review cycle for APS. This report outlines the results for each review type on a statewide basis and compares any historical data for the reader's analysis.

The Program Integrity Unit Manager develops an Annual Report to publish information about the status and effectiveness of all Quality Improvement interventions implemented in response to QA Process Reviews.

Procedure

THE QA LEAD WILL:
1. Create the report based on the final proficiencies for Central Intake or the region.
2. Provide the report to the QA Unit Manager two (2) WD prior to the due date for approval and signature.
3. Send the signed report to Central Intake Unit Manager or regional leadership, and APS leadership on the due date.

THE QA UNIT MANAGER WILL:

1. Review the Central Intake and Regional Final Reports for accuracy.
2. Once the Central Intake and Regional Final Report is completed and verified to be accurate, signs the report.
3. Create and post the statewide final report annually and seeks clarification and information from programs as needed to clarify results or explain circumstances that may be needed to properly analyze the data.
4. Publish the statewide final report in an MB and on the QA SharePoint site once the report is complete.

THE PROGRAM INTEGRITY UNIT MANAGER WILL:
1. Create and post the report annually to demonstrate the effectiveness of PIP interventions on overall proficiencies.
2. Post the report on the QI SharePoint site.

QA Unit Manager Responsibility
1. Creates and distributes any required final reports.
2. Requests training or clarification from leadership as needed.

ALTSA QA Senior Administrator Responsibility
1. Review and approve the statewide final report prior to presentation to APS Leadership for review, approval, and distribution.

The Program Integrity Unit Manager will:
1. Create and post the report annually to demonstrate the effectiveness of PIP interventions on overall proficiencies.
    a. Program Integrity Unit Manager will send draft information to the process review QI Lead to verify information, including data and status of interventions.
2. Post the report on the SharePoint site.

Adult Protective Services Leadership will:
1. Read the QA and QI final reports.
2. Ensure information from the QA and QI reports regarding process, interventions, and monitoring are made available to APS staff by way of newsletters, staff meetings, and other appropriate communications.

PART II: QUALITY CHECKS

The QA checks completed by Quality Improvement Coordinators (QIC) are very important because they ensure staff are protecting our vulnerable adults by following policy, procedure, and conducting thorough investigations. QIC QA reviews help identify training and policy concerns. The QIC reviews QA questions ensuring the health and welfare of the alleged victim. As a result, the QIC role is a critical part of the foundation for overall APS quality compliance and consistency.

a. Reviews are completed by QICs or their designee.
b. QA reviews and PIP checks are performed for new and experienced staff according to the direction of APS leadership.

c. All reviews are completed within the QA Monitor Tool, in Microsoft Forms, or tracked in Excel.
d. All remediation activities must be completed, and the review cycle closed within 30 working days of initial review.
e. Review data will be saved and reviewed from year to year for quality improvement purposes. Review activities are performed throughout the entire calendar year.

PART III: INTERRATER RELIABILITY

Purpose: To ensure consistency within the APS QA review process.

Prior to beginning the review cycle,
• The QA/QI team will complete three reviews together in training QA Monitor discussing each question and identifying what to look for.
• After that process, three intakes/investigations of each type (screen in, screen out, investigation, closed No APS) will be selected for independent practice review. Each reviewer will independently complete 3 reviews in training QA monitor. The other reviewer(s) and the QA Unit Manager will review those answers (Yes, No, or N/A) and any no responses given and compare for accuracy using the check spreadsheet. Any comments will also be reviewed to ensure accuracy and helpfulness. The group will return back together to discuss each review and the individual findings.
• Any discrepancies will be reviewed and verified within the How to Review guide.

During the compliance review cycle
• The QA unit manager will review 10% of each reviewer's cases for accuracy. Reviews will be completed on the check spreadsheet and shared with each reviewer.
• Each reviewer will select 2-3 reviews per week for peer review. Reviews will be completed on the check spreadsheet and shared with each reviewer.
• Any peer review will be completed with feedback provided at least 3 days before the end of the review cycle to ensure any necessary changes are made before providing QA data to central intake or the region.

Throughout the cycle, the reviewers are in communication with each other when questions arise on how to review situations which are not outlined in the How to Review guide or the training videos. If not in agreement, a discussion is held with the QA Unit Manager who will review the situation and applicable policy in addition to prior guidance. For questions if policy was followed that cannot be identified through review of Policy Tech guidance or previous decisions from executive leadership, the Senior Policy Advisor will be consulted for the final decision.

Check spreadsheets will be maintained in the APS QA Q: drive.

During the reviewer's probationary period,
- Complete the QA review training videos.
- Shadow a minimum of two other reviewers for 5 reviews each.
- The trainee reviewer will look at 10 historical reviews, comparing the historical reviewer's

answers and comments to information found in TIVA2 and the How to Review guide. The trainee reviewer will outline thoughts and questions to review with the QA Unit Manager.
• The trainee reviewer will complete 10 reviews in training QA monitor with review by the QA Unit Manager.
• This process will be completed before beginning QA reviews in production QA Monitor.

PART IV: APPENDICES

A. GLOSSARY OF TERMS

Agency – State agency
Change Request Committee – means QA and QI do not have sufficient information to determine if a change request should be upheld or overturned and determines APS leadership needs to make the final determination.
Department – This term refers to the Washington state Department of Social and Health Services (DSHS).
Designated Staff – Refers to the regional or Central Intake point of contact for QA/QA process.
Finding – A term used to describe an identified gap between policy guidance and what was found during a QA process review.
Overturn – means QA agrees with the information provided within a change request and overturns the process review finding.
Population –The entire population subject to review.
Unit Leadership – means the individuals responsible for the activities of a designated unit. This can include Unit Managers, Program Managers, and Regional Administrators.
Uphold – means QA and QI agree that the information provided in the submitted change request does not support overturning the finding, and the finding will remain in place.
Working days (business days) – defined as Monday through Friday, excluding federal and state holidays.

B. ACRONYM LIST

ALTSA Aging and Long-Term Support Administration
CMS Center for Medicare and Medicaid Services
CRC Change Request Committee
DRA Deputy Regional Administrator
DS Designated Staff
DSHS Department of Social and Health Services
MA Management Analyst
MB Management Bulletin
MSD Management Service Division
OAS Office of the Assistant Secretary
PIP Proficiency Improvement Plan
PM Program Manager
QA Quality Assurance

QI Quality Improvement
QIC Quality Improvement Coordinator
QMS Quality Management System
RA Regional Administrator
RCN Review Cycle Note
RCW Revised Code of Washington
SHPC Social and Health Program Consultants
SME Subject Matter Expert
SPA State Plan Amendments
TIVA Tracking Incidents for Vulnerable Adults
WAC Washington Administrative Code
WD Working Day

C. SAMPLE QA PROCESS REVIEW RESULT EMAIL TEMPLATE

Region X APS HQ QA Process Review has been completed and the following reports are attached to this email:

- The QA Review Data workbook includes the 2307 Proficiency with Details report, the data broken down by supervisor, case manager, a heatmap by offices and the 2303 Questions Requiring Action Report broken down by supervisor.
- The Findings and Analysis workbook provides a Data Analysis report with the questions, findings and analysis comments for each review that received a finding, the 2310 Analysis Comment Report, the 2303 Questions Requiring Action Report.

Also attached is the Remediation and Change Request Process guide, 2023 Remediations for APS Investigation guide and the Region X tracker.

What's Next?:

- Region X's 30-day remediation timeline is XXXX –XXXXX. Change Requests will need to be submitted by close of business on XXXXX (via QA Monitor).
- Most remediation items will be considered "Historical Data," which require no physical action; please encourage supervisors to facilitate learning opportunities with their staff regarding these items. Remediation completed by region must be documented in a Review Cycle Note (RCN) when an action is completed to remediate findings. Using the "Action Taken" drop down, the Review Cycle Note (RCN) must include information about how the finding(s) was remediated.

D. RESOURCES AND FORMS

Background
The QA Unit has transitioned to using a QA SharePoint as the primary means of communication with APS staff, Policy, Training, and anyone at APS interested in QA activities.
Members of the QA Unit have access to the QA Unit's internal SharePoint site. This site is only accessible to the QA Unit and other leadership staff as required. The site provides the tools, templates, and information needed to complete process reviews.

Procedure
Process Review Areas and Programs
1. Investigation
a. QA reviews the following areas:
i. Timeliness
ii. Documentation
iii. AV Interview
iv. AP Interview
v. Collaterals
vi. Decision Making Ability Screening
vii. Law Enforcement Referrals
viii. Outcome Reports
ix. Vulnerable Adult Status
x. Allegations
xi. Finding
xii. Protective Services
xiii. Supervisor Actions

2. Closed No APS
a. QA reviews the following areas:
i. Finding
ii. Law Enforcement Referrals
iii. Outcome Reports

3. Intake Screen In
a. QA reviews the following areas:
i. Timeliness
ii. VA Status
iii. Safety
iv. Referrals
v. Screen In accuracy
vi. Allegations
vii. Intake Priority

4. Intake Screen Out
a. QA reviews the following areas:
i. Timeliness
ii. VA Status iii. Referrals iv. Screen out reason

5. 90-Day Reason Code
a. QA reviews the following areas:
i. Reason code documentation

6. Safety and Risk Screening (Biennial)

a. QA reviews the following areas:
i. Screening evidence
ii. Staffing
iii. Timeliness

7. Documentation Timeliness (Biennial)
a. QA reviews the following areas:
i. Case notes
ii. File Uploads

Additional Information
a. Only closed investigations or completed intakes will be reviewed.
b. Additional reviews may be conducted as requested by executive leadership. Reviews are subject to change by leadership and a schedule is posted each year to clarify which reviews will occur that year and when during that year those reviews will occur.

QA Unit Manager Responsibility
1. Train new staff and ensure they can demonstrate they understand this procedure.
2. Conducts supervisory reviews of QA staff work to ensure policies and procedures are followed.
3. Request training or clarification from leadership as needed.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #

Nursing Services and Triggered Nursing Referrals

Chapter 24 describes the process for identifying and referring clients who may benefit from Nursing Services (NS) for all HCS and AAA clients. Not all will apply for DDA clients please reference DDA policies. This section also outlines what Nursing Services staff are responsible for: responding to referrals, performing nursing service activities (e.g., file review), and documenting their recommendations and activities.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Susan Worthington Nursing Services Program Manager
360.725.2638 susan.worthington@dshs.wa.gov
nursingservices@dshs.wa.gov

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BACKGROUND

What are Nursing Services?

Nursing Services are nurse consultants who offer clients, who are eligible for Medicaid Long Term Services and Supports, providers, and case managers, health-related assessments, and consultation to enhance the development and implementation of the client's plan of care. The protocols described in this chapter are critical to the health and safety of clients.

HCS Nurse Care Consultants (NCC), Area Agency on Aging (AAA) Case Managers, and RN Case Managers work closely to develop and implement an appropriate plan of care to address all triggered nursing referrals, most importantly skin integrity and to prevent pressure injuries from occurring. The National Pressure Injury Advisory Panel (2022) defines a pressure injury as:

"Localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device."

The injury can present as intact skin, skin redness or an open ulcer and may be painful. The injury occurs because of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities, and condition of the soft tissue.

*Licensed Practical Nurses (LPN) – AAAs can employ LPN(s) as nurse consultants to accomplish focused assessments for Skin Observation Protocol and other CARE triggered referrals for the purpose of data collection. This information will be brought back to the Registered Nurse for care planning.
For more information on LPN scope of practice: WA State Department of Health – Board of Nursing Advisory Opinion on the Registered Nurse and Licensed Practical Nurse Scope of Practice, #NCQA 3.02: https://nursing.wa.gov/sites/default/files/2022-07/NCAO13.pdf

**Nurse Consultants (NC) are only in the home to provide consultation and the nursing assessments listed above. If there is an emergency in the home the NC will provide guidance and skills within the nurse practice act (such as, CPR/first aid, etc.) until the emergency responders arrive.

Other Chapters for Nursing Services that are Available to ALTSA Clients

Skilled Nursing: COPES Waiver Skill Nursing - Chapter 7D
Nurse Delegation: Chapter 13
Private Duty Nursing: Chapter 25
Adult Day Health: Chapter 12

Nursing Services Responsibilities

A NC performs the following activities in relation to skin integrity.
Comprehensive Assessment Reporting Evaluation (CARE) review.

For CN contractors, the case manager will send form 13-776 with all necessary data elements., CARE assessment details, service summary, ROI.
Nursing assessment/reassessment (per the Skin Observation Protocol).
1:1 education and instruction for care providers and clients.
Care and health resource coordination; and/or
Evaluating health-related care needs service planning and delivery.

IDENTIFYING CLIENTS FOR NURSING SERVICES

Eligibility

Per RCW 74.09.520 (2) (b) and (c):

The rules shall require clients be assessed as having a medical condition requiring assistance with personal care tasks. Plans of care for clients requiring health-related consultation for assessment and service planning may be reviewed by a nurse.

The department shall determine by rule which clients have a health-related assessment or service planning need requiring registered nurse consultation or review. This definition may include clients that meet indicators or protocols for review, consultation, or visit. Nursing services are available to all Title XIX clients who are eligible for MPC, CFC, CFC-COPES, RCL, RSW or NEW FREEDOM.

For MPC - WAC 388-106-0200 (3)
For COPES - WAC 388-106-0300; WAC 388-106-0305

TRIGGERED REFERRAL CRITERIA

Health-related care needs that are not identified as a critical indicator or triggered referral can still be referred to Nursing Services. If a referral is not triggered in CARE, the case manager can use their professional judgement to make a referral to a nurse if the circumstances warrant. Discuss with your supervisor and follow office policy, then document in CARE all pertinent information.

The following are considered critical indicators for Nursing Services referral criteria. **One or more** of these criteria may indicate the need for a Nursing Services referral.

1.	**The presence of any one or combination of diagnoses that are unstable or changing.**
or	a) Diagnosis of insulin dependent diabetes ***and*** one or more of the following: ≥ 3 ER visits in the last six months-Consider if data self-reported or actual Recurrent infections

		Non-healing/deteriorating lesions Open lesions (foot screen) Vision impaired and the client is administering the injection(s) The client does not adhere to the prescribed nutritional eating plan. BMI < 19 or > 30 Presence of diagnosis of depression Presence of diagnosis of cellulitis Infection (cellulitis, drainage, or infection in foot)
or	b)	Diagnosis of quadriplegia ***and*** <u>one or more</u> of the following: UTI Current pressure injury Recurrent infection CPS (Cognitive Performance Score) score > 3 Overall self-sufficiency has declined in the past 90 days Treatment includes a ventilator or tracheotomy Incontinence Fecal Impaction
or	c)	In the last six months: ≥ 2 hospitalizations *or* ≥ 2 emergency room visits
or	d)	An indication on the assessment that the client has: "Pain daily" *or* A pain scale rating > 4 (5 to 10) ***and*** pain impact is "limiting activity" ***and*** pain treatment is ineffective
or	e)	Treatment needs that include <u>one or more</u> of the following, with the listed indicators: Tracheotomy/suctioning Indwelling catheter care Injections Wound/skin care Passive ROM Tube feedings ***and*** the client has: A UTI; or Recurrent infections; or ≥ 3 hospitalizations OR ≥ 3 ER visits in the last six months; Consider if data self-reported or actual: or A provider type that is not: 1) Nurse Delegator 2) Home health agency 3) Hospice 4) Facility staff 5) Waiver skilled nursing
2.	**The presence of a medication regimen that affects client assessment, service planning and delivery:**	
	a)	A medication level that is "must be administered to person" ***and*** the client.

		Is choking or gagging on medications or Is not taking medications as prescribed
or	b)	The client is declining assistance with medications ***and*** Is not taking medications as prescribed ***and*** In the last six months: ≥ 2 ER visits *or* ≥ 2 hospitalizations
or	c)	The client's medication regimen is complex ***and*** Has multiple prescribers ***and*** In the last six months: ≥ 2 ER visits or ≥ 2 hospitalizations or Is not taking medications as prescribed
or	d)	The client lives alone ***and*** Needs assistance with medications and the need is unmet ***and*** Frequency is daily ***and*** Classification Category is A Low or B Low
3.	**Nutritional status or weight concerns affecting service planning and delivery as evidenced by the client having (triggers could include oral problems/hygiene and dental problems):**	
	a)	Weight loss or gain, ***and*** a BMI of < 18.5 or > 30, ***and*** <u>one or more</u> of the following: Chewing problem Current swallowing problem Non-compliant with prescribed or advised eating plan. Poor appetite An appetite change
or	b)	A current swallowing problem ***and*** a BMI of < 18.5 or > 30 ***and*** the client is: On a mechanically altered diet *or* Using a dietary supplement
or	c)	Nutritional approaches that include: Enteral or Parenteral ***and*** the provider type is one of the following: CDWA (IP) Home care agency worker Informal support Client ***and*** there is no (one or more): 1) Nurse Delegation 2) Home health 3) Self-directed care 4) Waiver skilled nursing
or	d)	A client age 2-20 with a BMI of underweight (BMI for age 5th percentile) or overweight (BMI for age > 95th percentile).
4.	**The client is bedbound or has care needs related to immobility that affects assessment, service planning, and delivery. This may be triggered by:**	

	a)	The client is assessed as needing but not receiving: ROM passive, ROM active, splint or brace assistance, transfer, or walking; ***and*** The client's overall self-sufficiency has declined in the last 90 days: or The provider code is either: Client or family/informal supports CDWA (IP) Self-directed care
or	b	The client is assessed as bladder *or* bowel incontinent most or all the time ***and***: Uses incontinent supplies and has leakage; or Does not use incontinent supplies but has occasional incontinence, the client is assessed as having one or more of the following: Diarrhea A UTI History of recurrent urinary tract infections Constipation Fecal impaction
or	c)	The client ADL self-performance code in column A is 3 or 4 for one or more of the following ADLs: Bed mobility Transfer Walk in room, hallway, and rest of immediate living environment. Locomotion in room and immediate living environment ***and*** the client is assessed as having a fall in the last 6 months (marked in CARE as past 30 days or days 31-180)
5.	**Skin breakdown or history of skin breakdown. This may be triggered by:**	
	a)	An indication in CARE that the client has one or more of the following skin problems NOT related to pressure ***and*** the status is non-healing or is deteriorating: Abrasions, skin tears, or cuts Burns Open lesions Rashes Skin fold / perineal rash Surgical wounds Stasis ulcers ***and*** on the Treatment Screen one or more of the following is not there: Application of dressing Application of medication Wound/skin care Client needs treatment but does not receive it
Or	b)	Foot problems including:

	Fungus Infection Open lesions Ingrown toenail ***and*** the problem is non-healing or deteriorating ***and*** on the Treatment Screen one or more of the following is not there: Application of dressing Application of medication Wound/skin care Client needs treatment but does not receive it
6.	**CARE Assessment identifies the need for the Skin Observation Protocol (SOP) and the creation of a pressure injury prevention plan. Pressure injuries are also called bed sores, decubitus ulcers, pressure sores, and pressure ulcers. The SOP:**
	a) Is a pressure injury prevention plan that case managers and RN case managers will follow to prevent a pressure injury or the progression of a pressure injury.
	b) Specifies the responsibilities of case managers/social workers ***and*** nursing service respondents when a client meets the highest risk indicators identified in CARE.
	c) The SOP may be triggered by <u>one or more</u> of the following: Current pressure injury Quadriplegia Paraplegia Total dependence in bed mobility Comatose or persistent vegetative state History of pressure injury within 1 year Bed- and/or chairfast ***and*** cognition problems Bed- and/or chairfast ***and*** incontinent of bladder or bowel most or all the time Bed- and/or chairfast ***and*** insulin dependent diabetes mellitus (IDDM) Hemiplegia ***and*** cognition problems ***and*** bladder or bowel incontinence

Nursing Services may be used to provide health-related expertise regarding skin care/skin integrity in coordination with home health staff during transition or discharge from a home health agency, or other health care provider.

- Nursing Service activity would occur in collaboration with the case manager to ensure home and community-based service planning and delivery is meeting the functional and cognitive care needs of the client; and
- This service would primarily be a *consultative role* in reviewing the service plan for adequacy in relation to the health care needs of the client and interpretation of health-related, client-specific service needs.

Clients who meet the triggered referral criteria do not need to be referred for nursing services when their needs are being met by another resource or health care professional. Proper documentation of all the factors is important.

Note: Other resources may be available for AAA non-core clients. The referral criteria is the **minimum** set of criteria, as shown in the *Nursing Referral Indicators* screen of CARE, that you should use when considering a client for nursing services.

Examples include:

- Health-related assessment of the client being performed by home health or hospice agency staff.
- Client assessment and instruction to caregivers through Nurse Delegation.
- Clients receiving Private Duty Nursing and receiving nursing consultation from HCS or DDA Nursing Care Consultants.
- Clients residing in an Enhanced Adult Residential Care Center (EARC) or Assisted Living (AL) required to provide limited nursing services (WAC 388-78A-2310);
- Active and recent involvement of the client's primary care physician in the health-related assessment and service planning needs of the client.

TRANSFERRING & MAKING REFERRALS

Who Should I Refer the Case to?

** For HCS clients who were assessed in hospitals and skilled nursing facilities*

New HCS *in-home or residential*	**New and ongoing DDA** *in-home or residential*	**Ongoing AAA** *in-home*
HCS NCC (unless alternative local agreements allow you to refer it to the AAA)	Nursing Services resources. These include an AAA or a contracted agency or individual RN provider (DDA Policy 9.13)	AAA Rn or LPN Case Manager or contractors

Transferring Clients

Note that for both HCS and DDA, local agreements with AAAs may require additional referral forms or communication. Common activities across both HCS and DDA are:

- Nursing Referral Indicators in CARE are addressed.
- Skin Observation Protocol (SOP)*

HCS to the AAA

1. HCS staff must utilize HCS nursing resources first, before transferring the case (unless otherwise agreed to by the AAA)

2. Complete the Case Transfer Form in Barcode when:
   - Referring the case to the AAA for nursing services (per local agreement)
   - Transferring a case from one office to another (and nursing services have already been provided)
3. As applicable, check the following boxes on the electronic Case Transfer form (if necessary, include additional information in the Comments space):
   - Nursing services
   - In-home nursing services review by AAA needed (NOTE: The AAA may assign referred cases to a case manager with a request for nursing consultation or to an AAA RN/case manager)
   - Nurse Delegation
4. Local agreements may require additional referral forms or communication.

DDA Clients

Please refer to DDA Policy 9.13 for additional information on providing Nursing Services, including SOP. Use the DDA Nursing Services Referral Form (DSHS Form 13-911) to check:

- The type of Nursing Service activity(s) requested.
- The Nursing Referral or SOP reason(s) for referral; and
- Any special instructions or comments for the nurse.

The DDA Nursing Services Referral form can be faxed or emailed to the local NS resources, according to regional field office procedures and HIPAA compliance requirements (particularly when sent via email).

Nurse Delegation—For HCS SOP Triggered Referrals

In the situation where the Nurse Care Consultant (NCC) or RN Case Manager is **unavailable**, authorized staff may refer the Nursing Trigger – Skin Observation Protocol, to **any** available Nurse Delegator, who will address ***all*** other nursing triggers at the same time. The timeframes for Nurse Triggered referrals can be found in this document under "Responding to all referrals" (p.10 & 11). All RNDs are expected follow these timeframes.

The case manager will send out the HCS/AAA Nursing Services Form: HCS/AAA Nursing Services Referral Form (#13-776)

Note:
Ensure that you receive the following forms back in the specified timeframe.

- Basic Skin Assessment (13-780)
- Pressure Injury Assessment and Documentation (13-783) – (Form only needs to be filled out and filed when there is an actual pressure injury is confirmed)

* Please refer to DDA Policy 9.13 for RND referral for SOP

Communication

Contacts

When the protocol requires communication, verification, and exchange of information with non-professional caregiver(s), the HCS/AAA social worker/nurse or case manager will contact:

- Caregiver is employed by an agency — The home care agency supervisor or contact person
- Caregiver is an Individual Provider — CDWA (IP)

Timeframes

Service referral timeframes are maximums and are intended to ensure client referrals are sent in a timely manner. Timeframes may not be medically appropriate in every situation and may need to be shortened. The Nurse professional is responsible for evaluating each client on a case-by-case basis and determining whether shortened timeframes are necessary to meet a client's care or medical needs and implementing shortened timeframes as necessary.

Ineligible Clients

Clients assessed for services using CARE who are determined ineligible or declining may still trigger the Skin Observation Protocol. You must consult with your supervisor to determine the required response based on the client's caregiving and health care support related to their skin care needs and highest risk indicators.

RESPONDING TO ALL REFERRALS

Timeframes

- ***Business Week Monday-Friday; Excludes Holidays and Weekends.***
- ***Time Clock starts next business day. Example: Assessment Done Friday 5/1 (2 business days clock starts) Monday 5/4.***
- ***All staff has the responsibility to make sure to manage the coverage to stay within timeline.***

Other Triggers Nursing Referrals (excluding SOP)

2 business days	CM is required to make referral.
2 business days	Nurse is required to confirm receipt of the referral.
10 business days	Nurse will review and use nursing judgment if phone contact and/or visit to client is necessary and will document all actions. ** **If the nurse is unable to make timeline, document all efforts and barriers, inform supervisor, case manager and review and make contact (if required), as soon as possible.**

15 business days Complete all documentation.

29 working days **Total**

Triggered Nursing Referrals SOP

2 business days CM is required to make referral.
2 business days Nurse is required to confirm receipt of the referral.
5 business days Nurse will review file and if SOP referral is required, they must reach out to client, family member(s), or POA/Guardian and make phone contact. **** **If the nurse is unable to make contact within the timeline, document all efforts and barriers, inform supervisor, case manager, and make contact as soon as possible.**

20 working days Make visit if necessary and complete documentation.

29 working days **Total**

****Some referrals may require quicker responses. Based on the information you receive and the type of referral, you will provide services in a timely manner consistent with the client's need for care, safety, and best practice.**

HCS/AAA clients Use the table below for clients in the community (in-home or residential)
DDA clients Use DDA Policy 9.13

SITUATION	RESPONSE TIMES*
IS in jeopardy of imminent harm or placement in a hospital or nursing home.	May consult with Nursing Services for *immediate* triage. Refer the client to the most appropriate level of health care services (e.g., emergency room or physician). Nursing Services is not designed to be an emergent or urgent home visit responder.
IS NOT in jeopardy of imminent harm or placement in the hospital or nursing facility.	Confirm receipt of referral within two working days Identify and verify the need for nursing services. Initiate activities in a timely way according to the needs of the client.

Exceptions

Exceptions to the requested or planned Nursing Services activity timeframes may occur only when:

- The client is not in jeopardy of imminent harm or placement in the hospital or a skilled nursing facility.
- The referral source requests a shorter or longer activity time with justification.
- The client requests a shorter or longer activity time; or

- The client is not available for consultation or visit.

If the requested/planned activity time is not met, document the reason for the delay(s) in the Service Episode Record (SER). If the referral was made to a nurse without access to CARE and they report a delay, document that information in the SER. This note should document the plan for follow-up on the identified care need.

PERFORMING NURSING SERVICES ACTIVITIES

Once the nursing services staff (you) receive a referral, you may perform:

- A review of the CARE assessment
- Consultations (office, telephone or electronic)
- Visits (observation)
- Assessment

Collaborate with the client's case manager to determine the frequency and the scope of all nursing service activities, which are based on individual client need.

CARE Assessment Reviews

Review the CARE assessment and the Service Summary report including any pertinent Service Episode Record entries. The purpose of this review is to identify health-related:

- Problems that are not addressed by service interventions.
- Client and/or caregiver teaching needs.
- Care and resource coordination needs not addressed by the Assessment Details. Examples include:
  - Consultation with the physician, home health provider, and/or pharmacy.
  - Education regarding available community resources.
  - Phone consultation when the condition of the client changes; or
  - Consultation with the case manager regarding a referral to COPES or DDA Skilled Nursing, or Adult Day Health for an unmet, intermittent, skilled nursing or rehabilitative care need.

If the CARE assessment was developed by a nurse or the assigned case manager is a registered nurse, additional review is not necessary.

Consultations, Assessments, and Visits

Based on the CARE assessment review, you may need to perform any of the following consultation activities:

Nursing assessment/reassessment done in person, if unable to do in person, complete documentation of reason(s) why visit not done.

Instruction to care providers and client given in person. If unable, complete documentation on reason(s) why not given in person and what alternative method was used.

Care coordination.

Evaluation of health-related care needs.

The nurse will may need to assist the client with transfer or turning during the skin assessment to assess all areas of skin and will also provide teaching and/or instruction to a client or caregiver based on the referral indicator, pertinent physical problem(s), or a service planning need.

The standards of nursing conduct or practice in WAC 246-840-700(2)(a)(i)(A) define the nursing process as a systematic, problem-solving approach to nursing care, which has the goal of facilitating an optimal level of functioning and health for the client. This consists of a series of phases including assessment and analysis.

The registered nurse initiates data collection and analysis that includes pertinent objective and subjective data regarding the health status of the clients.

Dependent on the situation, nursing assessment can be an essential method to gather relevant information.

Coordinate with the client's case manager if changes are needed in CARE or regarding any referrals to ensure that immediate and ongoing needs are met.

These lists are based on client circumstances and need; they are not all-inclusive but *may* include the following activities for each.

Assessment or Instruction

- Perform a nursing assessment as needed, including vital signs, etc.
- Skin observation protocol
- Assessment of client positioning and mobility related to care needs.

Nursing Assessment/Reassessment

Review of medical/surgical history and pertinent treatments

Review of physical systems related to the functional or cognitive level of the client.

Psycho-social, emotional, cognitive assessment as pertinent to potential problems and referral critical indicators

Medication review-Based on the limited information available-Further data gathering may be needed by the nurse for specific questions.

Identification of client problems and caregiver teaching needs not currently addressed by the plan of care.

Client teaching

Follow CARE assessment and documentation guidelines (see LTC Manual Chapter 3 Assessment and Care Planning) for making or recommending changes in CARE. Contractors without access to CARE (such as Nurse Delegators, Private Duty Nurses, Skilled Nurses, etc.) will make recommended changes on Department-approved forms to be submitted to the case manager for review and revision to CARE as needed.

Educating Providers and Clients

You may also want to provide:

Disease process(es) or symptoms and how to effectively manage them related to the client's functional and cognitive ability, impacting the service plan or care delivery (i.e., incontinence, effects of immobility).

The purpose, interactions, and side effects of medications.

Behavioral interventions or alternatives to psychoactive medications or the use of physical or chemical restraints- this may require consulting with the client's primary care provider (PCP).

Safety and universal precautions.

Health promotion and disease prevention standards of care to promote client wellness and ability.

Care and Resource Coordination

- Consult and coordinate with all pertinent members of a client's health care team and facilitate health-related referrals.
- Provide education regarding available community resources and programs related to the health care needs of the client.
- Offer phone consultation or client reassessment related to a health care need.

Evaluating Health-Related Functional/Cognitive Needs or Interventions

If there are health-related needs affecting service planning and delivery, you may need to:

Observe, monitor, and reassess the client based on the referral critical indicator or other health-related needs identified.

Evaluate the client's caregiver training need when deficits are identified in skills required to meet the client's functional and cognitive service plan.

Enhance the plan of care, defining the services provided to the client through formal and informal supports based on assessment information, and with approval of the case manager.

Identify need for additional nursing services activities.

Prohibited Activities

You are not allowed to perform or to provide *skilled treatment* except in the event of an emergency (e.g., CPR or first aid). *Skilled treatment* is care that would require authorization and/or prescription and supervision by an authorized practitioner prior to a nurse providing it (e.g., medication administration or wound care). Refer clients with these needs to home health agencies or other appropriate health care professionals.

Documenting Results of Nursing Services Activities

Document the results of your activities (file review, office/telephone consultations, and visits) in CARE and client files, including any communication or service coordination required. ** Note, it is required that all nurse referrals are reviewed when the nurse is doing a triggered referral.

Follow these guidelines (Chapter 3 LTC Manual) for documenting in CARE based on how the Nursing Referral Indicator is marked. If you do not have access to CARE, please use the approved Department-approved forms.

Yes	Observations, instructions, or recommendations to the Critical Indicators List in CARE, regardless of the findings.
No	Observations, instructions, or recommendations **if** findings inconsistent with the current CARE information *or* new findings not previously assessed. If there are no new findings for the indicator(s) marked "no" during the provision of the nursing activity, document "no new findings" for the Nursing Referral Indicator.
Blank	Consult with the SW/CM for clarification of client assessment and Nursing Service activity need.

Department Approved Forms

If a referral is sent outside the agency, department approved forms should be sent to the contracted nurse or Registered Nurse Delegator for the purpose of documenting Nursing Service(s) activities. Using DSHS approved forms allows for consistency in the information given and reported.

Nursing Services Basic Skin Assessment (13-780)
Pressure Injury Assessment and Documentation (13-783)

You are expected to safeguard client information per confidentiality policies established in the LTC Manual, state and federal rules (e.g., HIPAA), AAA, and contract requirements. All emails of forms and requests should be sent through secure email accompanied by a copy of the client's signed consent, DSHS 14-012.

HCS/AAA SKIN OBSERVATION PROTOCOL

The following protocol outlines what to do when the protocol is triggered. The triggered referral could mean that a nurse is going to review the file or contact the client or visit the client. Once there is a triggered referral for SOP, the assessor needs to determine if the client has a:

1. Pressure injury; *then*
2. Caregiver who is treating the pressure injury; *then*
3. Professional or family/informal caregiver.

After determining these factors and it is deemed necessary, a referral is sent to an AAA RN, HCS NCC, or the contracted entity for Nursing Services. When a referral is sent the *nurse* will write the necessary documentation and the home visit note if a visit occurred. If the referral is not sent, due to no current pressure injury per the protocol, documentation for the SOP visit will be done by the *assessor*.

There are five scenarios for SOP documentation, depending on the presence/absence of a pressure injury and who is providing care/treatment when one exists.

1. A non-professional is providing treatment. – Example: CDWA IP, Agency HCA, Family Member, Informal Caregiver/support
2. A professional is providing treatment. – Example: Physician, Wound Care Clinic, ARNP, PA-C, RN or LPN, HHA Nurse, PT
3. A non-professional with a prevention plan in place, the caregiver is checking all pressure points, ***and*** there is no reported skin problems.
4. A non-professional is providing care and the caregiver is not checking all the pressure points or it is not known if a skin problem exists.
5. No one (neither professional nor non-professional) is providing skin care that has been verified as meeting the client's needs (visit required)

For more information on patient education, visit the Nursing Services Website.

What are the Skin Observation Protocol Requirements?

The Skin Observation Protocol is a **mandatory** protocol that must be completed for each client who has triggered a highest risk indicator. The protocol must be responded to, and all protocol activities provided according to the client's skin integrity and caregiver status. An observation is when an in-person visit to assess the skin integrity is required.

The protocol directs the case manager and/or nurse to:

Determine whether an observation visit is required or not by a nursing resource.
What activities must be completed by the case manager and/or the nurse; and
The documentation requirements for case management and nursing staff.

If the skin protocol is triggered, certain steps will be indicated to determine whether a Skin Observation visit is:

Not Required
Required
Delayed

HCS/AAA SOP Visit Not Required

Use the Skin Observation Protocol for each of the following situations:

1.	A **non-professional** is providing skin care treatment for a client who has a pressure injury. The HCS/AAA case manager must make the referral to the nurse on the same day as the assessment. (**Special medical circumstance that requires a same day referral to nurse**) a) Review the treatment with the caregiver(s) and client and decide if visit is necessary; b) Document what is being done and who authorized treatment; c) Verify by asking the caregiver(s) that they are checking **all** pressure points; d) Distribute educational materials and prevention plans as appropriate related to pressure points to both the caregiver(s) and client (colored pictures with text); e) Revise the plan as needed; f) Document all activities in CARE; g) HCS/AAA social worker will follow-up on RN recommendations.
2	A **professional** is providing skin care treatment for a client who has a pressure injury. HCS/AAA case managers/nurses or other contracted nursing resources must: a) Obtain name and contact information of Health Care Professional (HCP) and verify with the HCP that: i. There is a treatment plan in place; ***and*** ii. The client's skin has been seen by the HCP responsible for treatment according to timeframes recommended in the treatment plan or within the last 7 days. b) Communicate with the HCP as soon as possible: i. Verify that all pressure points are being checked and discuss response to treatment. ii. Request to be notified when client is discharged from care for pressure injury. iii. Document all activities in CARE **Exception:** If you determine that the HCP does not have a treatment plan in place and/or has not been observing pressure points as part of the plan, a nurse **must** make an observation visit, assess the client, and revise CARE as necessary. **Note:** The activities in this section of the protocol also apply to clients being assessed for in-home or residential services while receiving care from professionals in a hospital or skilled nursing facility (SNF). The Skin Observation Protocol must be completed for clients who are in a hospital or SNF at the time of the CARE assessment triggering the protocol.
3.	A non-professional is providing skin care with a prevention plan in place, the caregiver is checking all the pressure points, and there is no reported skin problem. The HCS/AAA case manager/nurse or other contracted nursing resource must: a) Verify that: i. The caregiver(s), or the client with assistance as needed, is checking all the pressure points and all the pressure points have been checked within the last 7 days:

	ii.	The prevention plan is meeting the client's needs, and the client and caregiver(s) have been advised of skin care issues;
	b)	Document what is being done as a prevention plan and who is providing the prevention plan in CARE;
	c)	Use the color pictures included with the protocol as a resource to ask the client or the caregiver(s) regarding the presence of any pictured skin conditions or change;
	d)	Revise the care plan as needed; ***and***
	e)	Document all activities in CARE
	Exception: If you determine that the non-professional care being provided through the prevention plan is inadequate or is not meeting the needs of the client, a nurse must make an observation visit and revise CARE, as necessary.	
4.	A non-professional is providing skin care, the caregiver(s) is **not** checking all the pressure points, it is not known if there is a problem, the client is cognitively intact, ***and*** the client declines observation:	
	a)	Probe for reasons the client doesn't want skin observed.
	b)	Suggest appropriate alternatives (such as asking if the client has checked their pressure points themselves or if another support person is reliable, have they checked?).
	c)	Use the color pictures included with the protocol as a resource to ask the client or caregiver regarding the presence of any of the pictured skin conditions or changes.
	d)	Document in CARE ***and***:
	i.	Refer to the HCS/AAA nurse or other contracting nursing resources for follow up; or
	ii.	Contact the client's primary care provider as soon as possible, discuss skin concerns and document; or
	iii.	Advise the client of skin care issues, educate and document
	e)	Do not complete the skin observation.
	f)	Document in CARE, on the appropriate screen(s), that the client has declined skin observation and follow CARE assessment and service planning procedures.
	g)	Discuss with your supervisor.

SOP Visit Required

Observation is required when the client meets the highest risk indicators and ***no one*** (neither a professional nor a non-professional) is providing skin care that has been:

- Documented and verified as meeting the client's needs as above in the "Not Required" steps 1, 2, and 3; *or*
- **All** pressure points are *not* being observed.

1.	Refer the client to the HCS/AAA nurse or other contracting nursing resources to complete the observation.
2.	Arrange to have a third-party present if you know in advance that there is a likelihood that you will need to observe the client's skin, or as requested by the client. a) When possible, involve the client in determining who this third party should be. Parental, guardian, or client representative consent must be obtained for those individuals with designated decision makers.
3.	Complete the observation (visit). a) Explain to the client what is involved in the skin observation and obtain their permission. b) Tell the client where the pressure points are. c) Help, or have the caregiver(s) help, if the client needs to partially undress. Be sure that there is privacy for the client, and the client remains covered except for the area being observed. d) Look at the back of the head, ears, shoulder blades, elbows, inside of the knees, "sitting" bones, tailbone area, hips, sides of ankles, and both heels. e) Observe for specific conditions as directed in the CARE assessment using the "Skin Problem" screen and skin observation descriptions as a guide. Includes: i. Skin intact ii. Persistent redness iii. Abrasion iv. Boils v. Open lesion
4.	If **no skin problem** is observed, document and revise CARE to include prevention plan(s) as appropriate.
5.	If a **skin problem is observed**: a) Determine if there are any health professionals aware of or involved with treatment of the client's skin problem. b) Contact any health professionals involved with treatment of the client's skin problem. Or contact the family representative if no health professionals are involved, the client is refusing treatment, *or* the health professional is not treating the problem. c) Document in CARE all observations and activities provided in the Service Episode Record or progress note. For those who do not have CARE access, use 1 each of Form #13-783 for **each** pressure injury described. d) Revise/Update CARE e) The HCS/AAA case manager must follow up with any RN recommendations.

SOP Visit Delayed

Anticipate barriers as much as possible and plan prior to the visit to have a caregiver, assistant, or family member present to help the client.
Be sure to document all activities including conversations/discussions.
Skin observations can be delayed when any of the following exist:

1.	It is unsafe *(e.g., threatening animals, sexually inappropriate or threatening behavior);*
2.	It is unsanitary (due to soiling or unhygienic conditions) ***and*** no caregiver is present to assist;
3.	It is difficult to observe because of the client's physical condition (immobile, needs transfer or position assistance, or client is without consistent or permanent housing) ***and*** no caregiver is present to assist; *or* client is in pain;
4.	Impossible to observe because the client refuses to allow observation, has an unreliable provider, ***and*** will not let anyone else in, and/or refuses services related to skin integrity over pressure points. *For the above scenarios, you must:* a) Discuss other resources and approaches with your supervisor within 1 working day ***and*** follow usual CM response times depending on results of conversation with supervisor. Use collateral contacts (e.g., family, health care provider) for information and assistance; b) Reschedule observation within 2 business days: c) Follow the usual CM time frames per the LTC manual, Chapter 3, under Timeframes. d) Refer to APS, CPS, or CRU if abuse, neglect, or self-neglect is suspected; ***and*** e) Document ALL your activities including any arrangements or referrals made, or discussions had.
5.	The client is cognitively intact and declines skin observation over pressure points ***and*** there is evidence of negative skin outcomes (foul odor, staining on clothing over pressure points or other visible signs). *Determine and provide any or all the following activities as appropriate to the client's situation.* ***Document all activities and conversations.*** a) Call 911 if emergency medical care is required; b) Refer to APS, CPS, or CRU as mandated and as appropriate if a negative skin outcome is believed to be the result of abuse and/or neglect; Refer to RCW 74.34 c) If HCS case manager or AAA Case Manager is not a nurse, immediately make a referral to the nurse or Nursing Services for an observation visit as soon as possible; d) Verify and document the observation visit was done; e) Make a referral for a home health nurse or to the primary care provider if treatment is needed;

	f)	Educate the caregiver by reviewing the section in the service plan that describes skin care over pressure points including prevention plans for skin breakdown over pressure points
	g)	Identify someone else to observe skin and all pressure points (caregiver, family member, or person with whom the client feels comfortable);
	h)	Collect collateral information re: skin problems over pressure points from health care providers, caregiver(s), family, or other involved parties;
	i)	Explore other appropriate services such as residential placement, different caregiver, community clinic, or other community-based resources (discuss with supervisor);
	j)	Discuss with all involved parties and come to consensus with concrete criteria about when or whether to terminate services (follow protocols established by the Challenging Cases Workgroup within your area);
	k)	Document all activities;
	l)	Incorporate recommendations in the LTC Manual Chapter 5 "Case Management" and "Challenging Cases Protocol" as appropriate: The case may be kept open to CM services.
6.	Client is cognitively impaired (CPS score >3) ***and*** meets the highest risk indicators ***and*** declines skin observation once *or* mildly objects to the observation.	
	a)	Using skilled interview and assessment techniques, request permission a second time.
	b)	Be sure the client understands as much as possible what you are requesting.
	c)	If the client has a legal representative, contact that individual for assistance with consent and to assist the client with the needed observation.
	d)	Document all activities and conversations.
7.	Client is cognitively impaired (CPS score >3), meets the highest risk indicators, consistently refuses skin observation, ***and***:	
	a)	The client's skin condition over pressure points is unknown; and
	b)	The client has a provider who won't let anyone else in; and/or
	c)	The client refuses services related to skin integrity over pressure points, d*o the following:*
		i. Refer to the "Challenging Cases Protocol" (LTC Manual Chapter 5)
		ii. Refer to and consult with your supervisor regarding other services;
		iii. Offer alternative services, a different provider, a residential placement, or a change in the way services are delivered;
		iv. Using skilled interview techniques to understand the basis of refusal
		v. Refer to APS, CPS, or CRU as mandated if there are allegations of abuse and/or neglect; Refer to RCW 74.34;

	vi.	Refer to 911, ER, or Designated Crisis Responder (DCR) if appropriate for involuntary treatment;
	vii.	If there are guardianship, capacity, or DPOA questions staff with your supervisor who may refer to Assistant Attorney General for consult;
	viii.	Document all activities and conversations.
8.	Client meets the highest risk indicators, but an observation was not completed due to culture or gender. *Be sure to document all activities and conversations.*	
	a) Consult with your supervisor as soon as possible to find a reasonable solution. A reasonable solution is:	
	i.	Timely;
	ii.	Respecting of personal and professional boundaries; ***and***
	iii.	Results in someone observing the skin and documenting what was done for the client

REPORTING REQUIREMENTS

Additional information on Nursing Services program utilization may be requested for program management needs related to strategic planning, program utilization and evaluation, and long-term care coordination with other state agencies providing Medicaid-funded care.

AAA's, Contractors & HCS Requirements

Each AAA office and HCS office providing Nursing Services should check with their respective leadership to see what reports may be required for internal use. **No** report is required to be sent to the ALTSA/DSHS Nursing Services Program Manager.

RESOURCES

Related WACs and RCWs

Nursing Services

WAC 388-106-0200 (3)	MPC Services
WAC 388-106-0300 (1 - 11)	COPES – own home
WAC 388-106-0305 (6)	COPES – residential facility
RCW 74.09.520(2)(b) and (c)	MA service and funding limitations

Standard of Nursing Conduct/Nurse Practice

Everyone, upon entering the practice of nursing, assumes a measure of responsibility and trust and the corresponding obligation to adhere to standards of nursing practice and follow best practice. You are

individually responsible and accountable for the quality and timeliness of nursing service you provide to clients.

18.79 RCW	Nurse Practice Act
18.130 RCW	Uniform Disciplinary Act
WAC 246-840-700	Standards of nursing conduct or practice
WAC 246-840-710	Violations of standards of nursing conduct or practice

Acronyms

AAA	Area Agency on Aging
ADL	Activities of Daily Living
AL	Assisted Living
ALTSA	Aging and Long-Term Support Administration
APS	Adult Protective Services
CARE	Comprehensive Assessment and Reporting Evaluation
CDWA	Consumer Direct of Washington
CFC	Community First Choice
COPES	Community Options Program Entry System
CM	Case Manager
CPS	Cognitive Performance Scale (when used with "score") *or* Child Protective Services
CRM	Case Resource Manager
CRU	Complaint Resolution Unit
DDA	Developmental Disabilities Administration
EARC	Enhanced Adult Residential Care
HCP	Health Care Provider
HCS	Home and Community Services
HIPAA	Health Insurance Portability and Accountability Act
IP	Individual Provider
MPC	Medicaid Personal Care
NC	Nurse Contractor
POA	Power of Attorney
RND	RN Delegator
SOP	Skin Observation Protocol
UTI	Urinary Tract Infection
WPC	Waiver Personal Care

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #

Private Duty Nursing (PDN)

Chapter 25 describes the Private Duty Nursing (PDN) policies and procedures eligibility requirements, how to determine and document need for PDN, and how to authorize services.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Kaila O'Dell, BSN, RN Private Duty Nursing Program Manager, HCS
360.725.3549 privatedutynursing@dshs.wa.gov

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BACKGROUND

Purpose

Private Duty Nursing (PDN) is a program that provides in-home or Adult Family Home based skilled nursing care to Medicaid clients 18 years of age and over who would otherwise be served in a Medicaid Medical Institution (MMI). Home and Community Services (HCS) is responsible for this service. PDN is an alternative to institutional care *and* is the program of last resort.

The purpose of PDN is to:

- Provide community-based alternatives to institutional care for clients who have complex medical needs and require skilled nursing care on a continuous and daily basis that can be provided safely outside of an institutional setting.
- Support the client, client family, formal and informal supports, who are responsible for assuming a portion of care above the approved amount of PDN hours.

The NCC case manager **must:**

- Ensure that applicants submit a Medicaid application, if not already a Medicaid recipient. Coordinate the financial eligibility process on behalf of the applicant.
- Determine eligibility through the CARE assessment, review of Skilled Nursing Task Log (SNTL), review of medical record, and other documentation to support client's medical care needs. WAC 388-106-1010 (3, 2b)
- Contact the client or client representative within two (2) business days of receiving referral. WAC 388-106-1010
- Assist the client with finding a PDN provider and ensure that the provider is contracted.
- Utilizing CARE tool, develop a plan of care specific to the client. WAC 388-106-1010 (3)
- Authorize services (i.e. determine the number of hours, consider ETRs, authorize in ProviderOne, and send the Planned Action Noice).
- Provide ongoing case management. PDN clients are **not** transferred to the AAA.

ELIGIBILITY

Clients must meet medical, financial, and program eligibility requirements. Financial and program eligibility may be completed concurrently. However, **PDN cannot begin until financial eligibility is established** (WAC 388-106-1010). If a client is assessed for Nurse Delegation and is determined eligible, they may refuse Delegation, but this does not make the client eligible for PDN.

HCS Clients Nurse Care Consultants (NCCs) determines eligibility. WAC 388-106-1010 (2b)
DDA Clients Nursing Care Consultant determines eligibility (clients age 18+) and/or refers to HCS for eligibility determination for clients age 18+ if they no longer meet DDA criteria.

Staff Case Management Responsibilities

HCS Clients Nurse Care Consultants (NCCs) are responsible for case management.

DDA Clients — Case Resource Manager **and** the Nursing Care Consultants (NCC) are collaboratively responsible.

Financial Eligibility

HCS clients — The HCS financial worker calculates client responsibility toward the cost of care.
DDA clients — The DDA LTC specialty team calculates client responsibility toward the cost of care.

Verify that the client meets financial eligibility requirements, which means the client is receiving Categorically Needy (CN), Alternate Benefit Plan (ABP) or Medically Needy (MN). If the client is in an adult family home, they pay room and board. If the client is on a Home and Community Based (HCB) Waiver, they may pay participation toward personal care depending on their income. The combination of participation, room and board, and third-party resource is called "client responsibility".

Table 25.1 Financial Requirements

PROGRAM	PARTICIPATES TOWARDS	NOTES
CFC + CORE Waiver or CFC + Basic Plus In-Home	Eligible for HCB waiver services	Income cannot be above the Medicaid Special Income Level (SIL). The Medicaid SIL is 300% of the federal benefit rate (FBR).
CFC + COPES	Eligible for HCB waiver services.	Income can't be above the monthly state NF rate plus the medically needy income level.
CFC Only	Client pays toward AFH room and board	A client cannot receive PDN in any other residential setting. A CFC only client is receiving CN or ABP scope of care.
MN - Regular	Spend down required, can use PDN to meet	MN and PDN services cannot be authorized until spend down is met and case shows active in ACES online.

Please note: MPC eligibility does not meet Nursing Facility Level of CARE

Functional Eligibility (Initial determination and Ongoing Eligibility Determination)

You must complete a face-to-face initial CARE assessment, a face-to-face annual CARE assessment, any significant change assessments, and a six-month desk review. The NCC will have two (2) working days from the date the referral was received to contact the client. If the client is unreachable after two (2) days of documented consecutive attempts, then the NCC will follow process of sending out 10-day letter to client/authorized representative. NCC will also escalate to supervisor.

Assessment and the Skilled Nursing Task Log (SNTL) and review of medical records, and/or additional documentation to support clients medical care needs:

1. Requires care in a hospital or meets Nursing Facility Level of Care; ***and***
2. Has unmet skilled nursing needs that cannot be met in a less costly program or least restrictive environment; ***and***
3. Is unable to have their care tasks provided through nurse delegation, COPES Skilled Nursing, or self-directed care; ***and***
4. Has a complex medical need that requires 4 (four) or more continuous hours of skilled nursing care and observation which can be *safely* provided outside an institution (for PDN AFH the client must meet this as well as require at least 8 hours of PDN care to qualify for all-inclusive PDN rate); ***and***

> Note**:** The need for a nursing assessment does not qualify a person for PDN

5. Is technology-dependent daily (See Table 25.2)
6. Requires skilled nursing care that is medically necessary, as defined by the client's physician; ***and***
7. Can supervise the care provider(s) or has a guardian who is authorized and able to supervise care or has a DPOA who is able to supervise for In-Home services, has family or other appropriate; ***and***
8. For In-Home services, has family or other appropriate supports who assume a portion of the care, not be nurse delegated; ***and***
9. Does not have other resources or means for providing this service.

Table 25.2 Functional Requirements for Technology-Dependent PDN Clients

SKILLED TASK	DESCRIPTION
A. Mechanical Ventilation	The client requires the use of *mechanical ventilation*, which takes over the active breathing due to your inability to breathe on your own due to injury or illness. A *tracheal tube* is in place and is hooked up to a ventilator that pumps air into your lungs; *OR*
B. Complex respiratory support	The client requires **two** of the following treatment needs: i. Postural drainage and chest percussion; *OR* ii. Application of respiratory vests; *OR* iii. Nebulizer treatments with or without medications; *OR* iv. Intermittent Positive Pressure Breathing; *OR* v. O2 saturation with treatment decisions dependent on the results; *OR* vi. Tracheostomy ***and***

	The client's treatment needs must be assessed and provided by an RN/LPN. ***and*** The client's treatment needs ***cannot*** *be nurse delegated or self-directed. If the task can be delegated, then the client is ineligible for PDN.*
C. Intravenous/parenteral administration of multiple medications	The client requires intravenous/parenteral administration of multiple medications **and** care is occurring on a continuing or frequent basis or:
D. Intravenous administration of nutritional substances.	The client requires intravenous administration of nutritional substances, **and** care is occurring on a continuing or frequent basis.

Primary Care Provider (PCP) Approval

PCP's medical orders can either be obtained by the NCC or the PDN Contractor but is necessary for the PDN Contractor to use the PCP's medical orders to develop a person-centered Care Plan. DSHS Form 15-594 is available for PDN Contractor's to use to document a person-centered Care Plan but is not a required form. The NCC approves the PDN Contractor's Care Plan after it has been completed, reviewed, and signed by the Primary Care Physician.

1. A primary care provider needs to document.
    - The client's medical stability.
    - Orders for medical services.
    - Approval of the PDN provider's plan of care; and
    - The client's appropriateness for PDN care.
      And
    - Primary Care Provider must approve the PDN's Care Plan (388-106-1046 (3).) This must be completed *initially* and reviewed and signed by the Primary Care Provider at least every six (6) months.

2. NCCs must approve the PDN's care plan (WAC 388-106-1010 (3) h(ii).)

CHOOSING A PDN PROVIDER

You may need to help clients choose their PDN provider. The PDN provider must have a PDN contract with the state and must be a(n):

- Home Health Agency licensed in WA State (WAC 388-106-1025); or
- Independent RN provider or an LPN under the supervision of an RN with a contract with the Medicaid agency to provide PDN services (WAC 388-106-1040); or

- Adult Family Home that is RN-owned and operated (WAC 388-106-1045); or
- Adult Family Home (AFH) – Adhere to WAC 388-106-1046 with a PDN Contract. To determine if AFH has an appropriately amended contract for PDN.

To determine if a PDN provider has a State contract visit:
https://fortress.wa.gov/dshs/adsaapps/Professional/ND/PDN.aspx

Contracting with a PDN Provider

If a Home Health Agency, Adult Family Home, or individual nurse (RN or LPN with RN supervision with a DSHS PDN Contract), wishes to contract with the state to provide PDN services, they should contact the PDN Program Manager at privatedutynursing@dshs.wa.gov.

A signed contract **must** be in place before PDN services can begin.

A PDN contract status will be visible from the PDN website: Private Duty Nursing | DSHS (wa.gov) either from the hyperlink, List of Contracted Providers, Find Private Duty Nurses (wa.gov) or Adult Family Home Locator, AFH Facility Search (wa.gov) . Please note that it is the PDN contracted providers choice if they do not want their information listed.

AUTHORIZING PDN SERVICES

Authorizing PDN Hours

1. Maximum hours that can be authorized without an ETR depend on the client's place of residence.
    a. Private Home At least four (4) and up to sixteen (16) hours per day of PDN RN/LPN
    AFH
    b. Up to eight (8) hours of PDN per day or the PDN All-Inclusive Daily Rate, for example, if a client does not require (8) hours of PDN per day based on the SNTL, then the client would not qualify for PDN All-Inclusive Daily Rate. The NCC will be responsible for reviewing the SNTL and make the appropriate determination.
    If the client does not meet the minimum requirements for the PDN all-inclusive rate, then the NCC would authorize the amount of daily hours of PDN assessed under (8) eight.
2. For clients receiving PDN and CFC or CFC+COPES personal care you must deduct the PDN hours from the hours that the CARE assessment generates per WAC 388-106-0130 (6)(e).
    a. For example: If the CARE assessment generates 344 hours, and per NCC assessment of SNTL with/without additional documentation determines 10 hours of PDN is needed daily, then the NCC would take 344 hours and subtract 310 hours of PDN (10 hours a day x 31 days a month = 310 hours) and would get 34 hours that can be utilized for personal care.

3. If the overall hours needed exceed the remaining number of hours CARE generates after PDN hours have been deducted, the client is not eligible for any additional CFC or CFC+COPES personal care hours without an ETR.
    a. For example: CARE assessment generates 344 hours, and per NCC assessment of SNTL determines client requires 16 hours of PDN and requires either additional PDN or IP hours above 344 then; PDN clients who are on a waiver program must receive a monthly ancillary service to remain eligible for the waiver.
4. For clients receiving only PDN in in-home setting, they are eligible for between four (4) to sixteen (16) hours of nursing services/day. The number of PDN hours they are eligible for between 4 to 16 hours will be determined by the NCC after reviewing the SNTL.

Requesting an ETR

1. You will need to request an ETR (WAC 388-440-0001) if:

- A client resides in a private home and the NCC determines that the client requires both PDN and CFC or CFC+COPES hours. PDN hours must be deducted from the CARE generated hours; If hours needed exceed the remaining hours after PDN hours have been deducted an ETR is needed. This ETR, "Type," should be noted in CARE as **Personal Care ETR** and sent to the **ETR committee**, who will then staff with the PDN PM manager to determine outcome and hours.
- A client resides in a private home, and the NCC determines that the client requires more than 16 hours of PDN from an RN/LPN per day. This ETR, "Type," should be noted in CARE as a **PDN ETR** and sent in CARE to the **PDN PM**.
  If a client resides in a private home and needs **both** a) greater than 16 hours PDN and b) additional CFC+COPES hours. There will need to be **two ETR's** for the client; one ETR for the PDN hours and send to the **PDN PM** and one for the care hours and send to the **ETR Committee** to be reviewed with the PDN PM.

2. Send the Skilled Nursing Task Logs to privatedutynursing@dshs.wa.gov anytime an ETR is being requested.

Authorizing Payment

Payments for PDN services are authorized through ProviderOne:

- Complete the P1 authorization for HCS and DDA using CARE service codes T1000 with service code modifier: **TD** (RN Hourly Rate) **TE** (LPN Hourly Rate)
- AFH All-Inclusive Daily/Specialty Rate use T1020 without any modifiers.
- Holiday Rates use service codeT1000 with modifier, TV:
- **Individual:** T1000, TD, TV (RN) T1000, TE, TV (LPN)
- **Agency:** T1000, TD, TV (RN) T1000, TE, TV (LPN)
- **Paid holidays are limited to:**

(1) The first day of January (New Year's Day);
(2) The third Monday of January (Martin Luther King, Jr.'s birthday);
(3) The third Monday of February (Presidents' Day);
(4) The last Monday of May (Memorial Day);
(5) The nineteenth day of June (Juneteenth);
(6) The fourth day of July (Independence Day);
(7) The first Monday in September (Labor Day);
(8) The eleventh day of November (Veterans Day);
(9) The fourth Thursday in November (Thanksgiving Day);
(10) The Friday immediately following the fourth Thursday in November (Native American Heritage Day); and
(11) The twenty-fifth day of December (Christmas Day).

- Use the ProviderOne Billing Manual for direction on how to complete authorization.
- Clients do not need to participate toward the cost of PDN services (PDN is a Medicaid State Plan-covered service).
  - Apply participation if the client is also receiving personal care (e.g., CCFC+COPES).
  - For HCS clients, financial staff will determine whether the PDN client has countable income above the Medically Needy Income Level (MNIL) and is required to participate toward the cost of COPES care.
- Inform the client that they may pay for any supplemental services not covered in the CARE plan.
- NCC to complete authorizations in CARE using service codes T1000 for in-home settings.

Note: Clients receiving PDN services are subject to estate recovery, depending on when they received services and their age.

Notifying the Client of Services

When hours of PDN services are initiated or changed, you must send your client the Planned Action Notice (PAN) that will be generated in CARE.

DETERMINING PDN HOURS FOR A CLIENT (INITIAL OR REASSESSMENT)

To determine how many hours to authorize for PDN:

1. Review the completed Skilled Nursing Task Log (SNTL) and any additional authorized medical records to *determine* the **number of PDN hours** the client requires as well as **client eligibility for PDN services**.
   a. If reauthorizing PDN hours for a subsequent 6-month period, the SNTL must be completed at least 7 days *prior* to the desk review or face-to face assessment. In addition, if the client has a change of condition and changes to care need assessment completed, the NCC must obtain a new 7 day look back of SNTL.

b. Each new assessment/re-assessment must be conducted by utilizing the SNTL to determine eligibility and hours. For example: if a previous SNTL shows more PDN hours per NCC determination and upon reassessment by the NCC, the SNTL shows less hours are needed then the NCC will make the necessary changes. The NCC will also ensure ETR requirements are completed to include supporting data and documentation. For example, justification, alternatives explored, etc.

PDN hours are determined based on SNTL assessment and determination. If a client previously had an ETR or additional hours, this is not a justification to continue. Each PDN client assessment will be independent of one another. The assessment will be based on clients PDN care needs and should be reflected in the SNTL.

2. Utilize informal supports in conjunction with PDN and CFC or CFC+COPES services. The NCC **must:**
    1. Determine availability of informal/unpaid supports and other non-department paid resources. Identify that informal supports are based on voluntary actions and are available if the source is willing and able to continue them.
    2. Complete a CARE assessment annually and conduct six-month desk reviews. The annual CARE assessment **must** be a face-to-face interview with the client. The review must also be completed more frequently if the client's medical condition or situation changes.
    Note: The designated PDN Skilled Nursing Task Logs must be completed for a period of *at minimum* 1 week prior to completion of the face-to face assessment and desk reviews.
3. Determine that care needs cannot be met through other programs.
4. Review the PDN service provider's plan of care, which must be updated and submitted every six months or more often if the client's medical condition changes to:
    i. Reassess the client's medical eligibility; ***and***
    ii. Review the number of PDN hours the client needs; ***and***
    iii. Ensure that the physician has reviewed and signed orders and the provider's plan of care.
5. Update authorizations in CARE and notify the client in writing regarding the outcome of your determination via a Planned Action Notice (PAN). PANs must be issued any time the Department approves, denies, increases, or reduces a client's benefit package.
    Note: The 14-225 is one of many forms that needs to be signed at each face-to-face assessment regardless of the service.

DEVELOPING THE PLAN OF CARE

HCS clients NCC develops the Plan of Care utilizing CARE assessment.
DDA clients NCC and the Case Manager develop the Plan of Care collaboratively.
Whoever develops the Plan of Care is responsible to meet with the PDN client (and family or guardian) and provide them a copy of the Service Summary and Planned Action Notice/Personal Care Results.

When the NCC develops the plan, they **must:**

1. Consider the client's quality of life as well as overall cost effectiveness and long-range costs.
1. Consider PDN AFH for those clients whose PDN costs will exceed the cost of 16 hours of Private Duty Nursing per day.
2. Utilize informal supports in the development of plan of care. Family members may provide skilled care tasks as well as provide any additional hours of care needed above that of PDN hour determination.
3. Include detailed schedules of all formal and informal providers. **Do not** schedule a PDN provider and an IP, personal aide, or home care agency to provide services at the same time. Services may not be duplicated.
4. Evaluate clients who share a household to see whether they could be served by one PDN provider at the same time.
6. Utilize LPN services instead of RN services when appropriate. If a private LPN is going to be contracted, they must have oversight by an RN per the Nurse Practice Act WAC 246-840-705
7. Document the **four (4) continuous hours of skilled nursing** from the Skilled Nursing Task Log (SNTL) as required for program eligibility and in the comment box on the *Treatment* screen or *Indicators* screen in CARE.
8. Provide the SNTL forms to the PDN provider. You must review the completed SNTLs to determine the number of PDN hours the client requires.
9. The SNTL, medical provider's plan of care, client medical record, CARE assessment and any additional medical information about client should all align to provide accurate information about the client's care needs. If there are questions the NCC, PDN provider, and medical provider will work together to ensure plan of care and CARE assessment aligns.

RESOURCES

Related WACs

WAC 388-106-1000	What is the intent of WAC 388-106-1000 through 388-106-1055?
WAC 388-106-1005	What Services may I receive under Private Duty Nursing (PDN)?
WAC 388-106-1010	Am I eligible for Medicaid-funded Private Duty Nursing services?
WAC 388-106-1020	How do I pay for my PDN services?
WAC 388-106-1025	Who can provide my PDN services?
WAC 388-106-1030	Are there limitations or other requirements for PDN?
WAC 388-106-1035	What requirements must a home health agency meet in order to provide and get paid for my PDN?
WAC 388-106-1040 *and* WAC 246-840-705	What requirements must a private duty RN, or LPN under the supervision of an RN, meet in order to provide and get paid for my PDN services?
WAC 388-106-1045	When may I receive Private Duty Nursing (PDN) services in a contracted PDN adult family home (AFH)?

WAC 388-106-1046	When may an Adult Family Home (AFH) be paid an all-inclusive daily rate for Private Duty Nursing (PDN) services
WAC 388-106-1047	What is included in the all-inclusive daily rate payment to the Adult Family Home (AFH) providing Private Duty Nursing (PDN) services?
WAC 388-106-1050	May I receive other long-term care services in addition to PDN?
WAC 388-106-1055	Can I choose to self-direct my care if I receive PDN services?
WAC 388-440-0001	Exceptions to the Rule (ETR)

Forms

PDN Skilled Nursing Task Log (SNTL)

Form 15-594 PDN Care Plan

Acronyms in this Chapter

ABP	Alternative Benefit Plan
AFH	Adult Family Home
ALTSA	Aging and Long-Term Support Administration
CARE	Comprehensive Assessment and Reporting Evaluation
CFC	Community First Choice
CN	Categorically Needy
COPES	Community Options Program Entry System
DDA	Developmental Disabilities Administration
ETR	Exception to Rule
FBR	Federal Benefit Rate
HCB Waiver	Home and Community Based Waiver
HCS	Home and Community Services, Aging Long Term Support Administration
IP	Individual Provider
MMI	Medicaid Medical Institution
MNIL	Medically Needy Income Level
MPC	Medicaid Personal Care
NF	Nursing Facility
PAN	Planned Action Notices
PDN	Private Duty Nursing
SER	Service Episode Records
SIL	Special Income Letter
SNTL	Skilled Nursing Task Log

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
10/2024	Kaila O'Dell		
12/29/2021	Kaila O'Dell		
3/4/2019	Whitney Hightower		
6/21/2018	Jevahly Wark		
12/2015		This information not tracked at this time of this revision.	

Administrative Hearings

The purpose of this chapter is to ensure that all persons have the right to apply for Long-term Care (LTC) services administered by the department and to:

a) Have their financial and functional program eligibility correctly determined by the department; and
b) Appeal any decision made by the department which they perceive as adversely impacting the authorization or delivery of LTC services, including approvals and increases.

Vendors have the right to an administrative hearing when the department determines that a vendor was overpaid by the department for either goods or services, or both and issues notice of the overpayment. RCW 43.20B.675, 43.20B.010 and RCW 41.05A.170.

Department staff has information about the administrative hearing process and the department's role in an administrative hearing.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Kim Averill — Interim Administrative Hearing Program Manager
360.725.3223 kimberly.averill@dshs.wa.gov

Tania Gariano — HCS Administrative Hearing Specialist/Financial
509.846.8636 tania.gariano@dshs.wa.gov

Vicky Gawlik — Adult Protective Services
360.725.2615 vicky.gawlick@dshs.wa.gov

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BACKGROUND

The administrative hearing process allows individuals the right to challenge a government action to verify it was valid and based on laws and rules. It is a legal proceeding but is designed to be user friendly for appellants who represent themselves (not attorneys) with relaxed rules of evidence and procedure.

In 2011 the Health Care Authority (HCA) became the single state agency for Medicaid. This means DSHS is a designee of the HCA for managing some Medicaid benefits and represents HCA in hearings that relate to Medicaid. DSHS is the single state agency for Temporary Assistance for Needy Families and Basic Food.

RIGHTS TO AN ADMINISTRATIVE HEARING

Clients and vendors have a right to an administrative hearing only when entitled by law and when aggrieved by a department decision/action.

1. **Clients** have a right to a hearing:
    a) For any action indicated on the Planned Action Notice (PAN) including, but not limited to approval, denial, reduction, or termination of services or eligibility;
    b) When the department determines a client received a benefit or more benefit than they were eligible for, and an overpayment notice was issued; and
    c) When the total number of in-home personal care hours or New Freedom budget being received is reduced because of a reduction or termination in the number of in-home personal care hours approved as an exception to rule[1] or the residential payment rate that was approved as an ETR is reduced or terminated.

2. **Vendors** have a right to a hearing when the department determines they were overpaid for goods and/or services provided to department clients on or after July 1, 1998[2], and notice of OP is provided to the vendor.

Resources:
RCW 74.09.741 Right to an Administrative Hearing (HCA).
RCW 74.02.080 Right to an Administrative Hearing (DSHS).

WAC 182-526-0085 Determining if a hearing right exists.
WAC 388-71-0562 Home Care Agency's Right to an Administrative Hearing.
WAC 388-115-0562 Consumer Directed Employer's Right to an Administrative Hearing.
WAC 388-106-1315 Hearing Rights for an ETR.

[1] There is no appeal right for a denial of an initial ETR request.
[2] In 1998 the legislature enacted RCW 43.20B.675, which requires the department to offer a "formal uniform appeal process" to vendors including the right to an adjudicative proceeding, which is governed by the Administrative Procedure Act and department rules.

REQUESTING AN ADMINISTRATIVE HEARING

Hearing requests must be made within a specific timeframe. See timeframes and deadlines for specifics.

1. A client may request a hearing in any of the following ways:
    a) Verbal request. Department staff must notify the Office of Administrative Hearings (OAH) IMMEDIATELY[3] of any verbal request from the client, preferably in writing. These requests can be entered into the Administrative Hearing Control System (AHCS) in Barcode by any staff with access to Barcode. Enter the hearing request in the client's own words, email it, print and fax or mail to OAH.
    b) Written request (of any kind). Department staff must notify OAH IMMEDIATELY[4] of any written request that doesn't go directly to OAH.
    c) The Request for Hearing form that accompanies every PAN. This form can be completed by the client and mailed or faxed to OAH. The client may also ask department staff to help them complete and submit the hearing request to OAH.
    d) Per the instructions on the Client Overpayment Notice to request a hearing for an overpayment issue.

2. Vendors may request a hearing related to an overpayment by using the instructions on the Vendor Overpayment Notice.

Resources
WAC 182-526-0095 How to Request a Hearing
WAC 182-526-0025 Use and Location of Office of Administrative Hearing (OAH)

[3] Not to exceed two calendar days.
[4] Not to exceed two calendar days.

NOTICES- SEE CHAPTER 27 "NOTICES"

When a client applies for or gets benefits, the department is required to send notice to alert clients about the decisions made about their benefits. Notices are the crux of the department's case in an administrative hearing and should accurately represent the action that was taken by the department, including the supporting authorities for the action. If the notice is fatally deficient, the department may lose the case on inadequate notice. Notices may be amended up to and during the hearing in most instances[5].

CASE MANAGER ROLE

1. The case manager remains responsible for case management activities, including completing an accurate assessment to determine correct eligibility.

2. In addition, the case manager:
    a) Notifies the client, informally over the phone or in person, AND in writing using the automated PAN, when the department takes an action affecting the client's services.
    b) Attempts to resolve any issues expressed by the client when they don't agree with the decision/action the department is taking. This includes but is not limited to:
        i. Reviewing the assessment with the client to ensure accuracy and to explain the assessment process and the CARE tool.
        ii. Gathering additional supporting information from collateral contacts including other health care professionals, when applicable.
        iii. Exploring alternatives to help resolve issues like:
            (1) Evaluating whether the client needs a reassessment and completing one if appropriate;
            (2) Checking the availability and suitability of programs or services which may be offered by other community social service agencies or informal supports; and
            (3) Assessing whether a request for an ETR is applicable.

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[5] **WAC 182-526-0260 Amending the health care authority or managed care organization notice.**

(1) The administrative law judge (ALJ) must allow the health care authority (HCA), HCA's authorized agent, or a managed care organization (MCO) to amend (change) the notice of an action before or during the hearing to match the evidence and facts.

(2) HCA, HCA's authorized agent, or MCO must put the change in writing and deliver a copy to the ALJ and all parties.

(3) The ALJ must offer to continue (postpone) the hearing to give the parties more time to prepare or present evidence or argument if there is a substantive change from the earlier notice.

(4) If the ALJ grants a continuance, the office of administrative hearings must serve a new hearing notice at least fourteen calendar days before the hearing date.

c) If the client does not agree with a decision made by the department and a resolution cannot be reached, explains to the client that an administrative hearing may be requested.
d) Informs the client that he or she will get continued benefits if they do not agree with a decision for a reduction or termination of services, if a hearing is requested before the effective date and pending the outcome of the hearing, unless they request not to receive them.
e) Notifies the client that up to 60-days of continued benefits may have to be repaid if the department prevails in the hearing.
f) Notifies the financial worker of continued benefits.
g) Documents the communications with the client in SER including that the administrative hearing process was explained to the client and the client's decision about whether to request a hearing, if known. Include the details about the hearing issue(s) and attempts made to resolve the issue(s).

For local OAH contacts use WAC 182-526-0025 or the OAH website or send requests to:
Office of Administrative Hearings (OAH)
PO Box 42489 Olympia, WA 98504-2489

h) Assists the client to request a hearing, as needed, when the client chooses to make a formal request, by using the Administrative Hearing Control System[6]. Submits the request immediately to the local OAH field office.
i) Notifies the local AHC of the verbal or written request for a hearing, and provides the AHC with the client's:
    i. Name,
    ii. ACES # and ProviderOne #.
    iii. Date of request, and
    iv. Administrative hearing issue.
j) When informed that a formal notice of an administrative hearing is received, documents the:
    i. Date of the request, and
    ii. Date of the hearing.
k) Provides the AHC with any physical records or other information that the AHC can't electronically access that would help the AHC decide if the department's decision/action was accurate.
l) Provides the AHC with any additional information that will assist in the AHC's preparation for the hearing.
m) Participates in the prehearing process, if requested by the AHC.
n) Participates in the hearing as a witness for the department if requested by the AHC[7].

Note: 182-526-0155
An appellant may represent themselves, or may be represented by a lawyer or paralegal, or by a relative, friend, or any other person of his or her choice, other than the department.

[6] The AHCS does not link to OAH, so after a request is completed in the AHCS, it must still be sent to OAH.
[7] HCS or AAA staff may not represent the appellant in an administrative hearing. Consult with program managers for any exceptions to DSHS staff representing the client. A case manager may be subpoenaed to testify as a witness for the appellant.

o) Documents in the SER when the client withdraws an Administrative Hearing request, and includes the date and reason. Notifies the AHC so that a formal request for withdrawal can be made with the client, AHC, and OAH.

It is assumed that vendors do not require the same degree of assistance as that of a client, and it is not the expectation that case manager or Administrative hearing coordinators provide it.

4. For vendor overpayment hearings, OFR notifies the vendor in writing using the Provider Overpayment Notice when there is an overpayment. The case manager follows the same basic process about providing documents and information to the AHC and participating in the hearing as indicated above for client.

ADMINISTRATIVE HEARING COORDINATOR ROLE

The AHC represents the department (and HCA) in all activities related to the hearing request. The AHC is responsible to know the laws and rules, the facts of the case they are presenting, and be able to apply the law and rules to the facts in the appeal.

The AHC:

1. Receives notice of the administrative hearing request from the Case Manager or OAH and documents all hearing related activities and hearing related information in the Administrative Hearing Control System (AHCS) in Barcode.

2. Uses the AHCS system to track all hearing related activities, document witness names, exhibits, and the hearing report.

   The Administrative Hearing Control System (AHCS) is a subsystem in Barcode used by AHCs to help in the tracking of cases for Administrative Hearings, printing DSHS forms, and keeping track of hearing statistics for both client and vendor hearings. Using the AHCS is mandatory for AHCs.

   Functionality of the AHCS includes but is not limited to:
   - Daily Hearing Schedule reports and prehearing and hearing calendars;
   - Availability to print hearing related forms like hearing withdrawals, AH Report template, Dismissal Order template, etc.
   - Tracking hearing events including dates, witnesses, the hearing issue and outcomes; and
   - Statistic Reports including appealed cases, pending cases, dockets with continuances, closes cases, dockets by program, etc.

3. Notifies the social worker/case manager and the CMs supervisor of the administrative hearing request and discusses the case with worker(s) involved and their supervisors, as appropriate.

4. Requests the case record and all applicable documents.

5. Reviews the records including but not limited to the CARE assessment and the PAN to ensure accuracy. If any errors are found they should be corrected at this time. Notices may be corrected at any time up to and through the hearing, depending on the type of error on the notice.

6. Reviews the HCS/AAA case to determine whether the department/agency made the correct decision/action.

7. Makes other contacts/reviews other information, as necessary, to determine and make a recommendation about the department/agency position. If the department/agency made an error in its decision or action:
    a. The decision/action is corrected;
    b. The appellant/appellant representative is contacted; and
    c. The hearing request is withdrawn at the applicant/client request if the issue is sufficiently resolved, and the client agrees with this step. This can be done in writing or by calling OAH with the appellant/appellant representative. This may require a written follow up letter requesting that the administrative hearing be withdrawn, by the client, depending on local OAH procedures.
    d. If the action has been reversed and the client does not want to withdraw their request for hearing, the AHC will request a motion to dismiss the case. There is no right to a hearing without an action.

8. If the appellant wishes to continue with the hearing, the AHC is required to initiate the prehearing meeting. The AHC contacts the client[8] and:
    a. Reviews the administrative hearing process and the role of the AHC.
    b. Describes both the informal and formal prehearing process and its purpose.
    c. Asks about the need for an interpreter, or other auxiliary aids (Administrative Policy No. 7.02 Equal Access to Services for Individuals with Disabilities) and informs OAH.
    d. Determines whether the appellant has legal or other representation, and if requested, may refer the appellant to legal resources.
    e. Informs the client that he or she will get continued benefits, when applicable[9], pending the outcome of the hearing, unless he or she requests not to receive them.
    f. Informs the client that up to 60-days of continued benefits must be repaid if the outcome of the administrative hearing is in favor of the department.
    g. Clarifies the issues surrounding the hearing and attempts to resolve them outside of the hearing process whenever possible.

9. Discusses the issues with department/agency administration or HQ Program Management staff and requests the assistance of the Assistant Attorney General's office (AAG) by contacting the HQ Program Manager(s) or requests assistance of AAA legal counsel if needed.

[8] The AHC does not have the same responsibilities to assist the IP through the Administrative hearing process.

[9] And if the client requests the hearing before the effective date of the notice.

10. Participates in the formal prehearing conference, if scheduled by OAH, or requests a prehearing conference from OAH when needed.

11. Acts as the contact person between OAH and the department, appellant, appellant legal representative or other person representing the appellant;

12. Develops the theory of the case and prepares the administrative hearing Report, DSHS 09-354 in the AHCS. This is a required document for all administrative hearings.

13. Notifies the department's witnesses of the date of the hearing, when they are required to be present, and helps prepare the witnesses for the hearing.
    This includes reviewing with the witness:
    a) The hearing issue
    b) The types of questions that may be asked by the AHC, appellant, and ALJ
    c) The exhibits that will be referenced that the witness may be asked to talk about during the hearing

    In addition, to increase the comfort of the witness, the AHC practices with the witness, emphasizes confidence and truthfulness and provides encouragement and support[10]. The AHC should never give the answers to the witness for the questions they plan to ask or tell them what to say. The AHC should only coach the witness so they are prepared.

14. Gathers exhibits and reviews what documents are available to present and support the department's case.

15. Provides the administrative hearing packet, including exhibits to OAH and to the appellant, at least five days prior to the hearing and includes the appellant in any "substantive" communications with OAH. The AHC must not participate in any *ex parte*[11] communications.

16. Arranges for the location (room) of the hearing, if applicable (OAH may make these arrangements). Most hearings take place via phone.

17. Presents the department's case to the ALJ and appellant at the hearing including opening and closing statements to clarify and summarize the issues and arguments, and facilitates witness testimony and cross examination. Opening and closing statements should be a summary of the department's position and should not be a reading of the administrative hearing report.

18. Reviews the ALJ's decision and informs the case manager and supervisor. If the department/action is not upheld, the department must implement the order by the end of the month the order was received and the AHC must decide whether to request a review of the

[10] Remember that the AHC may ask for a short recess. This may be an effective tool if the agency witness is anxious or scared and this is interfering with testimony. The witness will have to answer any question that has been asked before a recess will be granted but may benefit from this to break to compose themselves.
[11] See definition section

initial order to the Board of Appeals. In order to make this decision the AHC may consult with the social worker/case manager, supervisor, administrator/director, AAA attorneys, and with HQ Program Manager who may request consultation with the AAG's office.

Consultation with HQ is especially important when the initial decision, or a belief that a later decision by the Board of Appeals (BOA), may set a precedent that would have far reaching and/or long-term effects on eligibility, rules, policies, and costs, especially if the AHC anticipates the appellant could move the case through to Superior Court. The importance is to ensure a complete and accurate record and to get legal advice as appropriate.

If the department's position is upheld and the client received continued benefits, the AHC must notify the case manager who will terminate continued benefits and initiate the overpayment when appropriate.

19. Advises the client of the appeals process to BOA, as appropriate.

20. When known, refers the case to the HQ Program Manager if the appellant loses the BOA review and decides to appeal to Superior Court. HQ staff will coordinate with the AAG's office, which represents the department/agency in Superior Court[12].

21. Documents the actions in the AHCS in Barcode and files documents into the AH file. Sends the client hearing file to Document Management Services (DMS) for imaging when the hearing process is complete, (provider OP hearings are documented in the AHCS but not sent to DMS).

CONTINUED BENEFITS

Whenever the Department notifies a client that his or her benefits will be reduced or terminated, federal law allows the recipient to maintain benefits at the prior level if the recipient appeals the decision by requesting an administrative hearing prior to the appeal by/effective date on the PAN.

1. Clients automatically receive continued benefits if the appeal is requested prior to the appeal by date[13] on the PAN, unless they request not to receive them.
2. Continued benefits are in the amount indicated by the assessment under appeal, unless less benefit is requested by the client. They are authorized on the first day after the request for appeal. If the ALJ reduces or terminates benefits, the initial order takes effect at the end of the month during which OAH mailed the initial order, even if the client requests an appeal through the Board of Appeals.
3. If the ALJ reduces or terminates benefits, the first 60-days of continued benefits, starting on the date of the request for hearing from OAH, are subject to an overpayment and the department

[12] Also known as Judicial Review.
[13] For each Service on a PAN the date the client must appeal by, to receive continued benefits, is printed in the notice. For example: "To keep your services from being reduced until a hearing decision is made, you must appeal by 12/13/2019, and "If you appeal by 12/13/2019, we assume you want your services to stay the same until the hearing decision".

sends the overpayment to Office of Financial Recovery (OFR) if appropriate[14]. The recoverable funds that may be collected on the overpayment are from the effective date on the PAN out 60-days from the request of the hearing from OAH[15].

4. The overpayment is based on the additional benefit the client received over and above the amount required by the initial order. The order should state the effective date of the reduction or termination and the amount the client is eligible to receive.
5. If the client requests an appeal of the initial decision with BOA, there will not be any collection action from OFR until the BOA decision is reached.
6. Vendors do not receive continued benefits.
7. If the department prevails at the hearing, continued benefits stop at the end of the month the hearing decision is mailed. The department must complete an overpayment, when appropriate. See the Overpayment section for more information.

Resources
WAC 182-504-0130 Continued Coverage Pending an Appeal.
388-458-0040(5) What happens if I ask for a hearing before a change happens?

TIMEFRAMES AND DEADLINES

1. PANs must be sent to the client immediately after completing the assessment and must provide at least 10-days' notice before the effective date[16] of the action for services. For client services, the PAN in CARE automatically provides for at least 10-days' notice, using the ten-to-the-end policy.
2. If a request is received by OAH before the appeal by date on the PAN, the client receives continued service benefits, unless he or she requests not to receive them.
3. OAH must receive an appeal within 90-days[17] of the date the client receives the PAN.
4. Request for correction of clerical errors on initial orders must be received on or before the tenth calendar day after the order was served.
5. BOA must receive the request for review within 21 calendar days from the mail date stamped on the initial decision from OAH and should:
    a. Identify the parts of the initial order with which the department disagrees.

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[14] There may be certain situations where a client may have the kind of income that can't be garnished. The department must continue to submit the overpayment to OFR and OFR will determine whether or not the overpayment gets processed. Examples of income that may not be garnished may include: Income from Social Security, SSI, veteran's benefits, or retirement pensions, IRAs or 401(k) s.

15 For example:

- Date of the Notice is February 2nd.
- The appeal by date is February 29th.
- Effective date of reduction is March 1st.
- OAH receives the hearing request on February 8th.
- Continued benefits start on March 1st.
- The department prevails at the hearing that takes place in May.
- The overpayment clock begins on February 8th because that's when OAH received the request.
- 60 days is February 8th – April 7th.
- The department would collect from March 1st-April 7th (only 38 days).

[16] See Notices (5) for exceptions.

[17] Except in cases where good cause has been determined for a state only program, per RCW 74.08.080 and 74.09.741 effective 7/2023

b. Identify arguments/evidence as to why the department believes the ALJ's decision was in error.
c. Send a copy of the review request to the other parties.
d. Direct Appeals to:
Board of Appeals
PO Box 45803
Olympia, WA. 98504-5803

6. Request for reconsideration must be received by BOA within 10 calendar days from the date stamped on the Review Decision or Order.
7. Superior Court must receive the request for review FROM THE APPELLANT (the department has no rights for this review) within 30-days from the date stamped on the review decision or order from BOA.

Resources

WAC 182-518-0025 Washington apple health- Notice Requirements
WAC 182-504-0130 Continued Coverage Pending an Appeal
WAC 182-526-0110 Process After a Hearing is Requested
WAC 182-526-0550 Deadline for Requesting a Corrected Initial Order
WAC 182-526-0560 Review of an Initial Order by a Review Judge
WAC 182-526-0575 How to Request Review of an Initial Order
WAC 182-526-0605-0620 Reconsideration
WAC 182-526-0650 Service of Petition for Judicial Review

HEARING DECISIONS AND FINAL ORDERS

1. An Initial Order becomes a final order at 5 pm on the 21st calendar day after OAH serves the initial order unless:
    a. There is a request for a review of the initial order made to BOA.
    b. There is a request for an extension that is granted.
    c. Any party files a late request for review which is accepted[18].

2. When you receive a final order you must:
    a. Follow the judge's order.
    b. Contact HQ program management staff for consultation if needed.

Resources
WAC 182-526-0525 When an Initial Order Becomes Final

COMPONENTS OF THE ADMINISTRATIVE HEARING PROCESS

1. A **prehearing meeting** is an informal discussion with the appellant. The ALJ is not present. Prehearing meetings are required, by policy, for the AHC but the appellant can refuse to participate in a prehearing meeting. Although the prehearing meeting is voluntary for the appellant, it must be offered to every appellant as early in the hearing process as possible. It can be held by phone, in person, or by other correspondence. Prehearing meetings can be used to:
    a. Identify or clarify the issue(s) for the hearing and resolution where possible.
    b. Explain the department's decision to the appellant by reviewing the rules (WAC) the department relied on when making the decision being appealed.
    c. Arrange to give or receive documents as proposed exhibits including: additional medical documents from the appellant, documents or other evidence the department relied on when making the decision being appealed, etc.
    d. Answer the appellant's questions about the hearing process and rules that apply.
    e. Attempt to resolve the dispute through agreement and assist with the withdrawal of the hearing at the appellant's request.
    f. Advise the appellant about possible free legal help at: 1-888-201-1014.
    g. Discuss a request for a continuance, if necessary. If both parties are in agreement, call OAH together to request additional time to get more information, clarify issues, correct misunderstandings, make agreements, etc.

2. A formal **prehearing conference** with OAH may be requested if needed and is not already scheduled. A prehearing conference is generally required for overpayment hearings. If a prehearing conference is requested and granted (the ALJ must grant a request if it is filed with OAH at least 7 business days before a scheduled hearing date), all parties must attend. The

[18] Good cause must be established for a late request to be accepted. The department should instead request an extension of the timeframe, before the deadline, if more time is needed.

conference is scheduled by OAH and usually takes place by phone. The prehearing conference can be used to:

a. Simplify the issues. The department should be prepared to discuss the hearing issues.
b. Set the date, time, and place of the hearing.
c. Identify accommodation/safety issues.
d. Set a deadline to exchange witness lists and exhibits (which must not be less than five days before the hearing). Be prepared to know how many witnesses you expect to call and days you expect to need for the hearing.
e. Set deadlines for motions ("briefing" and "argument" deadlines).
f. Schedule additional prehearing conferences.
g. Discuss procedural matters.
h. Distribute written testimony and exhibits to the parties before the hearing.
i. Discuss other matters that may aid in the disposition or settlement of the proceeding.
j. Request a continuance if necessary.
k. Ask for a motion briefing schedule if wanting to file a motion.

3. A **hearing** is where the AHC, appellant, and witnesses come together with the ALJ, frequently by phone[19], to present the issues being appealed. The AHC may:
    a. Present an opening statement that states the issue and briefly summarized the evidence that will be presented at the hearing.
    b. Offer evidence to support the department's decision such as exhibits and witness testimony and may question the witnesses presented by the other parties.
    c. Give closing arguments where the facts presented at the hearing are applied to law. The ALJ or the appellant may also ask questions and the appellant may offer exhibits to support his or her position.

Resources
WAC 182-526-0175 Prehearing Meetings
WAC182-526-0195 Prehearing Conference

Most Social Services and Financial hearings fall under the HCA hearing rules: 182-526
HCA Hearings (WAC 182-526) include:
- Social Services Hearings- Services.
- Financial Hearings

DSHS Hearings (WAC 388-02) include:
- Food Stamps

RESOURCES

WACs and RCWs

WAC 182-526 Administrative Hearing Rules for Medical Services Programs (HCA)
RCW 34.05.410-34.05.494 General requirements for Administrative Hearings
RCW 74.09.741 Right to an Administrative Hearing (HCA)
RCW 74.02.080 Right to an Administrative Hearing (DSHS)
WAC 388-106 Long-Term Care Services
WAC 388-71 Home and Community Services and Programs

[19] The hearing may also be in person or some parties may be in-person and some by phone.

Glossary

WORD	DEFINITION
Administrative Hearing Coordinator (AHC)	An employee of the department who represents the department in all activities related to administrative hearings. The AHC is also the Health Care Authority hearing representative, or authorized agent of HCA, for certain HCA hearings
Administrative Law Judge (ALJ	An impartial decision-maker who is an attorney and presides at an administrative hearing. The Office of Administrative Hearings (OAH), which is a state agency, employs the ALJs. ALJs are not department employees or department representatives
Appellant	Term used for the client/rep or provider during the hearing process.
Board of Appeals (BOA)	An entity from HCA and DSHS responsible for reviewing the decisions issued by the ALJs as part of the appeals process. BOA review judges are attorneys who have the authority to review hearing records and initial orders for legal or factual errors. After their review, these judges enter final orders.
Client	For the purposes of this chapter, means an individual, who may also be the appellant, applying for Medicaid services (applicant) or an individual receiving Medicaid services. This also includes the client's chosen representative
Continued Benefits	When a Medicaid recipient's benefits are reduced or terminated by the department, and the recipient is able to maintain benefits at the prior level, if the recipient appeals the decision by requesting an administrative hearing with OAH by the appeal date on the notice.
Department	DSHS, Home and Community Services (HCS) and the Area Agencies on Aging (AAA) or their subcontracted entities. It also means Health Care Authority (HCA) because HCS and AAA staff represents HCA in most social services administrative hearings.
Department of Health (DOH)	A state agency separate from DSHS.
Exception to Rule (ETR)	Means an approved amount beyond the maximum hours/budget/daily rate generated by CARE when a client's situation differs from the majority. See 388-440-0001 for specifics.
Ex Parte Communication	Occurs when a party to a case, or someone involved with party, talks or writes to or otherwise communicates directly with the judge about the issues in the case without the other parties' knowledge.
Health Care Authority (HCA)	The single state agency responsible for overseeing Washington Apple Health (Medicaid), as well as other health care programs. HCS and AAA staff represents HCA in most social services hearings.
Office of Administrative Hearings (OAH)	A state agency that is independent from DSHS and HCA, which handles appeals of DSHS and HCA actions

Planned Action Notice (PAN)	A written form of communication used to notify clients of decisions about services and of the right to appeal that decision. It is the legal document/Notice that provides the client with the department's eligibility decision or decision about services and the authority that allows the department to take the action.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
11/21/2022 5/22/2025	Nina Banken Stacy Graff	• Updated contact information under "Ask the Expert" • Corrected minor typos • Removed all references to Individual Providers because of the implementation of the Consumer Directed Employer (CDE). Clients no longer have a right to an Administrative Hearing regarding their choice of provider. IPs no longer have an administrative hearing related to training/certification and will not receive department issued overpayment notices that are for dates of payment after the transition to the CDE. The CDE has a grievance process for clients and providers. • Updated contact information under "Ask the Expert". • Added "email" as an option to notify OAH of a hearing request. • Removed IP Planned Action and Stop Work Notice information due to the transition to the CDE. • Added "This is a required document for all administrative hearings" re: administrative hearing report. • Added information in footnote 13 about requesting a recess during the hearing if needed. • Clarified in footnotes that a request to Superior Court is also known as Judicial Review. • Removed most of the duplicative information about notices that can be found in chapter 27.	

		• Added footnote 17 about changes to statute related to hearing request timeframes for state only programs where good cause is shown. • Other minor wording changes add for clarification.	

Notices

The purpose of this chapter is to provide requirements and policy regarding Planned Action Notices (PANs) and other notices for client services.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Kim Averill Administrative Hearing Program Manager
360.725.3223 kimberly.averill@dshs.wa.gov

For specific program questions about PANs, contact the Program Manager who manages that program.

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BACKGROUND

Providing appropriate notice to clients and providers, prior to taking an adverse action in most instances, is required by statute/rule. While this chapter will not cover program specific notices, it covers general information about notice requirements that can be applied to particular situations.

GENERAL NOTICE INFORMATION

In general, notices to clients must include the following, when applicable.

1. **Action taken by the department**- the action the department took that impacted the client's benefit.
2. **Reason for the action**- the reason the department took the action.
3. **Legal authority**- specific rule, Washington Administrative Code (WAC); law/statute, Revised Code of Washington (RCW); or Code of Federal Regulation (CFR) that supports the agency action.
4. **Date of notice-** date the notice is completed and mailed.
5. **Effective date-** date the action takes effect.
6. **Contact information-** department representative's name and contact information.
7. **Information about hearing rights-** when applicable, information in the notice informing the recipient about their hearing rights.
8. **Information about continued benefits-** when applicable, information in the notice informing the recipient about continued benefits.

Important: Planned Action Notices generated in CARE include some auto-populated fields, including WAC citations. Ensure this information is correct and applicable. Modify info as necessary before sending.

CLIENT SERVICES PAN

This section describes the requirements and policy direction for completing PANs related to client services.

Notice requirements

When a client applies for or receives benefits, the department is required to send timely written notice in the client's primary language, when the department takes an action that impacts the client's benefits.

1. **Action**

   Examples of Actions taken by the department include approvals, increases, withdrawals, denials, reductions, terminations, and changes. Choose the **Action on the PAN** that most accurately reflects what the department is doing related to the client's benefits.

   Use this table to assist you in selecting the correct Action.

ACTION	USE WHEN	10 to the END?
APPROVED (includes renewals and changes)	• Initial eligibility decisions • Continued eligibility/services when there is no change • A change in services from one program to another, e.g. MPC to CFC • Adding a service	n/a
INCREASED	Services/rate increase	n/a
WITHDRAWN	Requests for services that are **withdrawn by the client** after the assessment and before services start. ***The department does not complete withdrawal PANs for actions or changes the department is taking.***	n/a
DENIED	• Initial functional ineligibility • Not eligible for requested service/program and services were never initiated or authorized.	Yes
REDUCED	• Services/program/hours/rate reduced	Yes
TERMINATED	• If a service/program has been initiated and authorized, select "Terminated." • Use when client requests termination.	Yes

2. **Reason**

   Select the reason that most accurately fits your situation. Reasons may include functionally eligible, not functionally eligible, not financially eligible, change of functional impairment, change in unmet need level, etc.

   TIP: select "other" and add a brief, plain talk, explanation for unusual situations.

3. **Legal authority**
   Include the specific WAC, RCW, or CFR that supports the action the agency took. WAC should be used first whenever possible. WACs related to LTC Services can be found in Chapter 388-106

4. **Date of notice**
   This is the date the notice is completed and mailed. This date is auto populated when the PAN is finalized in CARE.

   TIP: finalize and mail PAN on the same day. The day of mailing begins the count for 10 to the end, continued benefits, and hearing deadlines.

5. **Effective date**
   This is the date the action takes effect. If a client is no longer functionally eligible for in-home care services, the services will be terminated on the effective date. This means the client will no longer receive services on or after that date. The Effective date auto-populates for reductions and terminations.

   Important: To edit the effective date to allow more time for **translations**, complete an amended PAN. An amended PAN is currently the only way to edit the dates on a reduction or termination PAN.

   TIP: the end date of the authorization is one day before the effective date.

6. **Contact information**
   The case manager's name and contact information is auto populated into the PAN from CARE.

7. **Hearing rights**
   Clients have a right to a hearing when "aggrieved" by an agency decision. There must be an "action" to trigger a right to hearing. However, if a client asks for a hearing, regardless of whether the department made a decision or took an action, the department must assist the client in filing for an administrative hearing with the Office of Administrative Hearings (see chapter 26). In these cases,

the department's Administrative Hearing Coordinator will argue that the client does not have a right to a hearing. The local grievance policy should also be discussed with the client.

Clients have 90-days to appeal the department's action. Information about how to request a hearing and a Request for Hearing Form is included on each Service PAN printed from CARE.

Grievance Process: Each office has a written grievance policy and procedure. In situations where a client does not have a right to a hearing, he or she should be informed of the local grievance process. This may meet the client's needs outside of the hearing process.

8. **Continued Benefits**

Continued benefits allow a client to continue receiving services at their prior level while they wait for the outcome of their hearing.

For service reductions and terminations, a client is automatically entitled to continued benefits if they request a hearing by the **Appeal-by-date** (at least one day before the effective date on the PAN). A client can request not to receive continued benefits.

- The appeal by date is auto populated.
- If the effective date on the PAN is August 1st, the appeal-by-date is July 31st.
- Client must ask for a hearing by July 31st to be eligible for continued benefits.

Continuation of benefits terminates immediately if Office of Administrative Hearings (OAH) rules in favor of the department in the Initial Order. Client may be subject to an overpayment for the first 60-days of continued benefits if OAH rules in favor of the department.

NOTICE TIMEFRAMES

PANs should be completed and sent immediately after completing an assessment. 10-to-the-end policies, continued benefits, and hearing rights all offer clients protections and options if they disagree with a department decision.

1.Reductions and Termination:

When an Annual or Significant Change CARE assessment results in a **decrease** in residential rateor a **termination** of a service, the department must provide clients at least 10-days' notice prior to implementing the reduction or termination. This is called the **10-to-the-end policy**.

The reduction or termination becomes effective the first day of the following month that the PAN was finalized and sent to the client.

When a PAN is finalized with more than 10 days in the month, the dates would line up like this:

PAN finalized	7/10/2024
Date of Notice	7/10/2024
Appeal-by-Date	7/31/2024
Current Auth End Date	7/31/2024
Effective date	8/1/2024

When there are less than 10 days between the Date of Notice and the last day of the month, the effective date is the first day of the following month. This means the client will have more than 10 days notice.

When the PAN is finalized with less than 10 days left in the month, the dates would line up like this:

PAN finalized	7/23/2024
Date of Notice	7/23/2024
Appeal-by-Date	8/31/2024
Current Auth End Date	8/31/2024
Effective Date	9/1/2024

Refer to WAC WAC 182-518-0025 for certain exceptions to the 10-day notice requirements including incarceration, returned mail, death, receipt of Medicaid from another state, etc. 2.

2. Denials

When a client is found not to be eligible for services, send a denial-of-service PAN. The effective date is auto populated and is the same as the date of notice.

- The 10-to-the-end policy does not apply to denials.
- Denial PANs have no appeal-by-date because continued benefits are not relevant. A client will still have a right to request a hearing.

3. Approvals and Increases:

When an assessment results in the approval of a new service, increase in residential rate or in-home hours, or other service, the department IS required to send client notice of their benefits, but 10 days advanced notice is not required.

- Approval and increase PANs have no appeal-by-date because continued benefits are not relevant. Clients will continue to have a right to request a hearing.

- The effective date can be the beginning of the following month or immediately if needed (upon completion of the new assessment and client approval).

- If authorizing services mid-month, follow the instructions in the **Social Service Authorization Manual (SSAM)** to ensure authorizations are done correctly.

OTHER CLIENT NOTICES

This section describes the policy direction for completing other types of notices.

1. **When a client cannot be reached to complete the intake process**

   When a client makes a request for in-home services or services in a residential facility and the department is unable to reach the client to complete the intake process, send a 10-Day Form Letter - Intake requesting contact within 10-days so the intake process can be completed. A PAN is not required.

2. **When a client cannot be reached to schedule an assessment**

   When a client makes a request for in-home services or services in a residential facility and the department is unable to reach the client to schedule an assessment, send a 10-Day Form Letter - Assessor requesting contact within 10-days so an assessment may be scheduled. A PAN is not required.

3. **Notice of Decision on Request for an In-Home Personal Care Exception to Rule**

   Refer to LTC manual Chapter 3.docx , Exception to Rule (ETR) process for information on this type of notice.

4. **When a client becomes financially ineligible for LTC services**

   When a client is or becomes **financially ineligible**, **HCS financial staff *may* send the required notice** to the client, depending upon the ACES coverage group the client is on and the LTC program/service the client is receiving. The financial notice includes the required information, including hearing rights.

When financial sends notice to a client, a SS PAN is not required and should not be sent[1].

Use this table to determine when a SS PAN is required when a client is **financially ineligible**.	
Program	**Send PAN?**
MPC	Yes
Fast Track	Yes
MCS	Yes
MAGI based	YES[2]
HWD	In home-YES, Residential-No
CFC Classic	NO
CFC + Waiver	NO
Waiver (COPES or New Freedom)	NO
RCL	NO
PACE	NO
Non-Citizen Program (45 slot)	NO

[1] If a financial notice and a SS PAN are sent on the same action, the client will be given hearing rights in both instances for the same issue.

[2] The Health Care Authority (HCA) sends notices to clients about their WA Apple Health benefits, but the notice does not include information about LTC services. CMs receive a H002 tickler in Barcode to alert them that a MAGI client's benefits may be changing. Please refer to MB 16-050 for more information.

RESOURCES

Related WACs and RCWs

eCFR :: 42 CFR 431.206	Informing applicants and Beneficiaries
Chapter 388-458 WAC:	Notices to Clients
WAC 388-02-0260:	May the Department Amend a Notice?
Chapter 182-518 WAC:	WASHINGTON APPLE HEALTH—LETTERS AND NOTICES
Chapter 388-106 WAC:	Long Term Care Services
Chapter 388-71 WAC:	Home and Community Services and Programs
RCW 43.20B.675	Vendor overpayments—Goods or services provided on or after July 1, 1998—Notice—Adjudicative proceeding—Enforcement—Collection—Rules.
RCW 43.20b.010	Definitions (overpayments)
42 CFR § 433.304	Definitions (overpayments)

Other Resources

Social Service Authorization Manual Chapter 3.docx	Payment Issues notices for ETR's

Where to find Notice documents

Client Services PAN	CARE
10-Day Form Letter – Intake	In Translated Docs
10-Day Form Letter- Assessment	In Translated Docs
Notice of Decision on Request for an In-Home Personal Care Exception to Rule #05-246	CARE

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
3/27/2023	Stacy Graff	Removed references and sections that were related to contracted Individual Providers including: rejection of client choice of provider PAN, IP PANs, Stop Work Notices, IP payments and overpayments.	
4/1/2025	Kim Averill	Updated new DSHS logo and formatting Added spacing to page 2, General Notice information Minor wording and formatting changes to PAN action table pg 3 Reworded section on continued benefits Reworded section on 10 to the end Minor wording changes in section covering client PANs Deleted some text boxes and replaced with plain text to improve readability of page. Added more resource links in resource table	

Medicaid Fraud

The purpose of this chapter is to provide instruction and information to staff regarding suspected fraud, waste and abuse in Medicaid-funded programs.
Adult Protective Services staff please refer to Chapter 6 of the Long-Term Care Manual for instructions on reporting fraud.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Cheryl Timmons Program Integrity Manager
360.725.2530 cheryl.timmons2@dshs.wa.gov

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BACKGROUND

Federal regulation requires the Department to have methods and criteria to identify suspected fraud cases, procedures regarding investigation of these cases, and processes for referring suspected fraud cases to law enforcement officials.

When a complaint alleging Medicaid fraud is received, federal rules require the completion of a preliminary determination on whether there is sufficient basis to warrant a full investigation. Because direct line field staff in HCS, DDA and AAA offices conduct case management activities and are often the level of staff receiving this information, the preliminary determination is conducted at this level. If the preliminary results give staff reason to believe that an incident of fraud, waste or abuse has occurred, a referral for full investigation should be made to DSHS ALTSA/DDA Headquarters (HQ) for routing to the Medicaid Fraud Control Unit for their review and evaluation.

The Medicaid Fraud Control Unit (MFCU) conducts criminal and civil investigation and prosecution of health care provider fraud committed against the State of Washington's Medicaid program. MFCU also monitors complaints of resident abuse or neglect in Medicaid funded nursing homes, adult family homes and assisted living providers.

The guidance contained in this chapter is based on federal requirements, training materials offered by MFCU, and a collection of practices from field and headquarters program staff. Since this guidance document cannot cover or predict every possible fraud scheme or scenario, this information is presented as a resource to assist staff at reporting agencies when allegations of potential fraud are made, and to better understand the federal reporting requirements associated with Medicaid providers. HCS Headquarters program staff are available for consultation as requested.

Most Medicaid providers are honest, hardworking individuals and agency staff who provide high quality care that enables individuals to continue living in their own home and communities. However, a few individuals attempt to be paid for services they did not provide, for services that the client is not eligible to receive, or by other fraudulent schemes. By identifying provider fraud, we ensure a high-quality provider base to support vulnerable consumers and that taxpayer dollars are used accountably.

PRELIMINARY ACTION STEPS

If a fraud referral is going to be completed do not submit an ARF (Adjustment Request Form). No overpayments can be processed while a fraud referral is active.

If a referral is accepted by Medicaid Fraud Control Unit (MFCU), they will recover any overpayment due.

Case Managers and social services workers are at the front lines of the fight against provider fraud and are in a critical position to identify instances of suspected provider fraud. Reporting agency field staff have the most knowledge of a client/provider situation and are often the point of entry for awareness of

any suspicious acts. Field staff at AAA/HCS/DDA offices may receive information regarding a client or provider's actions that may indicate program rules are not being followed in multiple ways, such as:

- Tip received from an anonymous phone call or letter,
- Observation during regular case management activities,
- Contact by another interested party, or
- Information found in a report or data review.

CDE will also submit fraud referrals to DSHS. The referral will be shared with the local office staff as an FYI. If the Individual Provider is working for other clients, headquarters staff will work with CDE and local office staff to determine if Good Cause Applies (see page 5).

However, before a referral is made to the Medicaid Fraud Control Unit for potential investigation of a provider's actions, a preliminary review must be conducted at the field level or by CDE. This preliminary review contains action steps that are required to establish the credibility of the claim and to determine whether or not field staff or CDE believe behavior which rises to the level of fraud may be involved.

Professional judgment should be applied on a case-by-case basis to determine what steps are appropriate, as all situations are unique. Some steps to take as part of a preliminary review to determine the credibility of the allegation may include the following (if there is any concern that any of these actions might have an unintended influence on a subsequent investigation, contact the Program Integrity Manager for guidance):

- Talk to the client
- Talk to other involved parties
- Request and review the provider' timesheets/records of services provided. For CDE employees HQ staff will request shift details from CDE,
- Review and confirm the care plan and compare to what is being delivered
- Review invoices, staff logs, etc.
- Review the provider's contract file for any relevant documentation
- Gather documentation such as SER notes and/or provider education that occurred prior to current incident
- Consult with supervisor about possible actions before a referral is made, such as:
  - Increased monitoring of services
  - Unscheduled home/office visits (depending on provider type)
  - Conversations with provider regarding the allegation, with appropriate level of detail and reference to program rules (i.e. a reminder not to claim hours while a client is hospitalized).

Allegations are considered credible when they have "indicia of reliability" (see Glossary) or indicators of probability. Examples of some indicators that support the conclusion that the allegation may be true include, but are not limited to:

- Admission/confession to fraud activities,
- Supporting documentation,
- Verification by two or more sources,
- Clear patterns of misconduct,

- Continued misconduct after education on contract requirements (which should be documented in the contract file by the staff person who provided the notification),
- Any internal communications expressing concern about a provider's actions or conduct,
- History of multiple billing "errors", which result in a loss to the Medicaid program,
- A lack of reasonable legitimate explanation, etc.

It should be clear that the act under review is not accidental or inadvertent and is action by design. At the very least, it requires an intentional deception or misrepresentation made with the knowledge that the deception could result in an unauthorized benefit or payment, where the provider has made a knowing false statement. Not every overpayment is fraud, especially where an incident can be attributed to a mistake made by the provider.

If there is no pattern or history of behavior that persists over time, many times the most appropriate administrative remedy is to write an overpayment. When a pattern seems apparent, document the activity and corrective discussion with the provider, as well as any notification that was provided to correct the situation.

This documentation should be made in either the client's SER or the provider's contract file, whichever is most appropriate for the situation. If the behavior occurs again, this information will strengthen a referral as it will help establish a pattern of behavior as well as possible intent of the provider. Field staff should staff concerns with supervisors as appropriate.

Field staff should submit the referral package (see Provider Fraud Referral Policy & Process section for detailed instructions, page 9) with information and supporting documentation that addresses the allegations to the greatest extent possible. See also the Medicaid Provider Fraud Referral form (DSHS Form #12-210) and accompanying instructions for the specific information and required documentation. Following these instructions will provide assurance that quality referrals are submitted to MFCU for their evaluation and review. Be sure that all mandatory fields, those marked with an asterisk ("*"), are completed.

Examples of supporting documentation to submit with a completed referral form may include, but are not limited to:

- Provider Timesheets (if applicable) for a 3-6 month span, for the period of the identified concern,
    - For CDE employees HQ staff will request shift details from CDE,
- Documentation of any overpayment associated with the allegation,
- SER notes that document discussions with the provider regarding either the incident being investigated or any previous discussions with the provider on the same or similar topic,
- Name and contact information of any witness who would be contacted for more information during a full investigation. This could be the person who provided a tip to field staff, or someone who has additional information about the allegation or provider's actions,
- Documentation requested in the Provider Fraud referral form instructions, and
- Any other documents which support and substantiate the allegation.

PAYMENT SUSPENSION POLICY

In accordance with the Affordable Care Act (ACA) and federal regulation at 42 CFR 455.23, the State of Washington must ensure that federal funding is not provided to individuals or entities when there is a pending investigation of a credible allegation of fraud.

This means that system payments to a provider must be suspended when there is a credible allegation of fraud, unless Good Cause exists not to suspend payment. Terminating the provider's payment authorization is the equivalent of a payment suspension. If the payment is not suspended, or suspended only in part, federal rules require that a "good cause" exception must be documented.

- For referrals involving Individual Providers, the CDWA authorization does not need to be ended if CDWA confirms that a new Individual Provider will start serving the client.

Good Cause Exceptions

The federal rule allows that the reporting agency may find that good cause exists to:

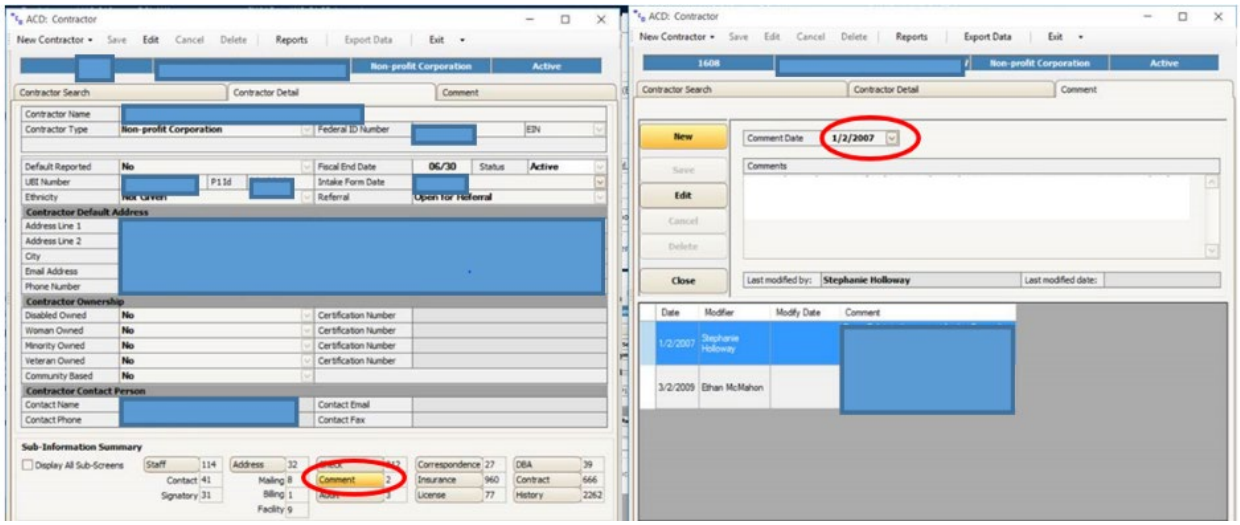
- Not suspend payments,
- Discontinue a payment suspension previously imposed, or
- Suspend payments only in part.

Documentation

If local office staff and CDE recommends that a Good Cause Exception based on client safety needs applies and is approved by DSHS HQ**,** the case manager (or designee) and CDE must ensure the applicable exception is documented, including the relevant facts, circumstances and any other information or supporting documentation to support the finding that a Good Cause Exception applies.

- For a provider with one or only a few clients, such as an Individual Provider, documentation of Good Cause Exception must be made in the client(s)'s SER.
- For Contracted DSHS providers a note in the provider's ACD contract file needs to be added to indicate that a referral was made, the date, a summary of the circumstances, and the Good Cause Exception that applies to the situation.
- For Contracted DSHS provider with several clients, such as an agency provider, documentation of Good Cause Exception must be made in the provider's contract file/ACD. Local or HQ Contract Staff may enter documentation of any monitoring action being considered and add a Comment to the provider's Contractor Profile in ACD to summarize all actions taken.

NOT Suspend Payment	Suspend Payment in PART
• Case manager must staff the case with Supervisor, considering all relevant factors and documentation to determine if a Good Cause Exception applies.	• The case manager who is making the referral must coordinate with the other case manager(s) of the provider's other clients to determine if there are any concerns regarding the provider. • The case manager must also staff the case with their Supervisor, considering all relevant factors and documentation to determine if a Good Cause Exception applies to suspend only in part.



Not Suspend Payment

If there is a good reason not to terminate the authorization of a provider (i.e. to allow a provider to continue working for the client) when a credible allegation of fraud is referred for potential investigation, this reason is called a Good Cause Exception and must be documented. **42 CFR §455.23** includes a provision for a good cause exception to not suspend payments. Allowable **Good Cause** reasons to either (1) NOT suspend payments, or (2) NOT continue a payment suspension previously imposed are:

Payment Not Suspended Due to Good Cause Exception

- MFCU (or other law enforcement agency) specifically requests that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.
- Other available remedies implemented by the State more effectively or quickly protect Medicaid funds.
- Based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, the suspension should be removed.
- Client access to care would be jeopardized by a payment suspension because of either of the following: (please indicate)
  - (i) The individual or entity is the sole source of essential specialized services in a community.
  - (ii) The individual or entity serves a large number of clients within a federally designated medically underserved area.
- MFCU (or other law enforcement agency) declines to certify that this matter continues to be under investigation.
- Payment suspension is not in the best interests of the Medicaid program.

Suspend Payment Only in Part

The federal rule allows that the reporting agency may find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part if there is a good reason to allow an individual or entity to continue working where there is an investigation of a credible allegation of fraud.

Suspending a payment only in part would be applicable when a provider has more than one client, the credible allegation of fraud is regarding only one client, and there are no issues with the remaining client(s). The applicable exceptions to suspend payment only in part are as follows:

Payment Suspended Only in Part Due to Good Cause Exception

- Client access to care would be jeopardized by a payment suspension in whole or part because of either of the following: (please indicate)
  - (i) The individual or entity is the sole source of essential specialized services in a community.
  - (ii) The individual or entity serves a large number of clients within a federally designated medically underserved area.
- The reporting agency determines, based upon the submission of written evidence by the individual or entity that is the subject of a whole payment suspension, that the previously imposed payment suspension should be imposed only in part.
- The credible allegation focuses solely and definitively on only a specific type of business area of a provider, and the reporting agency determines and documents in writing that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid.
- MFCU (or other law enforcement agency) declines to certify that this matter continues to be under investigation.
- The reporting agency determines that payment suspension only in part is in the best interests of the Medicaid program.

If none of the exceptions apply, the payment authorization must be terminated when a provider fraud referral is submitted to MFCU. Notice to the provider regarding the termination of the payment authorization must be sent within five (5) of the termination date on the authorization, in accordance with the federal requirement at 42 CFR 455.23(b).

PROVIDER FRAUD REFERRAL POLICY AND PROCESS

Considerations Before a Referral is Made

A referral should contain sufficient information to support the Department's belief that an illegal act by a Medicaid provider has occurred. There is **no** "minimum dollar threshold" which must be met in order to make a provider fraud referral. If staff suspect a situation is Medicaid fraud, a referral should be made using the guidance presented in this chapter. Intake staff at the MFCU will review and evaluate cases referred by DSHS and make a determination to accept a case for further investigation and potential

prosecution based on the information presented and their agency's criteria. Field staff should not "screen out" or decide not to make a referral based on an assumption that a case might not be accepted due to dollar value.

Before a provider fraud referral is submitted to HQ for referral to MFCU, the referring staff (i.e. case manager or contract manager) must staff the referral package with supervisor(s) and/or others per AAA or regional practice. This should include a review of the allegation circumstances, all relevant supporting information and documentation, and a determination regarding payment suspension, documenting good cause exception where applicable. Supervisor review should ensure all required components of the referral are met according to the referral form instructions, and to ensure appropriate professional judgment has been applied to the process.

Submitting the Medicaid Provider Fraud Referral Package

Complete the Medicaid Provider Fraud Referral form (DSHS Form 12-210) according to the form instructions, gather all appropriate documentation (see Preliminary Action Steps section), and submit this package to the email addresses listed in the table below. HQ program staff monitors the email inbox on a daily basis. **Reporting agency field staff should not make any provider fraud referrals directly to MFCU**, either via email, phone, or through the online complaint form. MFCU Intake Unit staff are available for consultation upon request, if field staff would like to consult regarding a case before considering it for referral.

For ALTSA Home & Community Services (HCS) Division Referrals	For Development Disabilities Administration (DDA) Referrals
Send referrals to this email address: ProviderFraudHCS@dshs.wa.gov	Send referrals to this email address: ProviderFraudDDA@dshs.wa.gov

HCS and DDA HQ program staff monitor the email Inbox regularly to receive referrals. These are reviewed for completeness and compliance with federal regulations, and then entered into a tracking system. Provider fraud referrals are reported to this centralized location for tracking purposes related to quality assurance and annual reporting. This process facilitates collaboration with Health Care Authority's Division of Program Integrity (DPI) and ensures a standardized reporting process is followed in order to meet mutual reporting requirements to federal authorizing entities.

HCS and DDA HQ program staff will forward the completed referral package along with any supporting documentation to the appropriate investigating entity, MFCU and/or the DSHS Office of Fraud and Accountability (OFA), as appropriate. HQ program staff will monitor, track, and report on the follow-up provided by the fraud investigators, as well as communicate with case managers and field staff as needed on a case-by-case basis.

Notices to Client and Provider

Send the appropriate notice to the Client and provider according to current practice and policy. Include WAC and CFR citations from the Resources section at the end of this chapter, as applicable, as well as any other applicable WACs which support the action being taken.

- If the provider is an IP, the Consumer Directed Employer will provide notice to their employee.

Payment authorization to provider should be end dated according to the Payment Suspension section, unless a Good Cause Exception applies. When a fraud referral is made, terminate payment to the provider immediately and according to the Payment Suspension section, unless a Good Cause Exception applies, or client selects another CDE IP. Contact the provider about the termination and send written notice within five (5) days of the termination date on the authorization. Contact the client for care planning purposes and send a PAN.

- If the provider is an IP, the Consumer Directed Employer will provide notice to their employee

Documentation of Referral

The referring field staff must ensure the provider fraud referral is documented, including the date of referral, relevant facts, circumstances and any other information or supporting documentation.

- For a provider with one or only a few clients, such as an Individual Provider employed CDE, document the referral in the client(s)'s SER.
- For a provider with several clients, such as an agency provider, a notation in the provider's contract file must be added to document the date of referral, relevant facts, a summary of the circumstances, and any contract or monitoring action being considered. Add a Comment to the provider's Contractor Profile in ACD to summarize all actions taken.

FULL INVESTIGATION

Cases that are accepted by MFCU for investigation will be assigned to a MFCU Investigator, who may contact field staff to request cooperation and records related to the provider being investigated. An investigation will continue until the appropriate legal action is initiated, or the case is closed or dropped because of insufficient evidence to support the allegations of fraud or abuse. A matter may also be resolved between the agency and the provider through other means, such as a warning notice to the provider, assessing an overpayment, terminating the provider's contract, or other sanctions as appropriate.

HCS and AAA field staff and case management staff as well as HQ program staff will cooperate fully with the investigatory and prosecutorial activities of the MFCU to the extent allowed by law and rule. This includes providing access to records or information kept by the reporting agency as well as making records and/or reports available upon request. An example of records which may be requested include a copy of the provider contract and any documents signed by the provider at contracting indicating awareness of and willingness to comply with program policies.

Further, DSHS and its contractors will cooperate with Health Care Authority staff with regard to the prevention and detection of fraud, waste and abuse as outlined in the Cooperative Agreement between DSHS and HCA, and by extension through the Memorandum of Understanding between MFCU and HCA.

WHEN A REFERRAL IS NOT ACCEPTED BY MFCU

When a referral is screened out or declined by MFCU, field staff will receive notification from either HCS/DDA program staff or from MFCU staff directly. Field staff may then decide to resume payment to a provider for either the same client or a different client. For agency providers, this may mean that a previously imposed payment suspension in part would be ended. Before resuming payment or ending any payment suspension consider if a Character, Competence & Suitability Review is appropriate.

- For an agency provider, please reference Policy & Procedure Manual for AAA Operations, Chapter 6: Interlocal Agreements, Subcontracts and Grievances for guidance related to contract monitoring activities.
- Staff with case management supervisor to ensure awareness of prior referral activity.
- Document CCS results in provider's contract folder and add a Comment to the provider's Contractor Profile in ACD with the CCS results and any monitoring activities or report(s).
- CDE will perform CCS as appropriate for their employees.

CONTRACT TERMINATION

According to DSHS Central Contract and Legal Services (CCLS), termination of a contract for default means a contractor is not in compliance with the expectations or requirements of the contract. Requests for termination for default must be staffed with a supervisor, then submitted to the Contracts Unit for routing to CCLS who makes the final review and determination of default.

The reporting agency may determine that a provider's contract should be terminated as the result of the actions or activities that gave rise to the provider fraud referral. Please refer to information presented in other chapters of the LTC Manual regarding contract termination processes, such as Chapters 3 and 5, or AAA Policy and Procedure Manual, Chapter 6.

Contract terminations resulting from a Medicaid Provider Fraud Referral are an annual reporting requirement to HCA and CMS, so this information is collected on the Medicaid Provider Fraud Referral form as well as through follow up with case management staff by HQ program staff. Reporting agency staff should respond promptly to any inquiry made by HQ program staff about planned contract action following a provider fraud referral.

REPORTING CLIENT FRAUD

The Office of Fraud and Accountability (OFA), an office within DSHS, investigates Medicaid client fraud. MFCU and OFA may collaborate on investigations that may involve both a client and a provider. When an intake report, tip received, or investigation indicates that a client may have committed fraud involving Medicaid funds, suspected client fraud should be reported to OFA using the Fraud Early Detection (FRED) process through Barcode. Some DSHS staff may not have access to Barcode. If this is

the case, the referring worker should complete the DSHS 12-209 Client Fraud Report form and send via email to the correct email addresses listed above.

RESOURCES

Related WACs and RCWs

WAC 388-71-0540 – 388-71-0561	Home and Community Services and Programs
RCW 74.66	Medicaid Fraud False Claims Act
74.67	Medicaid Fraud Control Unit
9A.56.030	Theft, 1st degree
9A.56.020(b) (4) & (5)	Theft by Deceptions
CFR 42 CFR §455.2	Definitions
42 CFR §455.12- 42 CFR §455.17	Preliminary & Full Investigation Requirements
42 CFR §455.21	Cooperation with State Medicaid Fraud Control Units
42 CFR §455.23	Suspension of Payments and Good Cause Exception

Acronyms

AAA	Area Agency on Aging
ACA	Affordable Care Act
ACD	Agency Contracts Database
ALTSA	Aging and Long-Term Support Administration
APS	Adult Protection Services
CCLS	Central Contracts and Legal Services
CCS	Character, Competence and Suitability Review
CDE	Consumer Directed Employer entity.
CDWA	Consumer Direct Care Network of Washington, the contracted CDE entity
CMS	Centers for Medicare and Medicaid Services
DDA	Development Disabilities Administration
DPI	Division of Program Integrity within Health Care Authority
DSHS	Department of Social and Health Services
FRED	Fraud Early Detection with OFA
HCA	Health Care Authority
HQ	DSHS ALTSA & DDA Headquarters
LTC Manual	Long Term Care Manual
MFCU/MFCD	Medicaid Fraud Control Unit/Division
OFA	Office of Fraud and Accountability
PAN	Planned Action Notice
SER	Service Episode Record
The Department	Department of Social and Health Services

Glossary

For purposes of Medicaid Fraud, and according to 42 CFR 455.2, the following definitions apply:

WORD	DEFINITION
Abuse	(meaning for this term as it is used within this chapter and not as it applies to Adult Protective Services investigations) means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
Credible allegation of fraud	Is an allegation which has been verified by the reporting agency (see definition below), received from any source, such as complaints received or observations during case management. Other sources could be patterns identified through report review or provider audits, information resulting from civil cases, or law enforcement investigations. Allegations are considered to be credible when they have "indicia of reliability" (see definition below) and the reporting agency (see definition below) has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.
Fraud	Means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
Indicia of reliability	Are signs, indicators or circumstances, which tend to show or indicate that something is probable.
Reporting agency	Refers to DSHS (also referenced within this chapter as "the Department") or any contracted AAA entity. This could mean any HCS, DDA, or AAA office.
Waste	Is defined as any activity that uses resources but creates no value. While all fraud is waste, not all waste is fraud. Waste is inefficiency that may be, for example, a medically unnecessary service, inefficient delivery of care, inflated prices, or excess administrative costs.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
11/2/20225/22/2025	Cheryl Timmons	Updated language of Good Cause process and added language to include CDE providers	n/a
01/06/2025	Cheryl Timmons	Added language about overpayments, made some grammar changes.	

APPENDIX

- 12-210 Provider Fraud Referral Form,
- 12-209 Client Fraud Referral Form,
- FRED link in Barcode (screenshot),
- Provider Fraud Fact Sheet – November 2014
- H17-023 (Amended 5/22/2017)

Roads to Community Living

Washington State's Money Follows the Person Project

The Purpose of this chapter is to educate staff about Roads to Community Living (RCL), what benefits the program has offered to participants and to provide instruction on how to utilize the services through the close of the project.

Ask an Expert

If you have questions or need clarification about the content in this chapter, please contact:

Julie Cope — Project Director for Roads to Community Living
360.725.2529 julie.cope@dshs.wa.gov

If you have questions regarding RCL for HCS, please contact:

RCL General Inbox — DSHSALTSARCLReferrals@dshs.wa.gov

Rebecca Kaiser — R1 RCL Enrollment Specialist
564.669.1282 rebecca.kaiser@dshs.wa.gov

Amanda Speck — R2 RCL Enrollment Specialist
360.870.6309 amanda.speck@dshs.wa.gov

Desiree Vallejo — R3 RCL Enrollment Specialist 360.890.2910
360.890.2210 desiree.vallejo@dshs.wa.gov

Samantha Dunham — RCL Quality Improvement Specialist
509.309.9435 samantha.dunham@dshs.wa.gov

Cassie Pizano — Complex Transition Specialist
360.972.6384 cassie.pizano@dshs.wa.gov

Any questions regarding RCL for DDA can be directed to: ddarclenrollmentintake@dshs.wa.gov

Tom Farrow — DSHS DDA Transitional Care Unit Manager
360.628.1818 tom.farrow@dshs.wa.gov

Ron Bryan — DSHS DDA Quality Improvement Specialist
360.791.6713 ronald.bryan@dshs.wa.gov

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WHAT IS THE ROADS TO COMMUNITY LIVING PROGRAM?

Roads to Community Living (RCL) is a statewide demonstration project funded by a federal "Money Follows the Person (MFP)" grant. The grant was received by Washington State from the federal Centers for Medicare and Medicaid Services (CMS). The purpose of the RCL demonstration project was to investigate what services and supports will successfully help people with complex, long-term care needs transition from an institution to a community setting.

Services and supports from the RCL demonstration project have proven successful and are being used to shape changes to Washington State's long-term care system. This will result in more people with complex long-term care needs being able to remain independent or transition from institutional into community settings in Washington State.

The RCL demonstration project has received approval to extend new RCL enrollments through the end of **2027**; the last date for individuals to receive RCL services has also been extended through **12/31/2028.** All new ALTSA RCL participants will be enrolled and managed by ALTSA HQ. RCL enrollment procedures for DDA remain unchanged. ALL RCL participants must be disenrolled by **12/31/2028.** The grant will be closed out with all expenditures finalized, reconciled, and submitted to CMS by **09/30/2031**.

As part of sustainability planning, demonstration and supplemental services that have proven to be useful will be added to the state plan and/or waiver. Those supplemental or demonstration services with low or no utilization will be allowed to sunset with the program. This process has already started and will continue. The goal is to ensure a seamless transition in Home and Community Based Services (HCBS) available in existing state plan and waiver programs once RCL is no longer available.

WHO IS ELIGIBLE FOR THE RCL PROJECT?

The RCL demonstration project will transition the last individual onto RCL services on 12/31/2027. The last date for individuals to receive RCL services is 12/31/2028 therefore all RCL participants must be disenrolled by that date. For those RCL participants who may be re-institutionalized during their 365 day post transition demonstration period, they will be allowed to finish the remainder of their 365 day demonstration period on or before the 12/31/2028 project end date. The grant will be closed out with all expenditures finalized, reconciled and submitted to CMS by 09/30/2031.

Individuals eligible for RCL are:

- People of any age with a continuous, qualified stay of **60 days or longer** in a qualified institutional setting (hospital, nursing home, RHC/ICF-ID); OR
- Individuals in a psychiatric hospital with a continuous stay of **60 days or longer** who are under the age of 21, or 65 and older.

AND each of the following:

- Receiving Medicaid-paid inpatient services immediately prior to discharge, including most of the ACES N group, also known as MAGI (see exceptions below)

- Interested in moving to a qualified community setting which includes the following: In-Home, Adult Family Home (AFH), Assisted Living Facility (ALF), Adult Residential Care (ARC), and Enhanced Adult Residential Care (EARC);
- On the day of institutional transition to begin the 365 day demonstration year, RCL participants must be functionally and financially eligible for waiver or state plan services (or Fast Tracked).
    - Please note: Individuals may be fast-tracked into the program while institutionalized to allow them to access pre-transition services while pending financial eligibility. However, it's important to note that while participants can receive pre-transition services through the fast-track process, they must meet be financial eligibility for waiver or state plan services on the day of institutional transition.

Individuals who are not eligible for RCL are:

- Individuals in the L04, L24, N21 and N25 state funded non-citizens medical benefits
- Individuals eligible and transitioning into a designated Residential Support Waiver (RSW) care setting.
- Individuals eligible and transitioning into an Enhanced Adult Residential Care - Specialized Dementia Care Program (SDCP)
- Individuals enrolled in Program of All-Inclusive Care for the Elderly (PACE).
- Individuals must choose which program is most appropriate to meet their needs.

Residents of institutions of more than 16 beds which are primarily engaged in providing diagnosis and treatment of care to persons with behavioral health diagnoses aged 21-64 years may be excluded from enrollment onto the Roads to Community Living program. To confirm whether your client is eligible for RCL, please reach out to: DSHSALTSARCLReferrals@dshs.wa.gov.

How to request RCL Enrollment for a qualified individual

1. Create an email including the following client information:
    - Client name
    - Client ACES ID
    - Qualified institutional name and admission date
        - Individual may be enrolled early for RCL, when the institutional stay is expected to exceed 60 days

Any requests for transition planning support (if needed)

2. Send the email
    - For HCS clients send the email to DSHSALTSARCLReferrals@dshs.wa.gov
    - For DDA client send the email to ddarclenrollmentintake@dshs.wa.gov

After the RCL enrollment request is received and processed, an email reply will be sent with the RCL Participant form attached. The case manager provides a copy of this form to the client. HCS

Headquarters staff will submit the form to DMS *(Example of RCL participation form is located under the Resources section)*

HCS and DDA Headquarters staff will complete RCL enrollment procedures, including adding the RCL RAC.

WHAT SERVICES ARE OFFERED UNDER RCL?

Participants enrolled in this project have access to:

- All services currently available under the Medicaid State Plans: Medicaid Personal Care (MPC) and Community First Choice (CFC) and
- Home and Community Services (HCS) and Developmental Disability Administration (DDA) Medicaid waivers provided in in-home settings (such as COPES); and
- RCL demonstration project services; and
- RCL Supplemental Services.

RCL project services are only available to the participant while in the institutional setting and during the project demonstration year (365 days after leaving the facility and residing in a community setting).

All RCL project services must be authorized by HCS, Area Agency on Aging (AAA), or DDA case managers.

For DDA: If the person is exiting an RHC, contact the RCL liaison in the DDA region where the person would like to live to determine what services are available.

WHAT ADDITIONAL SERVICES ARE AVAILABLE THROUGH RCL FOR ALTSA CLIENTS?

In addition to qualified services that are also available through state plan and waiver services [e.g. personal care [Individual Provider (IP), CDWA, agency caregiver, Adult Family Home (AFH), and Assisted Living facility (ALF)], Nurse Delegation, Adult Day Health, etc.], the following services are available for RCL participants when indicated in the plan of care and authorized by the case manager. For those RCL participants who are on the Address Confidentiality Program, please refer to Chapter 3: Assessment and Care Planning for further information.

Client Training: Behavior Support Services: H2019

Behavior Support services are for participants transitioning from institutional to community settings or requiring stabilization while residing in the community in those instances where the authorized Medicaid benefit amount, duration or scope of service does not meet the individual's needs.

CARE Assessment Documentation for Client Training-Behavior Support:

- On the Treatments screen in CARE: Select Client Training/Waiver under the Rehab Restorative Training header.

- On the Treatments screen in CARE: Select Client Training/Waiver under the Rehab Restorative Training header.
- On the Pre-Transition and Sustainability screen found below the Client Details section in CARE, select the Sustainability Goals tab. From the drop down, select the goal description, and describe the goal of behavior support in the comments. This section helps the provider understand the specific reasons for the development of a behavior support plan.
- On the Care Plan Supports screen, assign Client Training to the behavior support provider.
- Send the chosen behavior support provider a copy of the Assessment Details, Service Plan, and Sustainability Goals.

The behavior support provider will **develop a behavior support plan** within 30 days of the client's assessment and provide this to the case manager. The behavior support plan will address things such as:

- Factors that are associated with an individual's documented or identified behaviors.
- Written strategy of behaviorally specific interventions designed to address those behaviors and promote optimal functioning with recommendations for improving the client's overall quality of life, teaching methods and environmental changes designed to decrease the behaviors that may be impacting the client remaining or transitioning to a community setting.
- Direct interventions with the client to decrease the behavior that compromises their ability to remain in the community. This could include demonstrating and practicing new interventions and skills with formal and informal supports and significant others to support the individual in their community setting.
- Case Consultation regarding escalating situations.
- Make recommendations for treatment and assisting with making referrals for community behavioral health services

Community Choice Guiding (CCG): SA263

Payment for specialty services which provide assistance and support to ensure the participant's successful transition to the community and/or maintenance of community living as authorized by HCS and/or AAA staff. CCG services may include, but are not limited to the following:

- Locating and arranging appropriate, accessible housing; including working with local housing authorities and other community resource providers when applicable. A CCG may assist a client with touring AFHs and ALs to determine whether this setting is preferred by the client.
- When relevant, liaising with and among the client, nursing or institutional facility staff, case managers, housing providers (including AFH providers), medical personnel, legal representatives, formal caregivers, family members, informal supports and any other involved party.
- Necessary assistance to support the client's community living, including assistance in settling disputes with landlord.
- Educating client on tenant rights, expectations, and responsibilities.
- Assisting client with filling out forms and obtaining needed documentation to aid in maintaining successful community living (forms may include initial and renewal voucher forms, lease agreements, etc.).
- Providing emergency assistance to avoid utility shut-off and/or eviction.

- Assisting client in developing a basic household budget.
- Assisting client with locating and arranging transportation resources to effectively connect with community resources.
- Assisting client to locate and engage in community integration activities.
- Training or education to client about accessing community settings or health services.
- Personal skill development for client and/or caregivers related to the individual's care plan (including adult family home providers).
- Training or education to client about accessing community settings or health services.
- Assisting to find a qualified caregiver. See additional information in Chapter 7d: COPES

Note: CCGs do not have access to Carina but can assist clients with other tasks related to locating a potential IP and guiding the potential IP to CDWA for hiring, when authorized by the case manager. The case manager should follow the steps detailed in MB H21-083. See additional information in Chapter 7d: COPES.

NOTE: Services such as pest eradication, janitorial services and packing/moving services must be performed by a contracted provider who holds the Community transition and Sustainability Services (CTSS) contract and paid directly via ProviderOne. Authorizing a CCG to perform the CTSS scope of work is prohibited. HCS may consider using the HQ managed purchasing card when there is CTSS contracted provider capacity concerns. Further instructions on HCS use of the HQ purchasing card can be found in Chapter 10: Nursing Facility Case Management and Relocation

Community Choice Guide Issuing a Payment/Shopping: Client not Present SA266

Based on a client's eligibility:

- Shopping for necessary household goods/items or paying for rental deposits (to include first month rent), utility hookup fees, or rent/emergency rental assistance service when no client is present. **This shopping/paying code will rarely be authorized without the accompanying SA263 CCG Services code.**
    - This service assists clients transitioning out of institutions or when needed to stabilize a client's community living.
- This service code is to compensate the provider for the time spent shopping/paying when no client is present.
    - The provider is also reimbursed for the authorized purchases after it is verified the client received the goods or service. Authorization for the item/service is under a separate service code and case managers will process the reimbursement(s) for these one-time goods and services supports to the CCG as timely as possible. This reimbursement should not exceed 30 days after the CCG has provided an invoice/receipt as proof of the purchase.

- If the client is present or the CCG performs other CCG tasks related to payment/shopping to complete the payment/shopping , SA263 Community Choice Guide should be authorized. An example may include delivering the items and setting them up at the client's home.

Note: See Resources section for the Community Choice Guide Activity Tracking and Shopping/Paying Tracking forms. For more information on how to authorize CCG services please refer to the CCG Services SharePoint
For more information and guidance related to CCG services and authorization steps, please review Chapter 7d - COPES.

Community Transition Services- Items: SA296

Items may include, but are not limited to:

- Goods necessary to establish a residence such as essential household items and furnishings.
- Goods needed to help stabilize community living for a client.
- This service code can be utilized at any time during the enrollment and transition period for community transition goods as identified in the CARE plan.
  - For AFH Settings reference WAC 388-76-10685, and for Assisted Living Settings reference WAC 388-78A-3011 which outline resident unit furnishings in these settings. In the event a residential setting indicates they are unable to provide the required furnishings as outlined in WAC, notify the provider of their requirements as outlined in WAC, and also submit a referral to Residential Care Services (RCS) Complaint Resolution Unit (CRU) to document the provider's inability to meet residential unit furnishings per WAC. Referrals can be made online Residential Care Services Online Incident Reporting | DSHS (wa.gov) or via phone at 1-800-562-6078.

NOTE: Community Transition Services – Items (SA296) does not permit payment of tips. With online orders/pickups, some companies have added an automatic tip to the overall total of the transaction. This cannot be reimbursed using Community Transition Services-Items. If the automatic tip cannot be removed from the transaction total, shopping at these companies should be avoided altogether.

Paying a money order/casher's check fee as part of a move-in cost (payment of first month's rent/deposit) is allowable.

Community Transition Services: SA297

Services include:

- Packing assistance
- Moving assistance
- Utility set up fees or deposits
- Non-recurring health and safety assurances such as pest eradication, allergen control and/or one time cleaning.
- Rental deposits (all pre-tenancy funds required can be bundled as one deposit, staying within the service code limit)

- Non-recurring rental insurance

NOTE: Services such as pest eradication, janitorial services and packing/moving services must be performed by a contracted provider who holds the Community transition and Sustainability Services (CTSS) contract and paid directly via ProviderOne. Authorizing a CCG to perform the CTSS scope of work is prohibited. HCS may consider using the HQ managed purchasing card when there is CTSS contracted provider capacity concerns. Further instructions on HCS use of the HQ purchasing card can be found in Chapter 10: Nursing Facility Case Management and Relocation

RCL Supplemental Goods & Services: SA295

For services and supports after the client transitions out of an approved institutional setting which supports community living, use the SA295 service code. This service code can be used for the purchase of necessary one-time goods or services where the authorized Medicaid scope of service does not meet the client's needs. This service code should also be used to reimburse a CCG for Trial Visits. Excluded are rental subsidies.

NOTE: A contract is not required if another payment mechanism is utilized.
Options include:

- Using a client services HCS P-Card (state issued credit card available to HCS HQ staff); or
- Authorizing a contracted provider to pay for rental deposits and community living set-up fees directly and be reimbursed (such as a CCG).

Unit compensation to the contracted provider for issuing payment does not count towards the funding limits of SA295, SA296, and SA297.

Short-Term Rental Assistance

This supplemental service will cover up to 6 months of short-term rental assistance and associated utility expenses to bridge the gap between transition to the community and when federal, state, or local housing assistance is secured.

To access this resource, case managers will need to utilize the established process for the ALTSA Bridge Subsidy as outlined in Chapter 6a: ALTSA Subsidies & GOSH Services.

Emergency Rental Assistance: SA298

ERA is a one-time payment made directly to landlords on behalf of a client who is facing an immediate eviction due to non-payment of rent. As part of the assistance request, clients must demonstrate they are able to pay their rent going forward and maintain their independent housing as a part of their community setting stabilization. This resource should only be requested when there are no other community options to fully or partially meet the need. Please Reference Chapter 6b: Interim Housing

Resources (Motel Interim Stay for Transitions & Emergency Rental Assistance) for additional Housing Resource policy information.

ERA does not include pre-tenancy deposits or move-in costs, including first month's rent, required at move in. There are other resources that may cover these one-time expenses (e.g., service code SA297).

Motel Interim Stay for Transitions

The Motel Interim Stay for Transitions (MIST) is a service to pay for a short-term motel/hotel stay offered to minimize the number of voucher/subsidy holding clients who discharge to and/or experience episodes of homelessness while in housing search. MIST aims to minimize the time it takes to get vital LTSS in place and increase the client's chances of ending up on services in their own home. The service is authorized for a 6-month period at a time. MIST currently cannot be offered to clients who do not have a housing subsidy/voucher in hand to utilize. Please Reference Chapter 6b: Interim Housing Resources (Motel Interim Stay for Transitions & Emergency Rental Assistance) for additional Housing Resource policy information.

Environmental Modifications- In Home: S5165 UA

Minor physical adaptations to an RCL participant's in home setting as authorized in the plan of care to increase health, welfare and safety and provide greater independence. Must be of direct medical or remedial benefit to the participant, including but not limited to:

- Installation of ramps and grab bars
- Widening of doorways
- Modification of bathroom facilities
- Installation of specialized electric or plumbing systems.
- Installation of Assistive Devices

Excluded are adaptations or improvements that are of general utility and are not of direct benefit to the individual (e.g., carpeting, roof repair, central air conditioning, etc.). See General Utility modifications for more information. Adaptations which add to the total square footage are also excluded.

Note: The Housing Modification Property Release Agreement (Form 27-147) is required for Environmental Modifications completed in residences which are not owned by the client. For more information see Chapter 7d: COPES.

Environmental Modifications- Residential: S5165 UB

Minor physical adaptations to an RCL residential setting as authorized in a participant's plan of care to increase health, welfare and safety and provide greater independence. Must be of direct medical or remedial benefit to the participant, including but not limited to:

- Installation of ramps and grab bars
- Widening of doorways

- Modification of bathroom facilities
- Installation of specialized electric or plumbing systems.
- Excluded are adaptations or improvements that are of general utility and are not of direct benefit to the individual (e.g., carpeting, roof repair, central air conditioning, etc.). See General Utility modifications for more information. Adaptations which add to the total square footage are also excluded.

Environmental Modifications- General Utility Allowance: S5165 U3

Minor general utility adaptations to an RCL resident's home as authorized in a participant's plan of care to increase health, welfare and safety and provide greater independence. Must be of direct medical or remedial benefit to the participant, including but not limited to:

- replacing hot water heaters
- minor roof repairs
- repair of drywall
- Repairs to specialized electric or plumbing systems.

Note: The In home Environmental Adaptations General Utility and Repair Property Release Agreement (Form 27-147A) is required for clients who own their home or reside in a family owned home.

Assistive Technology (Non-CFC): SA075 U2

AT Goods and AT Services must be:

1. In response to an assessed and documented need in the Client's assessment and agreed to by the Client;
2. Authorized by the case manager to be implemented as part of and in accordance with a Client's service plan;
3. Within the coverage and any specific parameters of the Client's eligible program; and
4. A one-time AT Good or AT Service (not ongoing) that is not covered by Medicare, Apple Health, other insurances or resources.

AT Goods, including assistive equipment, are adaptive/assistive devices/items that increases a client's independence or substitutes for human assistance with an ADL, IADL, or health-related task.

The list of RCL AT covered goods is in alignment with the CFC AT Covered Item List and is updated in the CFC Chapter of the Long Term Care Manual (Chapter 7b). Further details, to include how to find and AT contracted provider, and limitations regarding this service, are located in the CFC Chapter.

Technology Support Consultation and Technical Assistance: H2014 U9

Technology Support Consultation and Technical Assistance services are for participants transitioning from an institutional stay to a community setting. Individuals statewide who want to transition to a

community setting will have access to receiving Technology Consultation and Technical Assistance along with their Assistive Technology (AT) benefit.

Technology Support Consultation will identify AT that could provide solutions to potential barriers to discharge. The Assistive Technology Provider (ATP) will evaluate the client's environment and abilities and make referrals for appropriate assisted technology to the case manager. The use of Assisted Technology will support client with ADL's and or IADL's to help client's community setting be more sustainable.

The participant will receive training and Technical Assistance from the ATP to support transition from the institutional setting to their community setting to ensure that they can use they AT to meet their needs.

To capture this in CARE, choose Other in the Treatments screen, indicate Assistive Technology Supports in the comments and assign to the Technology Support Services Provider in the Supports table.

The Technology Provider will **develop a technology support plan during the consultation with client** and provide this to the case manager. The Assistive Technology Provider address things such as:

- Assessment of technology support environment and skill building strategies
- Technology support planning
- Recommendations for maximizing existing technology and incorporating additional technology resources to increase access, engagement, and utilization of assistive technology.
- Case consultation with case managers as well as client and formal or informal caregivers
- Coordinating the purchasing of Assistive Technology
- Installation of Assistive Technology devices and equipment
- Education and training on incorporating technology use directly with the client
- Education and training to DSHS staff regarding assistive device utilization, digital literacy, and functional limitation concerns
- Assistance considers site-specific circumstances and culture

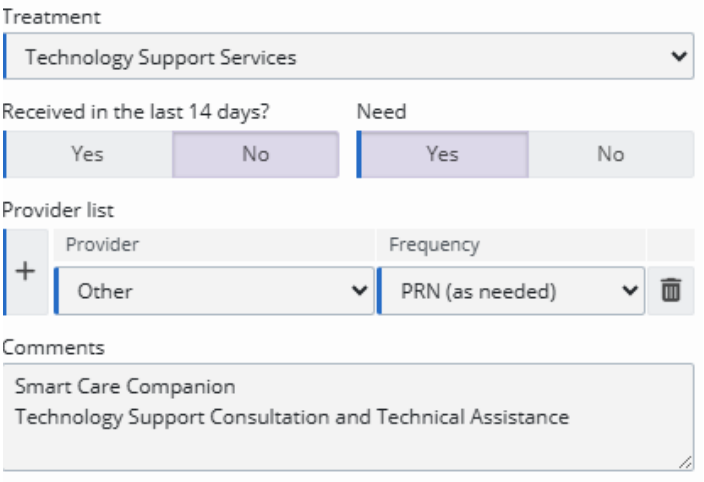
For additional resources please see the NFCM Workspace or Transition Academy HCS SharePoint sites.

Smart Care Companion: SA077_U2

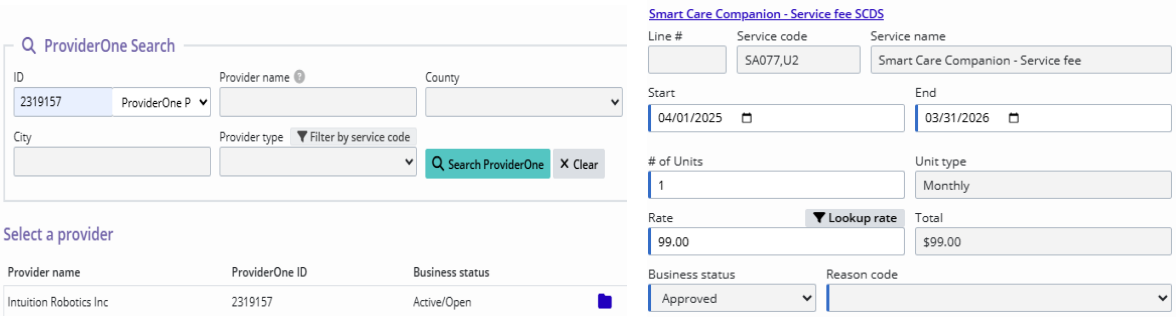
The Smart Care Companion service is a remote support service device that interacts and engages with a client to provide support through proactive suggestions, cuing and reminders for ADL &/or IADL tasks or health-related activities, and accessing their community.

The Smart Care Companion service is available to clients receiving in-home care services on the Roads to Community Living (RCL) program.

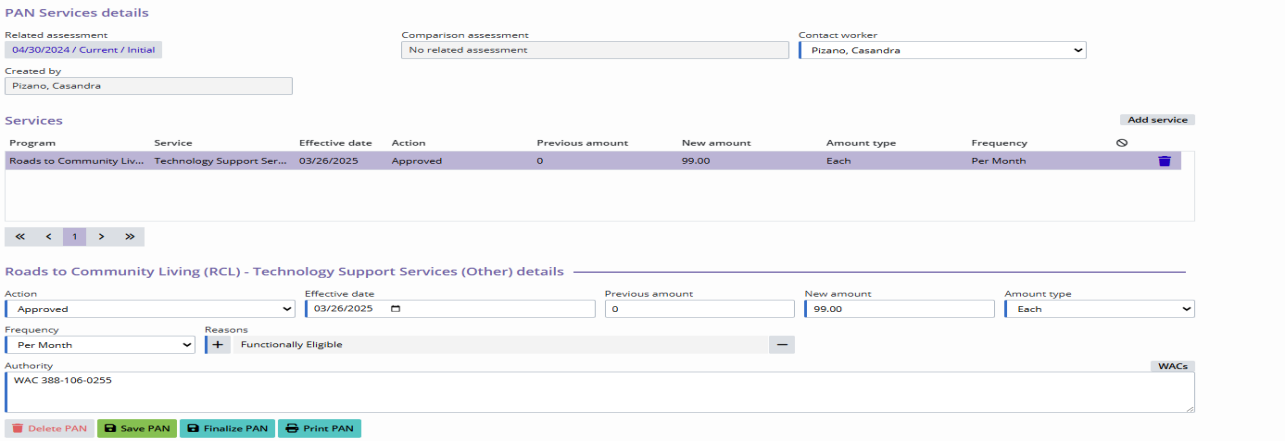
1. To make referral for ElliQ Smart Care Companion, go to the ElliQ DSHS Landing Page to complete provider designation form. Once submitted a confirmation email will be sent to case manager email prompting Provider One Authorization.
2. Under Treatments, choose "Technology Support Services" under programs. In the Provider field, choose "Other". Include a short comment noting Smart Care Companion, and Technology Support Consultations and Technical Assistance, if applicable.



3. Update Provider one authorization in CARE to include rate and frequency of service.



4. Complete PAN indicating Roads to Community Living (RCL) as program. In the service field choose Other HCS Services indicating Technology Support Services as the name of service.



- **Note:** Planned Action Notices (PAN) must be completed and provided to the participant and their representative when ALTSA makes a decision regarding eligibility, service, or denial/termination of a provider. The PAN includes information regarding the planned action and appeal rights.

For additional resources please see the NFCM Workspace or Transition Academy HCS SharePoint sites.

Other services available under Roads to Community Living:

- Durable Medical Equipment (See Blanket code lists)
- Spec. Medical Equipment Service/repair: K0739
- Non-Medical Equipment and Supplies: SA421
- Client Training Medical: H2014-UC
- Client Training Non-Medical: H2014-UD
- Non-Medical Transportation: T2003
- Technical Assistance: S5115-U6
- Wellness Education SA080
- Home Delivered Meals: S5170
- Pantry Stocking: SA420 U1
- Personal Emergency Response System (PERS):

PERS Service Codes	P1 Code
PERS Installation Fee	S5160
PERS standard/basic unit	S5161
- Fall Detection add-on service (AT) to PERS standard/basic unit	S5161 – U1
- GPS add-on service (AT) to PERS standard/basic unit	S5161 – U2
- Medication Mgmt System add-on (AT) to PERS standard/basic unit	S5161 – U3

When in doubt, send questions and concerns to:

HCS: DSHSALTSARCLReferrals@dshs.wa.gov

DDA: ddarclenrollmentintake@dshs.wa.gov

HQ RCL Staff are happy to help!

Are all the RCL services available anywhere in the State of Washington?

Some services may be limited according to regional contracted provider availability. One of the goals of the RCL demonstration project is to help identify and expand contracted provider capacity and resource availability when the services and supports meet the RCL demonstration project criteria.

*If there is a specific client need for a contracted service provider that does not exist in their local area, notify the associated Area Agency on Aging contracts management and the HCS Resource Support and Development teams of this need.

Where may individuals receive services under RCL?

Places where individuals may receive services during the RCL 365 day post transition demonstration period are called qualified community settings. Qualified community settings under RCL include:

- The individual's owned or leased home or apartment (including Supported Living when the client holds the lease)
- A home or apartment owned or leased by the participant's family; or
- Adult Family Home (AFH), Assisted Living Facility (ALF), Adult Residential Care (ARC), and Enhanced Adult Residential Care (EARC).

Authorizing RCL services for HCS clients

Once the HCS individual is enrolled in RCL on the RCL Enroll/Disenroll screen, the case worker may authorize pre-transition services while the participant is a resident in the qualified institutional setting:

1. Have the individual or their representative complete the Consent for Services (DSHS 14-012) form, Acknowledgement of Services (DSHS 14-225) form, and Rights and Responsibilities (DSHS 16-172) Form assisting as necessary.
2. Document in the CARE assessment, a SER and/or the Sustainability Goals screen in CARE the service(s) being authorized, and/or the items to be purchased,
3. Following all procedures in the Social Services Authorization Manual, authorize necessary services. List all RCL services on the appropriate screen(s) in CARE. For example, if an individual is authorized RCL Client Training: Behavior Support services, "Client Training/Waiver" should be included in the Treatment screen, choosing the appropriate provider type and frequency on the Provider List. In the "Supports" screen connect this treatment to contracted Professional Support provider as a paid task.

For RCL services that do not have a distinct treatment, follow this guide as to which treatments to choose:

RCL Service	Treatment Screen

Community Choice Guiding	Community Integration
Community Transition Goods or Items (including One Time Pantry Stocking)	Community Transitions Goods or Items
Community Transition Services	Community Transition Services
Client Training: Behavior Support	Client Training/Waiver
Non-Medical Transportation	Non-medical transportation
Technology Support Consultation & Technical Assistance	Technology Support Services
Short Term Rental Assistance (to include MIST and ERA)	Housing Subsidy

When the participant is approaching a transition date from a qualified institution:

1. Complete the CARE assessment including all transition services authorized and move it to current. Reminder: an assessment can be moved to Current status with any authorized paid service. Many RCL participants receive a variety of services to support transition planning and these are authorized prior to personal care starting.
2. Ensure all services and identified equipment are delivered and in place at the time of transition.
3. Send care planning documentation to the participant and any individuals involved in care planning, as necessary, per instructions in Chapter 3: Assessment and Care Planning.
4. Follow instructions as outlined in the LTC Manual to obtain approval on the plan of care, send all required documents/forms to the individual/representatives and providers, and complete required documentation of these activities.

Tip: As a best practice, it is helpful for the individual to visit their new setting prior to transition to determine if additional supports or services will be needed. Additional equipment may be identified, or it could be as simple as rearranging items for easier access to prevent falls.

For example, if a person is returning to their own home after a hip replacement, they may need items in the kitchen moved to a new place so they can reach them without falling when they are home alone (for example, pots and pans that are kept in a low cabinet may need to be relocated). This could include a home evaluation by OT/PT or a home visit with a CCG or other contracted provider.

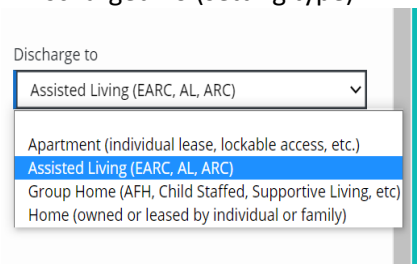
Upon confirmation of participant's transition from the institution:

Update the following fields on the RCL Enroll/Disenroll screen in CARE:

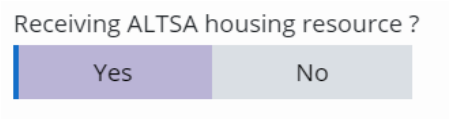
1. Enter the discharge date in the "Actual discharge date" field (this must match with the discharge date on the NFCM/Acute Care hospital/State hospital screen).
    - Please note: The individual's 365 day demonstration year clock does not begin until this field is complete.

2. The "Projected end date" field will populate with an auto calculated RCL year-end date,

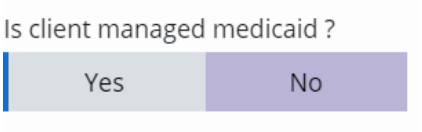
3. Discharged To (setting type).



4. Indicate whether or not the participant is receiving ALTSA Housing resources as part of their transition plan
    - *Review LTC Manual* Chapter 6a-d: Housing Resources for ALTSA Clients *for more information regarding ALTSA Housing resources*



5. Indicate whether or not the participant is receiving managed Medicaid services (N series or enrolled with a Managed Care plan for apple health benefits).
    - *Review LTC Manual* Chapter 22: Managed Care *for more information regarding managed Medicaid services*



6. Create a new entry on the Residence screen with updated address information.

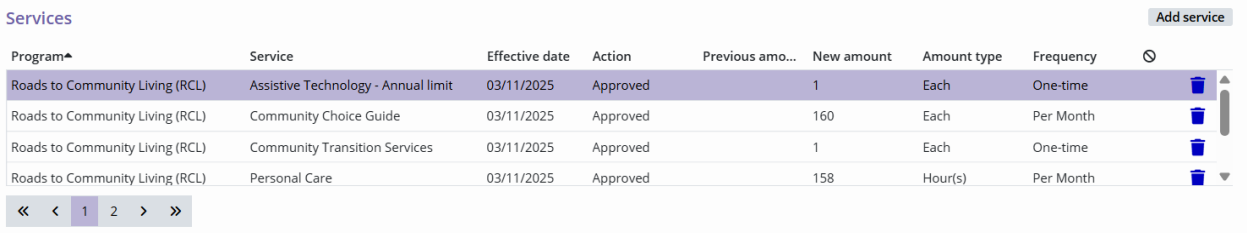
7. On the Care Plan screen, ensure "Roads to Community Living" is the selected program in the "Client chosen program" field.

8. Update the RCL RAC end date. Ensure the RCL RAC end date matches the "Projected end date" field date from the RCL Enroll/Disenroll screen

9. Using the DSHS 14-443 form, notify the Public Benefits Specialist of the discharge date from the nursing facility/acute care hospital/psychiatric hospital and complete the RCL portions. The RCL start date is the date of discharge and the RCL end date is the projected end date as indicated on the RCL Enroll/disenroll screen. (Reminder the RCL 365 day end date needs to match the RCL RAC end date).
    - **Note:** For Managed Medicaid participants the RCL Demonstration period is documented in the client tab in Barcode under Customer Information Notes. See Chapter 10: Nursing Facility Case Management and Relocation for more information about the NFLOC screen in ProviderOne.

Important note: The case worker should closely monitor all financial letters during the 365 day RCL demonstration period. If the participant receives a termination letter, contact the financial worker immediately. *Eligibility should not be terminated due to changes in functional or financial status.* ***Participants who were eligible for RCL at discharge are eligible for RCL until the end of their 365 day demonstration service year regardless of change in functional or financial status.***

10. Create the authorization(s) and send a Planned Action Notice
    - **Note:** Planned Action Notices (PAN) must be completed and provided to the participant and/or their representative when ALTSA makes a decision regarding eligibility, service, or denial/termination of a provider. The PAN includes information regarding the planned action and appeal rights.



11. As a best practice, it is highly recommended to schedule a joint case staffing between the case worker and AAA/Residential Care Case Manager to facilitate a smooth transition.

12. Transfer the case to the AAA or Residential Care Case Manager per local policy. Refer to existing Case Transfer Guidelines in Chapter 5 of the LTC Manual. Make sure to note on the Case Transfer form that the individual is an RCL participant and include the projected end date of their 365 day demonstration year as detailed on the RCL Enroll/Disenroll screen and as indicated on the RCL RAC screen.

When in doubt, send questions and concerns to:
HCS: DSHSALTSARCLReferrals@dshs.wa.gov
DDA: ddarclenrollmentintake@dshs.wa.gov
HQ RCL Staff are happy to help!

AUTHORIZING RCL SERVICES FOR INDIVIDUALS ENROLLED IN DDA

While the person is still in the DDA institutional facility, the CRM shall:

- Send enrollment referral to DDARCLEnrollmentIntake@dshs.wa.gov

When the participant is approaching discharge from the facility, the DDA CRM shall:

- Complete the DDA assessment.
- Following all CARE notification protocols, distribute necessary assessment related documents (PAN, Service Summary, etc.).
- Notify the financial worker that the individual is an RCL participant on the RCL version of the DSHS 15-345 in Barcode and include the following:
  a) The date of discharge from the institutional setting onto RCL services.
  b) The setting that RCL services will take place (in-home, AFH, etc.).
  c) The new address.
  d) A request to complete the Authorized Representative (AREP) screen in ACES per normal procedures so the CRM can receive the financial letters.
  e) A request that the financial worker open a waiver program in ACES.

Upon confirmation of the participant's transition from the institution:

Update the following fields on the RCL Enroll/ Disenroll screen in CARE:

- Actual Discharge Date (this must also be updated on the NFCM screen if discharging from a nursing facility).
  - Please note: The individual is not considered to be on their 365 day demonstration period until this field is complete.
- Discharged To (setting type).
- Indicate whether or not the participant is receiving an ALTSA housing resource.
  - See Chapter 6a-d for more information regarding ALTSA Housing Resources.

- Indicate if the participant is managed Medicaid (check in ACES if you are unsure).
- Update the Contact Details screen with the current address information.

Update the end date for the RCL RAC. The RCL end date is the Projected End Date listed on the RCL Enroll Disenroll screen which populates once the discharge date is entered.

Important note: The HCS/DDA case worker should closely monitor all financial letters during the 365 day RCL demonstration period. If the participant receives a termination letter, contact the financial worker immediately. *Eligibility should not be terminated due to changes in functional or financial status.* ***Participants who were eligible for RCL at discharge are eligible for RCL until the end of their 365 day demonstration service year regardless of change in functional or financial status.***

How much may I spend on RCL services?

RCL services can only be authorized for a **MAXIMUM of 365** days following discharge from an institutional setting. Services may be used during the demonstration year and are intended to be intensive, if needed, at the beginning of transition, and to lessen over time. Case managers must also plan for services which are necessary for maintenance of community living after the end of the 365 day period. You can find the RCL end date by checking the "Projected End Date" field on the RCL Enroll/Disenroll screen in CARE. This field auto-populates based upon the discharge date entered.

Since one of the goals of the project is to promote flexibility and develop individualized and person-centered transition plans, spending guidelines **are dependent on the participant's circumstances and needs**. (The DDA Assessment and rates calculator will be used to determine the funding available for individuals enrolled in RCL through DDA.)

When utilizing RCL Services:

- Document in the CARE Assessment, a SER or the Sustainability Goals screen:
  - How the services or supports being authorized are of direct benefit to the participant's successful transition and community living.
  - Ensure services authorized are consistent with needs identified in the CARE assessment.
  - The process followed that demonstrates that any equipment purchased is in addition to that supplied by Medicare/Medicaid and does not replace it.

Follow all purchasing protocols as instructed by headquarters. Note:

- Receipts for all purchases must be included in the participant's electronic case record (ECR). Attach all receipts/bids to the Social Services Invoice/Receipt Packet Cover (02-615).
- The case manager must verify the participant received the goods purchased. This can be done by having the contracted provider, like a Community Choice Guide (CCG) verify or by contacting the client directly. The case manager must document the receipt of goods in a SER.
- Services can be reauthorized at the end of the Maximum Length of Service included on the Service Code Data Sheet.

- For example, if additional services are needed after authorizing Client Training: Behavior Support services for a three month period of time, three additional months may be authorized.

- Service maximums are cumulative for each service *per occurrence*. For example, if the service limit for a given code is $5000, all the goods purchased over the maximum length of service per the Service Code Data Sheet cannot total more than $5000 without an ETR during a transition. If the service is needed at a later date due to a different event, the service may be authorized again with the service limit available. See Service Code Data sheets for detailed information.

ETR Considerations Personal Care:

HQ ETRs will only be used for additional necessary personal care hours or daily residential rate.

Community Transition or Sustainability Services:

If authorizations for a necessary service/item exceed the maximum amount allowable, you must complete a local ETR prior to exceeding the maximum limit. Each region will use their local ETR process for RCL services.

Bathroom Equipment:

Follow all procedures to request bathroom equipment through the ETR process as outlined in the Social Services Authorization Manual. Please reference bathroom equipment ETR protocol in Ch 7d: COPES.

Chapter 3: Assessment and Care Planning has detailed information on the Exception to Rule (ETR) Process.

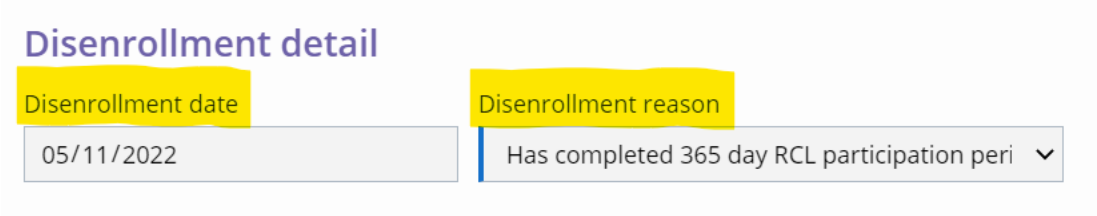
ACTIONS FOR HCS, AAA AND DDA TO PREPARE FOR THE END OF THE RCL 365 DAY SERVICE PERIOD

Approximately 30-60 days prior to the end of the individual's 365 day service year, the CM/CRM/CNC should check in with the RCL participant and ensure the client continues to be stable in their community setting. This is an important period of time to determine if the client is in need of any of the RCL package of services prior to the demonstration year ending. Does the client require an updated assessment? If so, follow usual assessment procedures. Ensure that any necessary steps are taken in order for the participant to maintain successful community living, including an evaluation of functional and financial program eligibility for services after the participant's 365 day demonstration period has expired.

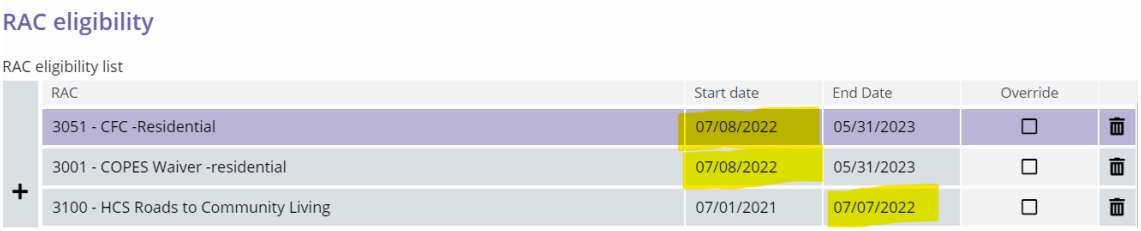
NOTE: The assessment may be moved to Current prior to the end of the 365 day demonstration period. However, in order to maximize the enhanced match received for RCL services, end date the RCL RAC to match the Projected End Date on the RCL Enroll/Disenroll screen and open the new RAC identifying the on-going service program(s) starting the day after the RCL Projected End Date. The RCL RAC should be assigned for the maximum length of time based on the Projected End date which considers any disenrollments and re-enrollments which pushed the Projected End Date out beyond the original 365 days (you can use a custom tickler as a reminder to change the RAC at the appropriate time). When ending the RCL RAC and starting the on-going program(s) RAC mid-month, this action may require modifying/splitting of the service payment line, please review P1 Social Services Manual for procedure steps.

At the conclusion of the participant's 365 day demonstration period, the CM/CRM:

1. Adds the Disenrollment Date to the RCL Enroll/Disenroll screen in CARE.
2. Indicates "Has completed 365 day RCL participation period" as the Disenrollment Reason in CARE



3. Amends the end date of the RCL RAC (HCS 3100 or DDA 3701) and adds the on-going applicable state plan/waiver HCBS RAC the individual is eligible to receive based on functional and financial eligibility (see **Note** above).



4. Follow instructions as outlined in Chapter 3: Assessment and Care Planning to obtain approval of the plan of care, send all required documents/forms to the individual, representatives and providers (including PANs), and complete required documentation of these activities.

5. For Classic Medicaid participants, Notify the PBS on a DSHS 14-443 (for HCS/AAA) or a DSHS 15-345 (for DDA) in Barcode and include:
   a) The date of the disenrollment from RCL services.
   b) The program the participant is functionally eligible for (state plan/Medicaid waiver), and this program start date.
   c) The setting of the services (in-home, AFH, etc.).

d) Update the address, if necessary.

For individuals who are managed Medicaid and enrolled with a Managed Care Plan (also known as the MAGI, ABP or MCS group), additional steps must occur as part of transition planning for the end of the RCL 365 day service period.

- 90 days prior to the end of the 365 day demonstration year, begin pursuing a disability determination, if enrolling the individual onto a waiver program (i.e., COPES, New Freedom, Basic +, Core, Community Protection, or CIIBS) or prepare to transition the client to ABP-CFC only.
- 60 days prior to the end of the 365 day demonstration year: If the RCL client is utilizing waiver services or is wishing to access Waiver services after RCL expires, assist the client with submitting a LTSS application for a financial determination of waiver services (i.e., COPES, New Freedom, Basic +, Core, Community Protection, or CIIBS).
- 30 days prior to the end of the 365-day service period, the case worker should review eligibility status with the Public Benefits Specialist.

Public Benefits Specialists must follow instructions as outlined in the *Apple Health Medicaid Manual*.

When in doubt, send questions and concerns to:
HCS: DSHSALTSARCLReferrals@dshs.wa.gov
DDA: ddarclenrollmentintake@dshs.wa.gov
HQ RCL Staff are happy to help!

WHAT ARE THE CASE WORKER'S RESPONSIBILITIES WITH THE RCL PROGRAM?

HCS/AAA: Once a participant is enrolled in the RCL program, the case worker provides primary case management, including the authorization of RCL services.

DDA: The designated CRM and regional RCL liaison will continue to work collaboratively throughout the duration of the grant process. The assigned CRM will assume primary responsibility for requesting waiver approval and authorizing waiver services for eligible individuals at the end of the first year of grant participation.

How often do I need to assess the participant?

As outlined in Chapter 3: Assessment and Care Planning, the CM/CRM/CNC will use professional discretion to determine if an updated assessment is needed during the course of the client's 365 day RCL service year. The Annual assessment will likely be completed within the RCL service year and likely will not correspond with the RCL end date. RCL will remain in place until the end date as indicated on the RCL Enroll/Disenroll screen in CARE. A general check in with the client within 60 days prior to the end of the RCL 365 day service year is recommended to plan for the transition onto waiver or state plan services when the RCL services end. *See **Actions for HCS, AAA and DDA to prepare for the end of the RCL 365 day service period** section for more information.*

If a participant is re-admitted into an institutional setting:

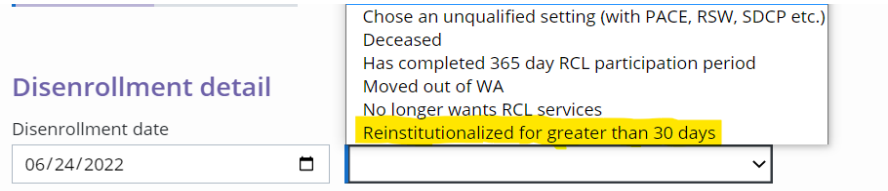
For nursing facility admissions, follow all protocols in the Ch 10 Nursing Facility Case Management and Relocation chapter (making sure to update the NFCM screen in CARE with the admit date and facility name).

For other institutional admissions (acute care hospital, State Psychiatric Hospital etc.) please note the following:

- For an institutional stay less than 30 days, do not disenroll the participant (the RCL 365 day service period continues uninterrupted) and do not end date the RCL RAC.
    - Keep services which will support the RCL enrollee's return to the community in place. This could include Community Choice Guide services and Client Training Services.
- For an institutional stay greater than 30 days, the participant must be disenrolled in CARE following all disenrollment procedures:

a) Record the Disenrollment Date and Reason

i. The Disenrollment Date is the date of re-admission to the institution once the stay has extended beyond 30 days (backdating to accurately reflect the readmission date is acceptable).



ii. Choose "Reinstitutionalized for greater than 30 days" in the Disenrollment Reason field of the RCL Enroll/ Disenroll screen in CARE.

iii. Choose from the drop down the reason the participant was reinstitutionalized.

b) A client can be immediately re-enrolled to access RCL services to support their transition and return to the community. This will ensure the client can access the remainder of their RCL demonstration period. The RCL RAC can be extended to reflect the ongoing RCL services which will support this transition.

When in doubt, send questions and concerns to:

HCS: DSHSALTSARCLReferrals@dshs.wa.gov

DDA: ddarclenrollmentintake@dshs.wa.gov

HQ RCL Staff are happy to help!

What is the procedure for RCL participants who have received services but who choose not to receive personal care services in the community?

In order for participants to remain on the RCL program for the full 365 days post institutional transition, they must accept an RCL paid service from the RCL community transition and sustainability package of services. For those participants who choose to decline all paid services in addition to declining personal care services, follow the Termination of Services guidelines and procedures as outlined in Chapter 5: Case Management. In addition, update the RCL screen to formally disenroll the participant from RCL on the RCL Enroll/Disenroll screen in CARE following all disenrollment procedures.

Can RCL participants choose not to participate in the RCL project?

HCS/AAA: Yes. When a participant or their representative wants to withdraw from the RCL project, work with the participant to resolve issues, if possible. If the participant still wishes to disenroll in RCL but wants to continue to receive state plan or waiver services, a CARE assessment and financial eligibility determination must be completed to establish the participant's eligibility for the appropriate Medicaid waiver or state plan program.

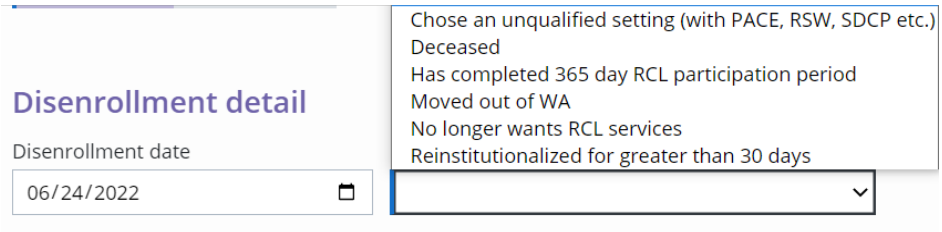
DDA: Yes. If a participant wishes to withdraw from the project, they may return to an RHC that has a vacancy. The participant may request to return to the same living unit if it is available.

RCL services for all participants must end by day 366 (on or before day 365). At that time, they must be transitioned to the waiver or state plan services available to them based on their financial and functional eligibility.

How do I disenroll an RCL participant?

An RCL participant is an individual who moved out of an institution on the RCL program and started their 365 day demonstration year. An RCL participant must be disenrolled when they:

a. Reach the end of their RCL 365 day participation period
b. Return to an institution for longer than 30 days (they can be immediately re-enrolled to utilize the days remaining in their 365 day service year upon next transition)
c. Move out of state (an RCL participant moving to a state with an MFP grant may be eligible to enroll in that state's MFP program. Click here for a current list of MFP states/Project Directors.)
d. No longer want the service(s)
e. Deceased



1. Enter the Disenrollment Date on the RCL Disenroll screen in CARE
   a) For participants who returned to an institution for greater than 30 days, use the admission date (backdate)
   b) For participants who died while on RCL, use the date of death
   c) For participants who reach the end of their service year, the date should not extend beyond the 365 days of RCL eligibility. (The day of discharge is Day 1; the disenrollment date must be on or before the "Projected End Date" on the RCL Enroll/Disenroll screen in CARE.)
2. End date the RCL RAC and select the applicable Medicaid waiver or state plan RAC based on the individual's functional and financial eligibility (no payment correction is necessary if the individual discharged onto the RCL program and was receiving RCL services).
3. Send the participant a Planned Action Notice updated with approved on-going program(s).
4. Notify the Public Benefits Specialist using Form 14-443 (HCS/AAA) or a DSHS 15-345 (DDA) in Barcode and include:
   a) The date of the disenrollment from RCL services.
   b) Which program the participant is functionally eligible for (state plan/waiver) and the start date for this new program (if applicable.)

What is the process to re-enroll a participant who has been disenrolled for a reason other than completing their 365 days in the community?

Note regarding reenrollments:

- *A new 60 day length of stay is not required.*
- *A new Consent form (14-012) does not need to be signed by the individual.*

RCL re-enrollment questions and concerns can be directed to:

HCS: DSHSALTSARCLReferrals@dshs.wa.gov

DDA: ddarclenrollmentintake@dshs.wa.gov

HQ RCL Staff are happy to help!

1. If the participant was disenrolled due to returning to an institution for greater than 30 days:
   a) Prior to authorizing any transition services, create a new enrollment on the RCL Enroll/Disenroll screen in CARE by clicking on the "plus (+) button.
   b) The Enrollment date can be as early as one day following the Disenrollment Date if transition planning begins immediately, or it can be as late as the same day as the subsequent Actual Discharge Date if no transition services were utilized.
   c) Re-enrollment restarts the RCL "clock", recalculating the Projected End Date.
   d) This process can be followed as needed throughout the participant's RCL service year until there is no time remaining on the RCL "clock":
   e) Complete SER note of the re-enrollment.
   f) Upon transition, follow all other instructions regarding transitioning from the institution including entering all the required information on the Enrollment screen and NFCM screens in CARE.

What is the process to disenroll an individual from RCL prior to discharge?

If an individual no longer wishes to discharge on RCL, passes away prior to discharge, or discharges to an unqualified community setting from the institution, the individual must be disenrolled from RCL on the RCL screen and the following RAC changes are needed:

- For HCS: RAC 3100 – HCS RCL Roads to Community Living must be replaced with 3101 – HCS-RCL Disenroll/No post-discharge services.
- For DDA: RAC 3701 – DDA Roads to Community Living must be replaced with 3702 DDA- RCL Disenroll/No post discharge services.

What about Contracting?

All LTC contracts are executed through the AAA unless other local agreements are in place that state otherwise. RCL services are contracted utilizing the same procedures as other client service contracts. Obtain a list of current contracted providers from your local AAA office. Notify your regional ALTSA HQ Resource and Development team member and/or local AAA Contract Managers if you find there is a network capacity need for contracted providers in your area.

For DDA contracts, refer to the DDA RCL Coordinator with questions.

Note: In addition to specific contracted duties, each provider is responsible for reporting any instances of abuse, neglect, or exploitation of a vulnerable adult or child.

Note: All IPs must be currently employed with Consumer Direct Care Network (CDWA) before becoming a paid provider for a participant who is being served in the RCL project.

How is the project evaluated?

The Centers for Medicare and Medicaid Services (CMS) requires regular reports on RCL participants in their demonstration year. In addition, CMS evaluates grantees semi-annual reporting to monitor progress and identify challenges and improvement opportunities with participating state's MFP programs.

RESOURCES

Money Follows the Person Tribal Initiative

The MFP Tribal Initiative focuses on developing inclusive service contracts and engaging potential partners at the state, tribal and county levels for improved and culturally inclusive service delivery of ALTSA services, including tribal contracted support services. The initiative's goals are to:

- Identify American Indians/Alaska Natives (AI/AN) who are living in institutions and assist them to return to their community of choice.
- Develop culturally inclusive service systems and providers to support American Indians/Alaska Natives once they returned to their communities.
- Support tribal contracts to provide long-term services and supports.

Information about the Money Follows the Person RCL Project

Public HCS website: Roads to Community Living (RCL) | DSHS (wa.gov)
Public DDA website: Roads to Community Living | DSHS (wa.gov)
Public TI website: Money Follows the Person Tribal Initiative | DSHS (wa.gov)
Federal website: Money Follows the Person | Medicaid

WAC 388-106-0250-0265

RCL Enrollment Form (managed by HCS HQ)

RCL Enrollment Form 12.2024 - BLAN

Client Services Purchasing Card Process (HCS Only):


HCS Purchasing Card.docx

DMS Packet Cover form:

02-615 DMS Pkt Cover.pdf

General Utility & Repair Allowance form:

27-147A FINAL.pdf

Community Choice Guide Activity Tracking Form:

CCG Activity Tracking Form - Inst

CCG Activity Tracking Form WEEI

CCG Activity Tracking Form MON

Technology Support Consultation and Technical Assistance Desk Aid:

Desk Aid for Technolgy Consulta

Non Medical Transportation Request Process

Non-Medical Transportation Requ

HCS Decision Making for Transitions/Authorized Representative

ALTSA Power of Attorney vs. Uniform Guardianship
ALTSA- How to Identify a Guardian

HCS-Decision-Making-for-Transitions.pdf

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
03/2025	Samantha Dunham Cassie Pizano Desiree Vallejo	• Corrected end dates of RCL demonstration project • Added clarification regarding fast track and RCL • Added clarification on process to authorize Client Training: Behavior Support Services • Added clarification that Community Transition Services – Items does not permit payment of tips. • Added MIST information • Added Smart Care Companion service information • Added 14-225 and 16-472 as necessary forms to be completed upon authorizing RCL services for HCS clients • Updated treatment names for Community Transition Goods/Items, Community Transition Services and Short-Term Rental Assistance • Added the process to disenroll an individual from RCL prior to discharge • Added Money Follows the Person Tribal Initiative information and website • Updated PAN example	
10/2024	Samantha Dunham	• Provided clarification on RCL demonstration year and CARE Plan period misalignment. • Added Public RCL Website links for DDA and HCS	
7/2024	Samantha Dunham	• Revised the format of the chapter to outline eligibility prior to RCL service descriptions. • Provided clarification on concurrent authorization of SA263 and SA266. • Included RCL services PAN screen shot example. • Added CCG Activity Tracking form to Resources Section. The Form includes the option for providers to submit the form directly to the Imaging Unit via fax.	
4/2024	Julie Cope	• Included form of 27-147A for General Utility and Repair Allowance. • Added Description of Technology Support Consultation and Technical Assistance service (H2014 U9) • Added Service Code Data Sheet links for Pantry Stocking (SA420-U1)	H24-018

		• Included additional direction for NFLOC communication for RCL enrolled participants of MAGI or MCS Medicaid programs into ProviderOne.	
11/2023	Amanda Speck	• Clarification on SA266 Purchasing and CCG reimbursement timeliness. • Included additional service information for: Trial Visits, Pantry Stocking & Non Medical Transportation • Amendment of SA297, SA296 and Environmental Modification service code purchase limits without ETR.	H23-090
08/2023	Stephanie VanPelt	• Added Emergency Rental Assistance information • Added P-card information and guide • Added Environmental Modification General Utility Allowance information • Updated RCL project dates • Updated DMS packet cover form 02-615	H23-071
09/2022	Stephanie VanPelt	Included RCL Referral shared email box Removed detailed description of RCL eligible settings. Updated RCL enrollment/disenrollment instructions to reflect CARE Web migration Aligned RCL case management and transfer procedures with the State Plan and Chapter 5.	H22-042
5/2022	Stephanie VanPelt	Extended RCL Project through 12/31/2026	H22-028
06/2021	Stephanie VanPelt	• Updated RCL qualified and unqualified community settings. • Updated RCL eligibility criteria from 90 days to 60 days continuous qualified institutional stay. • Addition of Residential Unit Furnishings WACs and guidance	H21-050
03/2021	Stephanie VanPelt	• The RCL project has been extended through 12/31/2022 • Updated language in the eligibility section to reference the state funded non-citizens medical benefit instead of the acronym AEM and updated language related to PACE program	H21-018
8/2020	Stephanie VanPelt	Updated RCL Expert Contact information Clarified Services available to RCL Participants Added CCG Tracking Forms in Resource Section	H20-031

Introduction to the Medicaid Transformation Demonstration

This section will provide a brief overview of the 1115 Medicaid Transformation demonstration waiver often referred to as Medicaid Transformation Project (MTP). Throughout this chapter it will be referred to as "MTP". The primary focus in the chapter is on the Older and aging adults and family caregivers provision and the Housing & Employment provisions of MTP.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Resa Lee-Bell 1115 Waiver Program Manager
564.999.1287 Resa.Lee-Bell@dshs.wa.gov

Whitney Joy Howard Housing Integration Unit Manager
360.791.2358 Whitney.Howard@dshs.wa.gov

Mike Corcoran Employment Unit Manager
360.725.2614 Michael.Corcoran@dshs.wa.gov

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WHAT IS MTP?

MTP or Medicaid Transformation Project (aka MTP 2.0) is a five-year 1115 demonstration waiver with the Centers for Medicare and Medicaid Services (CMS) that provides up to $1.1 billion federal investment. This funding is not a grant. The 1115 waiver allows the state to "waive" certain Medicaid requirements in order to test innovative, sustainable and systematic changes that will help improve the overall health of Washingtonians. During the five years of the waiver, the state must demonstrate that it will not spend more federal dollars on its Medicaid program than it would have spent without the waiver.

The Demonstration is a part of the Health Care Authority's (HCA) Healthier Washington Initiative. Over the next five years, the goals of the Demonstration are to:

- Expand coverage and access to care, ensuring that people can get the care they need.
- Advance whole-person primary, preventive, and home- and community-based care.
- Accelerate care delivery and payment innovation focused on health-related social needs.

The current five-year period for this waiver began on July 1, 2023 and ends June 30, 2028.

WHAT ARE THE INITIATIVES UNDER MTP 2.0?

MTP 2.0 consists of seven provisions. They are as follows:

- **Older and Aging Adults and Family Caregivers**: supports Washington's aging population and family caregivers who provide care for their loved ones.
    - Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)
        - These programs will broaden the array of service options that enable individuals to remain at home and avoid or delay the need for more intensive care. The state has created a system of care focused on outcomes that support unpaid family caregivers in caring for loved ones, delay or avoid need for more intensive long-term services and supports (LTSS), create better linkages within the health care system, and continue its commitment to a robust LTSS system for those who need it.
    - Long-Term Services and Supports Presumptive Eligibility (LTSS PE)
        - This program is a package of services that provides individuals an opportunity for expedited access to specific home and community-based services in their own home and Medicaid medical coverage, for a limited time, while full functional and financial eligibility are being determined.
- **Housing and Employment:** Foundational Community Supports (FCS) provides supportive housing and supported employment services to our most vulnerable Medicaid beneficiaries. These services are designed to promote independence and recovery by helping participants find and maintain stable housing and employment.
    - Foundational Community Supports – Supported Employment
        - These services assist those individuals who want to work and meet FCS criteria. Supported Employment services are designed to be person-centered and offer individualized, one-to-one supports to individuals interested in employment in the community. FCS creates a system of

services which will provide pre-employment and post-employment services to an individual at any point in their pathway to employment. The services are not time-limited but are intended to support the individual for as long as there is an identified need. Individualized Supported Employment services include: identifying career and occupational targets, developing ongoing relationships with prospective employers, assisting with the interviewing and hiring process, benefit planning supports, and once hired, support with maintaining employment.

- Foundational Community Supports – Supportive Housing
  - Washington has offered Supportive Housing benefits through Foundational Community Supports since January 1, 2018. Supportive Housing provides dedicated housing support to people with complex needs wishing to live independently. The service provides wraparound support, which means facilitating cross sector coordination of all services the person needs and wants. Supportive Housing services may be an option for individuals who want to live independently and have a history of unsuccessful housing episodes without coordinated, focused support services. These specialty services provide assistance and support to aid an eligible individual in searching and finding housing (pre-tenancy services) and support an individual maintain their independent housing (ongoing tenancy support services).

- **Behavioral Health:** Washington State believes behavioral health–which includes care for our minds or bodies when substances are misused–is just as important as physical health care. Under the Medicaid Transformation Project (MTP) 2.0, these programs support individuals who are receiving services for substance use disorder (SUD) treatment or serious mental illness. MTP 2.0 also includes SUD and other behavioral health services for people in prisons and jails, with the goal of continued recovery once they reenter the community.
  - SUD IMD program
  - Mental health IMD program
  - Contingency management for SUD treatment
- **Reentry from a Carceral Setting**: Reentry services under MTP provides essential services for individuals leaving a state prison, county/city jail, or youth correctional facility.
- **Continuous enrollment:** Includes continuous two components: Apple Health enrollment for children, ages 0 through 5 provides continued benefits for eligible children, ages 0 through the end of the month in which they turn 6 years old and Apple Health postpartum coverage expansion which provides continued benefits for individuals from the end of the pregnancy through 12 months of postpartum.
- **Health-related social needs (HRSN):** HRSN is composed of 3 provisions: Community Hubs which focuses on community-based care coordination, including screening patients, determining patient needs, connecting patients to community organizations that can provide those needs, and more; Native Hubs which is a statewide network of Indian health care providers, tribal social service divisions, and Native-led, Native-serving organizations focused on whole-person care coordination; and Other HRSN services including nutrition, housing, rental subsidies, transportation, and other non-medical HRSN services that help a person live their healthiest life. Rental subsidies up to 6 months is a specific HRSN service for

individuals transitioning out of institutional care or congregate settings, such as nursing facilities, large group homes, congregate residential settings, Institutions for Mental Diseases (IMDs), correctional facilities, and acute care hospitals, or Homeless, at risk of homelessness, or transitioning out of an emergency shelter as defined by 24 CFR 91.5, or Youth transitioning out of the child welfare system, including foster care. This program provides financial assistance to individuals at risk of homelessness so they can pay their rent and have stable housing.

- **HRSN System:** This program provides infrastructure investments to support the readiness for HRSN service delivery. Investments include technology, planning, workforce development, and convening.

The Older and Aging Adults and Family Caregivers as well as Housing and Employment programs are operated through Home and Community Services (HCS).

MTP Resources

MTP Community Workspace: the MTP SharePoint site that contains useful information, training videos, desk aids, and a Q & A forum called Conversation Cafe`.

Health Care Authority's Healthier Washington Website

HCS MTP Intranet site

ALTSA MTP Internet site

Acronyms

MTP	Medicaid Transformation Project
CMS	Centers for Medicare and Medicaid Services
HCA	Healthcare Authority
MAC	Medicaid Alternative Care
TSOA	Tailored Supports for Older Adults
LTSS PE	Long-Term Services and Supports Presumptive Eligibility
LTSS	Long-Term Services and Supports
FCS	Foundational Community Supports
HRSN	Health-related social needs
IMDs	Institutions for Mental Diseases
HCS	Home and Community Services
CFR	Code of Federal Regulations
SUD	Substance use disorder

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
November 2019	Debbie Johnson	Moved to new template	H19-0xx
May 2024	Resa Lee-Bell	Incorporated language from June 2023 CMS Approval/STC's	
April 2025	Resa Lee-Bell	Addition of Acronyms Style Formatting Update	

MAC & TSOA

Chapter 30b provides a description of Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) offered under the Older and Aging Adults and Family Caregivers provision of the 1115 Medicaid Transformation Demonstration waiver. These programs are intended to support unpaid family caregivers and their loved ones so they can remain in their chosen communities.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Resa Lee-Bell 1115 Waiver Program Manager
587.999.1287 Resa.Lee-Bell@dshs.wa.gov

Adrienne Cotton MAC & TSOA Program Manager, State Unit on Aging
360.764.9077 Adrienne.Cotton@dshs.wa.gov

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BACKGROUND

The intent of the Older and Aging Adults and Family Caregivers provision under the Medicaid Transformation Project – 1115 Demonstration Waiver, is to expand care options for people, ages 55 and older, so they can stay at home and delay or avoid more intensive services, and providing assistance to unpaid family caregivers, ages 18 or older, who provide care for their loved ones. The MAC and TSOA programs are both found under the Older and Aging Adults and Family Caregiver's section. These programs are helping change the Medicaid health care delivery system by:

- Providing additional options for people with long-term care needs.
- Increasing access to services for people on the cusp of poverty to reduce:
    - A potential health decline.
    - The need to move out of home.
    - The spending-down of limited resources.
- Slowing the growth trend of traditional Medicaid-funded services, including Medicaid long-term services and supports.
- Providing unpaid family caregivers with supports and knowledge to continue providing care while also taking care of themselves.
- Helping people remain at home for as long as possible, and to maintain independent living.

Both MAC and TSOA are mirrored after the state funded Family Caregiver Support Program (FCSP). FCSP which was established in 2000 and is available in every county in Washington. The FCSP program was developed with the concept that supporting unpaid family caregivers keeps Washington families together and means less people need expensive long-term care placement or services. If family caregivers become unavailable, it is likely that older adults would need to access more costly in-home and residential services. These caregivers need support to help prolong their ongoing caregiving activities as well as ensure their own mental and physical health stays intact while coping with related challenges. Research demonstrates that it is critical to understand how a caregiver is feeling about their role in order to better tailor support to their individual needs. The FCSP has shown that the majority of caregivers show significant improvements on key outcomes when their stresses and burdens are addressed.

For more information about the FCSP see Chapter 17a the LTC manual.

PROGRAM DESCRIPTION & ELIGIBILITY CRITERIA

The Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) fall under the Older and Aging Adults and Family Caregivers provision of the 1115 demonstration waiver. Eligibility for both programs is based on the care receiver, although services may be provided to both the care receiver and/or the unpaid caregiver. MAC provides support for unpaid family caregivers caring for Medicaid-eligible people who are not currently accessing Medicaid long-term services and supports such as Medicaid Personal Care (MPC), Community First Choice (CFC), and Community Options Program Entry System (COPES) programs. The unpaid family caregiver, who must be at least 18 years old, is the individual who provides care to their care receiver and does not receive direct, public, or private payment such as a wage for the caregiving services they provide. An unpaid family caregiver may be a

spouse/partner, adult child, other family member, a friend, or a neighbor and does not need to be a Washington State resident. The unpaid family caregiver and the care receiver are collectively referred to as the dyad.

TSOA serves individuals who are functionally eligible but not yet financially eligible for Medicaid or are receiving limited Medicaid coverage based upon a specific set of criteria (such as Medically Needy or Medicare Savings Program). Services under TSOA can support someone with an unpaid family caregiver (the dyad) or someone who does not have an unpaid family caregiver.

For more information about financial eligibility and ACES coverage groups for MAC and TSOA see the MTP Community Workspace on the ALTSA SharePoint site.

Both MAC and TSOA programs are designed to offer the right amount of services, at the right time in order to divert or delay the need for more comprehensive Medicaid long-term services and supports. Both programs are funded 100% by federal Medicaid dollars and offer the same services, with some exceptions. MAC and TSOA services can only be received by care receivers living in a private residence such as their own home, independent living, or another's home rather than a licensed residential facility (i.e., adult family home or assisted living facility).

A care receiver may have more than one caregiver. However, the care receiver only has one benefit amount (service dollars). The funds must be shared between the identified unpaid caregivers.

An unpaid caregiver may be supporting more than one care receiver. For example, an adult daughter may be providing care to both her mother and her father. In this situation, if both parents are enrolled in MAC or TSOA then each parent would have a separate benefit amount that could be used to support their daughter/unpaid caregiver.

There are also scenarios where a MAC or TSOA dyad caregiver is inquiring about being a TSOA individual. The below is a helpful chart on determining when caregivers can also be care receivers themselves and what necessary steps are required:

Program	Can CG be TSOA Ind?	MTP Exception to Rule (ETR) local required?
Caregiver (such as IP, home care agency or unpaid CG) for CFC/ COPES client	Y	N** Best practice is for MTP case worker to consult with CFC/COPES case worker to ensure there is a safe plan of care for both CFC/COPES client and TSOA Individual.
FCSP CG	Y*	Y**
MAC/TSOA CG	Y*	Y**

		Local ETR must be requested annually for dyad CG to be a TSOA individual.
*Things to Consider: Does the request make sense for the situation? What tasks is the CG doing and what tasks does the individual/CG need help with as a CR? **Why is the ETR needed? What makes this situation different from the majority? Is this a safe plan of care?		

MEDICAID ALTERNATIVE CARE (MAC)

MAC helps unpaid family caregivers provide high-quality care for their loved ones, while also tending to their own health and well-being. MAC serves dyads (care receiver and unpaid caregiver). Applicants may request services through either the AAA or HCS front door. An example of a dyad who may want to access MAC services is one who:

- Does not want or need a more comprehensive Medicaid LTSS program, or
- Doesn't want to risk estate recovery

To be eligible for MAC, the care receiver must meet **ALL** the following eligibility criteria:

- Be age 55 or older
- Live in their own home or another's home (not a licensed residential facility)
- Currently be enrolled on a Categorically Needy (CN) or Alternative Benefit Plan (ABP) Medicaid coverage group (Apple Health)
- Meet nursing facility level of care (NFLOC) but has chosen not to receive Medicaid long-term services and supports through the state's other programs.

There is no client participation/responsibility or estate recovery with MAC and TSOA programs.

TAILORED SUPPORTS FOR OLDER ADULTS (TSOA)

TSOA establishes a new eligibility category and benefit package for people who may need Medicaid long-term services and supports in the future. TSOA helps people and families avoid or delay impoverishment and the future need for Medicaid-funded services. TSOA serves dyads (care receivers and unpaid caregivers) as well as individuals who do not have an unpaid family caregiver. Dyads and individuals without an unpaid family caregiver may access services through either the AAA or the HCS front door. An example of an individual who may want to access TSOA services is one who:

- Does not want or need a more comprehensive Medicaid LTSS program,
- Doesn't want to risk estate recovery, and/or
- Feels that paying participation would cause an unsustainable financial hardship.
- May be over the resource limit for traditional Medicaid LTSS programs.

To be eligible for the TSOA program, whether for the dyad or an individual, the care receiver must meet **ALL** of the following eligibility criteria:

- Be age 55 or older
- Live in their own home or another's home (not a licensed residential facility)
- Be a US citizen or have eligible immigrant status
- Not currently be eligible for Categorically Needy (CN) or Alternative Benefit Plan (ABP) Medicaid coverage (Apple Health)
    - Note: TSOA applicants may be on a Medically Needy (MN) or Medicare Savings Program (MSP) ACES coverage group and still be financially eligible for TSOA. This coverage group only provides limited scope of Medicaid benefits from Health Care Authority (HCA).
- Meet nursing facility level of care (NFLOC)
- Meet financial requirements:
    - Income up to 400% of the Supplemental Security Income (SSI) Federal Benefit Rate per WAC 182-513-1635
    - Countable non-excluded resources are at or below the current monthly private nursing facility rate multiplied by six months for a single applicant or, for a married couple with a community spouse (CS), non-excluded resources are at or below a combination of the current monthly private nursing facility rate multiplied by six months plus the current state spousal resource standard for the spousal impoverishment protections community (SIPC) spouse. The state spousal resource standard may change annually on July 1st. Resource eligibility for TSOA is described under WAC 182-513-1640, WAC 182-513-1660, & WAC 182-513-1640 .
    - Standards chart can be found here.

For MAC and TSOA care receivers, the nursing facility level of care (NFLOC) assessment and the financial eligibility review must be completed annually. Each NFLOC assessment completed post-presumptive eligibility, should be completed by AAA MTP staff and will not require confirmation by HCS staff. HCS financial staff (Public Benefit Specialists) will conduct the annual financial eligibility review.

INTAKE AND SERVICE DELIVERY FLOW

Intake and service delivery flow consists of taking a person through the process of accessing services. Medicaid Alternative Care (MAC) and Tailored Support for Older Adults (TSOA) programs may be requested through either the AAA or HCS front door. During the intake process, applicants are educated about the long-term services and supports provided by ALTSA and the settings for which they are offered, including functional and basic financial eligibility criteria. Upon the applicant making an informed decision to receive either MAC or TSOA services; the MTP Presumptive Eligibility (PE) screening can be completed. If an applicant

MAC and TSOA service provision is unique: The AAA GetCare systems interface with the CARE system to ensure seamless service delivery flow.

chooses another service offered by ALTSA; the appropriate referral or intake can be completed. If the applicant indicates that ALTSA LTSS are not needed or are declined; the applicant should be referred to alternative community resources, including other state or federal funded programs offered through the aging and disability network including Older Americans Act and Family Caregiver Support Program (FCSP).

The PE screening will be completed in either the GetCare or CARE systems. AAAs primarily use the GetCare systems. GetCare interfaces with CARE, TCARE, Barcode and ProviderOne (P1). PE screenings and confirmations completed by HCS are done in the CARE system.

Role of AAA and HCS staff

AAA MTP staff work in the GetCare system after having person-centered conversations with participants about available programs, services, settings and providers. If MAC or TSOA is the participant's program choice, AAA staff complete the following:

- Intake in GetCare
- Presumptive eligibility (PE) assessments
- Annual Nursing Facility level of care assessments
- GetCare or TCARE® screenings
- GetCare or TCARE® assessments
- GetCare or TCARE® Care Plans
- Service enrollments and authorizations
- Eligibility notifications and other required notices to care receivers
- Obtain signatures on required DSHS forms (see Forms and Notices section)
- Voter Registration Assistance at intake during the Presumptive Eligibility screening, whenever the care receiver's home address changes, and during annual nursing facility level of care (NFLOC) assessments. Refer to MB H18-030 for more information.
- On-going case management
- Administrative hearings, as necessary

Designated HCS MTP intake workers, using CARE, will also work with clients to conduct person-centered conversations about available programs, services, settings, and providers. If the MAC or TSOA program is selected by the participant, these designated workers will complete the following:

- Intake in CARE
- Presumptive eligibility screenings and initial functional eligibility (NFLOC) determinations
- Confirmation of initial functional eligibility (NFLOC) via review of the PE assessments completed by AAA workers in GetCare and sent to CARE via an interface.

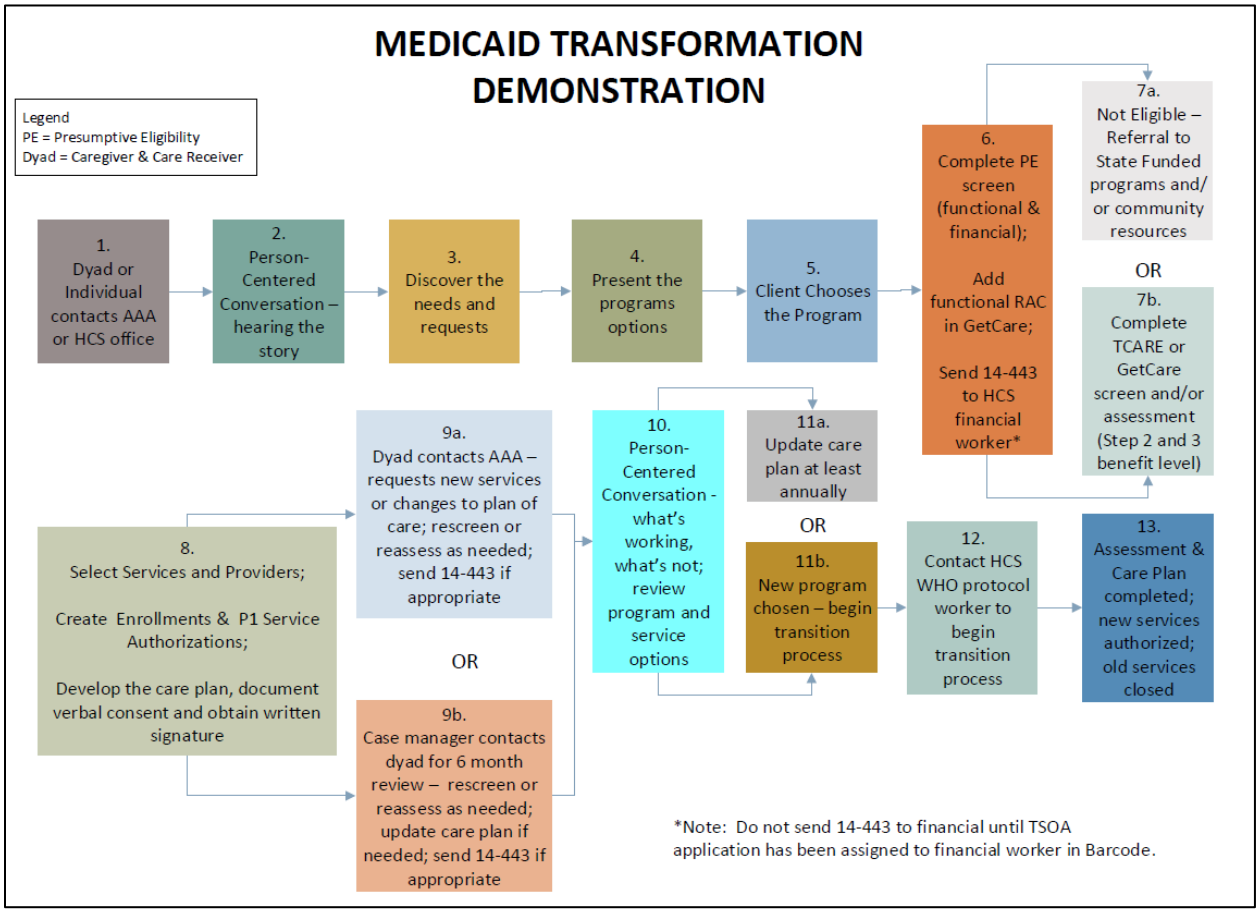
HCS Public Benefit Specialists (PBS)/financial workers will process TSOA applications and confirm financial eligibility for TSOA. Some MAC care receivers, if the applicant is eligible for Medicare or is age 65+, will also be managed by the HCS PBS. HCS PBS complete the annual financial eligibility reviews for the TSOA and MAC cases they oversee. MAC applicants and recipients, authorized under N-track or MAGI group of eligibility, are managed by the Health Care Authority (HCA). PBS utilize ACES, Barcode, AVS, Lexus Nexus Asset Reports, Employment Security Department Data, Washington State Pension

Data, Social Security Online Queries, as well as other additional systems to help determine financial eligibility for programs.

In order for certain tasks, such as full eligibility confirmation to be completed by HCS, information must be confidentially shared between AAA and HCS offices. Warm hand-off (WHO) protocols, developed between each AAA and their respective HCS partner, focus on confidential and quick communication so that participants receive seamless service provision. See the Warm Hand-Off section in this chapter for additional information.

Whether services are requested through the HCS or the AAA front door, HCS ensures the care receiver is assigned a ProviderOne (P1) ID number. HCS will match to existing records or links each new care receiver to the ProviderOne (P1) system. The P1 ID number is sent electronically from the care receiver's record in CARE to their record in GetCare. The P1 ID number allows AAA staff to create enrollments and service authorizations and send them to P1. P1 will then auto-generate authorization notices to the provider, the care receiver, and the caregiver. Once an authorization is accepted by P1 and the service is provided to the care receiver and/or unpaid caregiver, providers may submit a claim to P1 for payment against that specific authorization.

The chart below depicts the intake and service delivery process.



Community Living Connections - GetCare

Community Living Connections (CLC) GetCare is the client management information system used by AAAs to complete intakes, presumptive eligibility (PE) assessments, annual nursing facility level of care assessments, screenings and assessments, PE notices, MTP Service Notices, enrollments and authorizations.

GetCare is also used to create:

- Step 1 and 2 care plans for dyads and TSOA individuals, and
- Step 3 care plans for TSOA individuals.

GetCare is the system of record for care receivers enrolled in the MAC and TSOA programs.

For MAC and TSOA, System of Record means information provided through GetCare takes precedence over information from any other system involved in the service delivery flow with exception to social security numbers. P1 is the system of record for social security numbers.

TCARE®

TCARE® is the evidence-based assessment tool and information system used by the AAAs for completing:

- caregiver screens for Step 2 dyads,
- Step 3 care plans for dyads,
- assessments and consultation worksheets for Step 3 dyads.

Care plans for dyads at Step 1 and 2 and care plans for TSOA Individuals at Step 1, 2, and 3 are completed in GetCare. Care Plans for dyads at Step 3 are completed in TCARE.

CARE

Comprehensive Assessment Reporting and Evaluation, CARE, is the case management information system used by HCS to:

- complete intakes, presumptive eligibility screenings, and initial functional eligibility confirmations;
- obtain ProviderOne ID numbers for care receivers; and
- share information such as functional RACs and AAA staff information with ProviderOne.

ProviderOne

ProviderOne is Washington State's Medicaid Management Information System (MMIS) and is the system used by all Medicaid providers to submit claims to be paid for services provided. It is the system of record for care receiver's Social Security Number (SSN) as this systems interfaces with federal databases to confirm accuracy of SSNs.

ProviderOne "talks" to many different systems such as ACES, Barcode, Agency Contracts Database (ACD), CARE, and GetCare. If any of these systems are down (experiencing technical difficulties) updates from those systems to ProviderOne may be delayed. Some changes made in GetCare and CARE will be processed overnight and updated to the care receiver's file in ProviderOne. For example, when the AAA staff, functional RAC, or RU change, the primary case manager and RU fields will be updated overnight for any authorization with current or future end dates.

All ProviderOne authorizations for payment are made under the Care Receiver's ProviderOne ID in the Care Receiver's GetCare profile.

Refer providers who want more information about ProviderOne (such as how to become a provider or how to get paid) to HCA's website for social service providers.

Agency Contracts Database (ACD)

Medicaid-funded contracts, paid through ProviderOne, are stored in the statewide DSHS system called ACD. In order to validate social service authorizations for contracted services, and for payment to be processed through ProviderOne, a corresponding active contract must exist in ACD. An interface between ProviderOne and ACD will supply contract information for such validation. Once a contract goes into signed status in ACD, the contract and provider information automatically is sent to ProviderOne allowing for service authorizations and payments to be completed.

Automated Client Eligibility System (ACES) and Barcode

ACES is used by the State of Washington's Department of Social and Health Services and supports the operations of the department by integrating DSHS programs under a single, client-based, on-line system. The ACES system is a tool for determining program financial eligibility, issuing Medicaid benefits, management support, and sharing of data between agencies.

Barcode is an application with an array of workflow and document management functionality. It tracks case management contact information, communication with the public benefits specialist and financial eligibility determination and integrates this information with the ACES system.

TIVA2

TIVA2 (Tracking Incidents of Vulnerable Adults) is used by Adult Protective Services (APS) and Residential Care Services (RCS) to assist with tracking and trending critical allegations of abuse and neglect across settings, providers, and alleged perpetrators.

An outbound interface between TIVA2 and CARE identifies when a care receiver with an active MAC or TSOA RAC has been identified as an alleged victim in an APS or RCS intake and then CARE interfaces with GetCare to provide the MTP case manager notification via a message on the AAA staff's GetCare

dashboard. Further information about the intake or outcome notice can be reviewed by clicking on the APS/RCS ribbon in the care receiver's record in GetCare.

Presenting Program Options

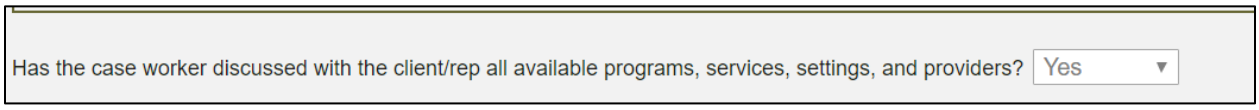
When individuals contact the AAA or HCS office for the first time or when individuals who are currently receiving services want to understand more about available programs, services and supports, it is important for AAA and HCS staff to facilitate a person-centered discussion. The full range of available programs, services, providers and settings should be presented, with enough information to allow people to understand options that best suit their needs.

The focus of this discussion should be an "important to, important for" approach, which is similar to motivational interviewing and other related approaches to person centered discussions.

The following tool was developed to help with understanding the program options available:
Decision Tool for Program Options

For more information about person centered conversations see the MTP Community WorkSpace on the ALTSA SharePoint site.

HCS and AAA staff must document in CARE – SER notes and in GetCare and TCARE® care plans that they have discussed all available program, setting, provider and service options such as FCSP, MAC, TSOA, MPC, CFC, COPES, New Freedom, nursing facility care, etc. with the care receiver prior to enrollment into a program. Below is a screen shot of the question in the GetCare care plan. The answers available in the drop-down list include "Yes", "No", and "Unknown".



Warm Hand-Off Standards & Protocols

The Warm Hand-Off (WHO) Protocol is the plan for how and when information and/or documents will be shared between AAA staff and HCS staff to ensure seamless and confidential service provision for clients of the MAC and TSOA programs.

In each program there is essential information, such as intakes, presumptive eligibility, P1 ID number and program start/end dates, which must be sent back and forth electronically between GetCare, CARE and Barcode. The Warm Hand-Off Protocol details how this sharing of documents and information is going to occur and within what timelines. The WHO protocol also requires names and contact information of lead staff at local HCS (social services and financial) and AAA offices to be known to each counterpart, providing a point person to ensure seamless service delivery for clients.

The WHO protocol also provides instruction for how information will be confidentially exchanged if usual ways of handing off cases are not operational. For example, when computers are down for a day and documents still need to be warmly handed off between AAA and HCS partners, or there is a delay in

determining final eligibility for a dyad. The contingency section in the WHO protocol details how data will be exchanged so that seamless service delivery is provided to clients.

In the evaluation section of the WHO protocol, each AAA and HCS partner provides a plan for how each area's respective WHO Protocol will be evaluated. For example, it should include details about how the plan will be reviewed to determine if it is working or needs modifications or updates. Also included is information about what systems will be put in place to ensure seamless and timely handoffs and how often the lead contact staff between offices will touch base to review whether the process is working as designed.

WHO Protocol Due Dates:

MAC/TSOA Hand-Offs	Work flow	Maximum # of days
NFLOC Prescreen Information for confirmation of NFLOC eligibility	From AAA Staff to HCS CM	2 business days from PE screening lock date
TSOA Financial Application	From client (with assistance from AAA) to HCS PBS	30 calendar days from PE screening lock date
Prescreen Information for service authorization	From HCS CM to AAA Staff	2 business days from PE screening finalize date
ProviderOne ID for new clients	From HCS CM to AAA Staff	2 business days from receipt of PE screening from AAA
NFLOC Functional Eligibility confirmation	From HCS CM to AAA Staff	10 business days from receipt of PE screening from AAA
TSOA only: Confirmation whether a TSOA financial application was received	From HCS PBS to AAA Staff	30 calendar days from PE start date
TSOA only: Care Receiver Financial Eligibility Determination	From HCS PBS to AAA Staff	45 calendar days from receipt of TSOA financial application

Each AAA is required to develop and maintain a MAC/TSOA WHO Protocol as part of their contract with ALTSA for this Medicaid Transformation Project. For additional information or questions about your local MAC/TSOA WHO Protocol, contact your supervisor.

AAA & HCS Warm Hand-off Protocol Standards

PRESUMPTIVE ELIGIBILITY (PE)

What is PE?

PE is a process that allows us to gather preliminary information, based upon the self-attestation of the care receiver/designated representative, to decide that the care receiver appears to meet eligibility criteria. The two components reviewed for determining PE are financial and functional. The ability to authorize services under PE allows services to be delivered to dyads or individuals more quickly while the full eligibility determinations are being completed.

	MAC	TSOA
Financial	• Care Receiver's Medicaid Coverage Group = ✓ Categorically Needy (CN) or ✓ Alternative Benefit Plan (ABP) WAC 182-513-1605	• Income up to 400% of the Supplemental Security Income (SSI) Federal Benefit Rate per WAC 182-513-1635 • Countable non-excluded resources are at or below the current monthly private nursing facility rate multiplied by six months or, for a married couple, that non-excluded resources are at or below a combination of the current monthly private nursing facility rate multiplied by six months plus the current state spousal resource standard for the spousal impoverishment protections community (SIPC) spouse, based on the individual's verified household resources per WAC 182-513-1640 . Rates can be found here.
Functional	Nursing Facility Level of Care (NFLOC) WAC 388-106-0355	Nursing Facility Level of Care (NFLOC) WAC 388-106-0355

PE Time Period

Services are available under PE for a limited time. The PE time period begins on the date the PE screening is completed and ends with the earlier date of:

- The day the decision was made by the HCS public benefits specialist on the TSOA financial application;
- The date it was confirmed by HCS case worker that care receiver did not meet functional eligibility criteria; OR
- The last day of the month following the month that the PE screening was completed (when no TSOA application was submitted).

Any Care Receivers who have already been determined financially eligible (for example, most MAC Care Receivers), will be fully eligible once HCS confirms functional eligibility, therefore may never enter the program under presumptively eligibility.

Example 1: Susy Que's PE assessment was completed in GetCare on August 19, 2024 and the NFLOC confirmation was made by the HCS case worker on 8/21/24. Susy submitted her TSOA application on September 12th and continued to receive services under PE until October 5, 2024, when the HCS financial worker was able to determine full financial eligibility.

PE RAC start date = the date PE was completed and locked (8/19/24)
Initial PE RAC end date = 9/30/24
PE RAC end date extended to allow financial worker time to process application = 10/31/24
Financial worker's eligibility decision = 10/4/24
Full Eligibility RAC start date = 11/1/24
Full Eligibility RAC end date = 8/31/2025
TSOA program start date for 14-443 = the date PE screening was completed and locked (8/19/24)

Example 2: Susy Que was determined to meet TSOA PE criteria on August 19, 2024. Her NFLOC confirmation decision was completed on August 21, 2024 and indicated that she did not meet NFLOC criteria. Susy Que's PE period ends August 21, 2024 and she is no longer eligible to receive services under PE. Had Susy received any paid services between August 19th and 21st, the AAA staff would also need to create the NOPE RAC (start date 8/19/24 and end date 8/21/24) to mirror the closed PE RAC. This will move the service expenditures out of the TSOA funding bucket into the NOPE funding bucket. The PE RAC start and end dates should match the NOPE RAC start and end dates.

PE RAC start date = the date PE was determined (8/19/24)
PE RAC end date = 8/21/24
TSOA program start date for 14-443 = the date PE was determined (8/19/24)
TSOA program end date for 14-443 = the date NFLOC confirmation results (8/21/24)
NOPE RAC start date = 8/19/24 (only use this RAC if care receiver received TSOA services)
NOPE RAC end date = 8/21/24 (only use this RAC if care receiver received TSOA services)

Completed means "Locked" in GetCare and "Finalized" in CARE

Example 3: Susy Que was determined to meet TSOA PE criteria on August 19th and the NFLOC confirmation was made that day. She did not submit her TSOA application before September 30, 2024, the last day of the month following the month her initial services under PE were authorized. Her PE period ends September 30th and she cannot receive TSOA services until she submits a TSOA application and a financial eligibility decision is made by the HCS financial worker. In this case, Susy may decide to receive FCSP services until her financial eligibility for TSOA is completed. However, FCSP services are limited and expenditure levels vary, therefore FCSP may have waitlists depending upon the budget at the local AAA.

PE RAC start date = the date PE was determined (8/19/24)
PE RAC end date = 9/30/24
TSOA program start date for 14-443 = the date PE was determined (8/19/24)

TSOA program end date for 14-443 = 9/30/24

Dyads and TSOA individuals may only receive services under PE once every twenty-four months. For instance, in example 2 above, Susy would not be eligible to apply for PE and receive MAC or TSOA services under PE for two years (October 2024). She would be able to request and receive MAC or TSOA services prior to October 2024, but would need to wait until her full eligibility (both financial and functional) had been determined prior to services being authorized.

Completing the PE Screening

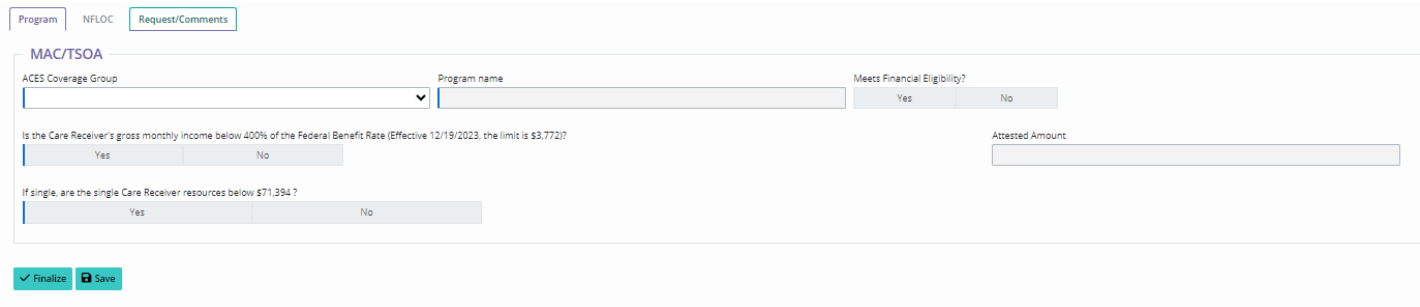
The Presumptive Eligibility screening tool has been built into CARE and GetCare to allow both HCS and AAA workers to complete the screening. This allows a MAC or TSOA applicant to enter either "door" to begin the intake process and access services in the most efficient manner.

CARE, the tool used by HCS, has a MTP node that includes the PE screening functionality. Below are screen shots of the financial and functional sections in CARE.

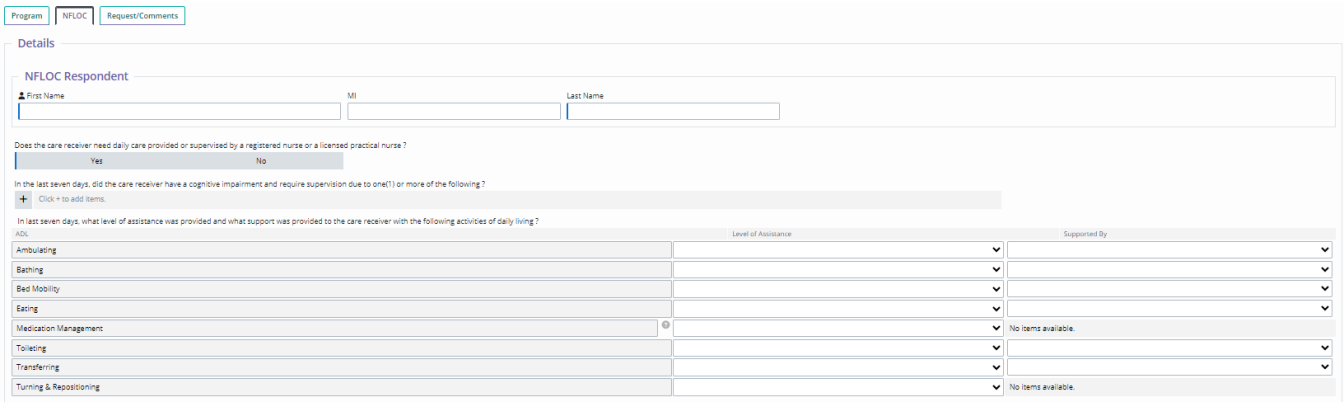
The financial eligibility component of the PE screening includes two main elements: income and resources. For TSOA applicants we use the care receiver's self-attested gross monthly income. For calculating the amount of resources for a care receiver we must consider their marital status. If the care receiver is married, we must use the self-attested amount of resources for both the care receiver and their spouse.

If a married couple are both applying for services, each TSOA applicants self-attested gross monthly income would be used. Example: Married Couple Care Receiver #1 has a self-attested gross monthly income of $2,000 a month and Married Couple Care Receiver #2 has an self-attested gross monthly income of $6,000 a month. Married Couple Care Receiver #1 would be within the income limits and would be PE eligible but Married Couple Care Receiver #2 would show to be over income for the program and would be PE ineligible. For resource amounts, if married, we must use the self-attested amount of resources for both the care receiver and their spouse (regardless if both are applying for services or only one individual in the couple is applying).

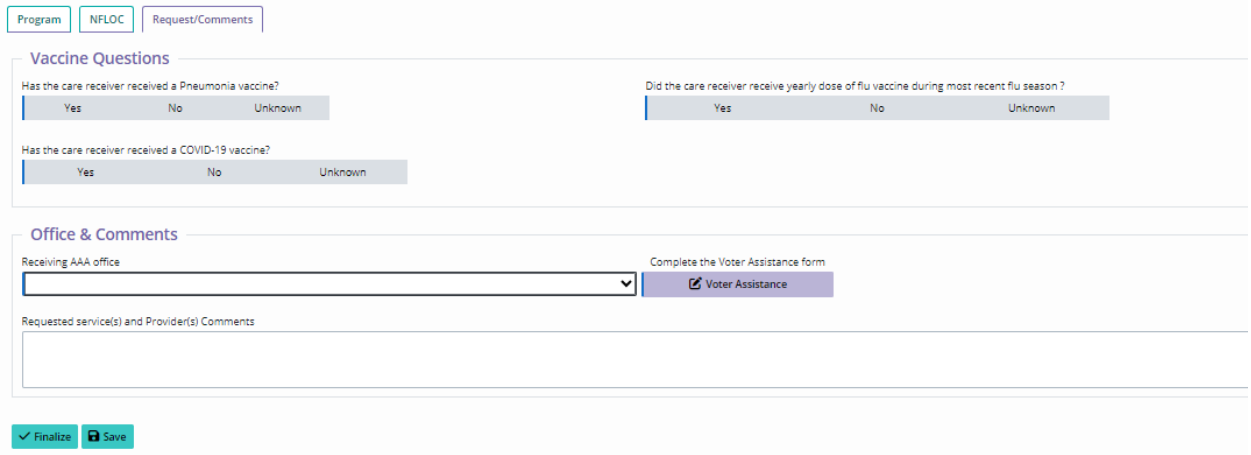
Financial PE questions in CARE:



Functional eligibility questions in CARE:



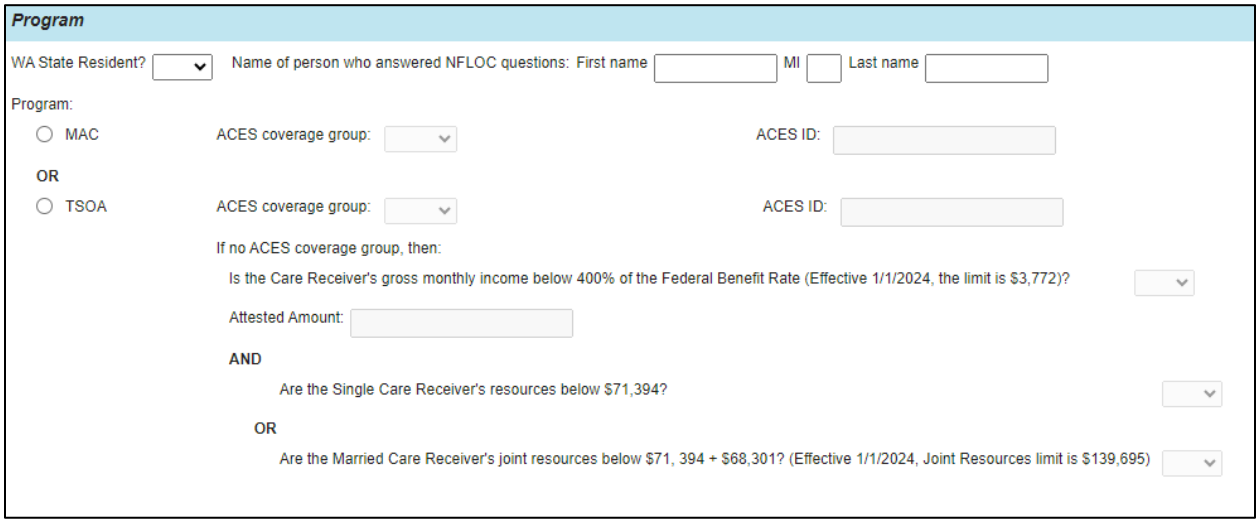
Vaccination Discussion & Comments in CARE:



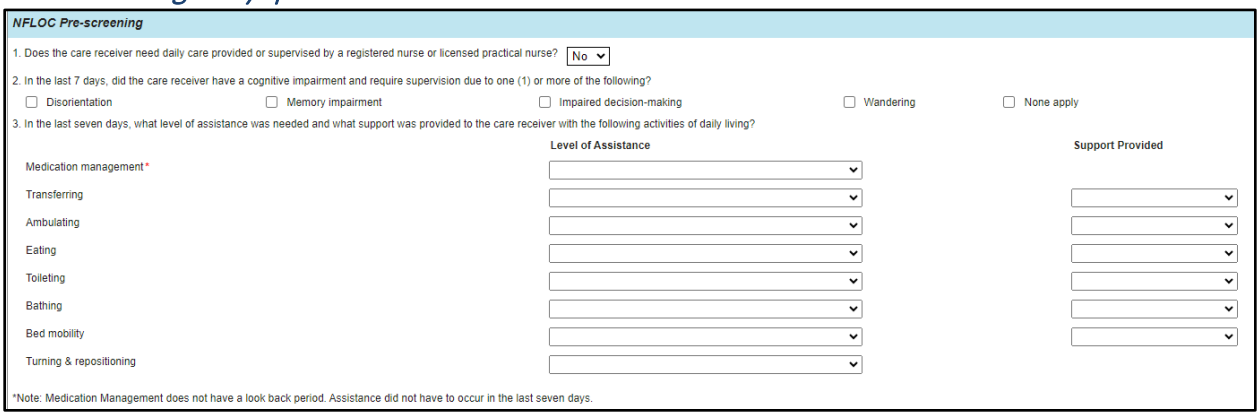
Training materials related to completing PE screening in CARE can be found in CARE Web - CARE Web Help – Presumptive Eligibility.

GetCare, the tool used by AAAs, includes the PE screening in the Assessments section. The screen shots of the financial and functional sections of the PE Assessment in GetCare are as follows:

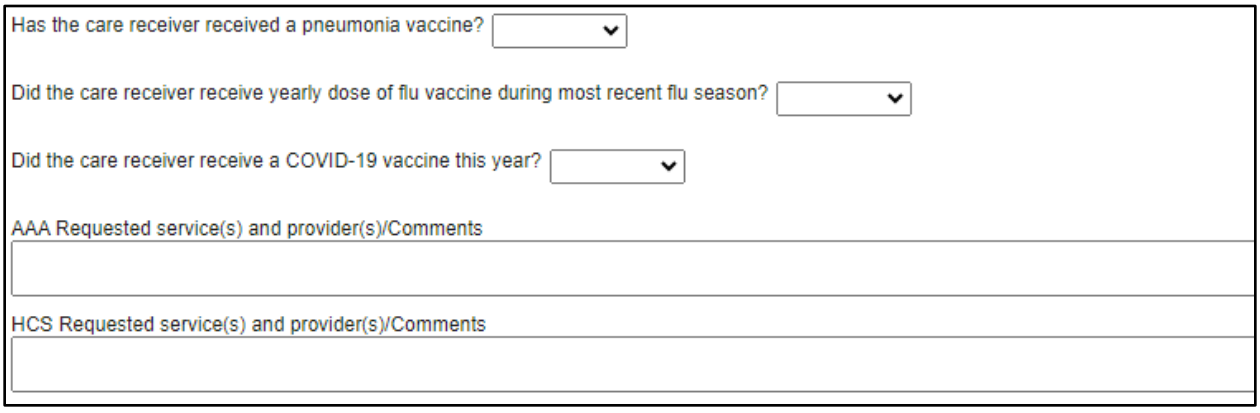
Financial eligibility questions in GetCare:



Functional eligibility questions in GetCare:



Vaccination Discussion & Comments in GetCare:



Training materials related to:

- Completing a PE assessment in GetCare can be found here on the MTP Community WorkSpace
- ACES coverage groups and the related financial (ACES) RACs can be found here on the MTP Community WorkSpace
- A video, Introduction to Recipient Aid Categories, to help with understanding RACs can be found on the MTP Community WorkSpace.

CARE and GetCare had existing terminology before the two systems were connected for MTP. The below is a cross walk of some of the language which can be used to aid in communication between HCS and AAAs:

NFLOC – Level of Assistance Crosswalk	
CARE	GetCare
Independent	Independent
Supervision	Minimum
Limited	Moderate
Extensive	Maximum (Both Extensive and Total in CARE =Maximum in GetCare
Total	Maximum (Both Extensive and Total in CARE =Maximum in GetCare
Did not occur/No Provider	Did not occur/No Provider
Did not occur/Client not able	Did not occur/Client not able
Did not occur/Client declined	Did not occur/Client declined
Independent (CARE does not have the GetCare value of "Declined to State". It is not part of the NFLOC eligibility criteria. If "Declined to State" is selected in GetCare, CARE will display "Independent"	Declined to State (This GetCare value does not count in NFLOC eligibility)

For more detailed information about RACs see the RAC section of this chapter.

NFLOC Confirmation

HCS MTP workers must confirm all initial NFLOC eligibility decisions (whether the care receiver is found eligible or ineligible). AAA workers complete all annual NFLOC reassessments. HCS does not need to confirm annual NFLOC decisions.

Confirmation of NFLOC will be completed using the following processes:

AAA Intake:
When completing the PE assessment in GetCare, in order to facilitate WHO protocols, the AAA worker will:

- describe in the comment box the type of *daily* care provided or supervised by a RN or LPN if the answer to NFLOC question #1 is "Yes";
- describe in the comment box the cognitive impairment that caused the need for supervision, if the answer to NFLOC question #2 is something other than "None Apply"; and
- add any additional information in the comment box that may be useful for the HCS worker confirming NFLOC eligibility.

To complete the NFLOC confirmation, the HCS worker will review:

- any comments submitted with the PE screening completed by the AAA worker;
- the level of assistance and support provided coding to ensure the coding looks accurate based upon the definitions of the coding; and
- contact the AAA worker who completed the PE screening when clarification is needed on the comments submitted or the coding selected by the AAA worker.

HCS will avoid contacting the care receiver or NFLOC respondent to ask the NFLOC questions again, if at all possible.

HCS Intake:
When completing the PE screening in CARE, the HCS worker will:

- describe in the comment box the type of daily care provided or supervised by a RN or LPN if the answer to NFLOC question #1 is "Yes";
- describe in the comment box the cognitive impairment that caused the need for supervision if the answer to NFLOC question #2 is something other than "None Apply"; and
- add any additional information (including an unpaid family caregiver if identified in the screening process) in the comment box that may be useful for the AAA worker to know.

When the PE screening completed in CARE is sent to GetCare, the NFLOC decision is considered confirmed and will be reflected as such in both CARE and GetCare.

When the PE screening is completed in CARE, the AAA worker will:

- review the comments submitted by the HCS worker who confirmed NFLOC eligibility and seek clarification as needed;
- if the care receiver does not meet NFLOC eligibility, proceed with the program denial process; and
- if the care receiver does meet NFLOC eligibility, proceed with sending the PE program approval notice, completing screening and assessments, care plans and creating the enrollment(s) and service authorization(s).

Additional information:
The AAA and HCS worker may decide to complete the PE screening via a 3-way conference call or have additional ways to communicate information related to the PE screening. Please add this to your area's Warm Hand-Off Protocol if using this approach.

PE Notices

The following templates for the required PE notices are in GetCare and are accessible by clicking the "Write Client" button which is visible after opening the identification ribbon of the care receiver's file section. The care receiver's specific details can be added into the templates, printed and mailed to the care receiver and unpaid caregiver, if there is one. GetCare will also send the completed notice to Barcode to be entered into the care receiver's Electronic Case Record (ECR). All PE notices will be generated by AAAs in GetCare even for those that begin as HCS intakes.

NOTICE TYPE	PURPOSE	# of TRANSLATED LANGUAGES
MAC PE Approval	To provide notification to care receiver that PE has been approved	8
TSOA PE Approval	To provide notification to care receiver that PE has been approved	8
MAC PE Denial	To provide notification to care receiver that PE has been denied	8
TSOA PE Denial	To provide notification to care receiver that PE has been denied	8

The top eight languages available besides English are:

- Spanish
- Korean
- Somali
- Russian
- Laotian
- Cambodian
- Chinese
- Vietnamese

The translated version of the PE approval or denial document must be stored in the care receiver's GetCare electronic file cabinet (ECF).

FINANCIAL ELIGIBILITY

As noted previously, HCS financial workers otherwise known as Public Benefit Specialists (PBS), determine full financial eligibility for TSOA care receivers based upon information submitted on the financial application (18-005– Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Supports). The HCS PBS workers also manage MAC care receivers who are not receiving this service under a MAGI coverage group (N-track). If the MAC care receiver is receiving their CN – ABP Medical through the N-track then those cases are managed by the Health Care Authority (HCA). HCS and HCA financial workers are also responsible for completing the financial eligibility review (ER) each year.

Applications can be completed electronically through Washington Connection web portal (www.washingtonconnection.org) or by using the paper form 18-005. Paper applications can be submitted to:

- a local Home and Community Services (HCS) office visit dshs.wa.gov/office-locations
- faxed to 855-635-8305
- mailed to PO Box 45826, Olympia WA 98504-5826.

Intake workers at HCS or AAA offices may also assist the client with submitting their application.

Documents Needed by Financial Workers

Financial workers will need to gather information from the care receiver in order to determine their financial eligibility. The table below identifies the types of documents that may be requested:

Verification Needed	Examples of what may be used
NAME, AGE, CITIZENSHIP, ID	Birth certificate Driver's license Immigration documents Passport Adoption papers Military papers Divorce decree
SOCIAL SECURITY NUMBER	Social Security card or application receipt Tax statement Pay stubs
INCOME SOURCES	Pay stubs* Tax returns Self-employment records Letter from employer Proof of unemployment Social Security* SSI
RESOURCES & OTHER ASSETS	Bank/credit union statements (for the month the TSOA application was received)* Note: if TSOA was requested on the LTC application 18-005 then bank statements may be requested for additional months Passbooks Life and burial insurance policies Stocks, bonds, annuities, notes, trust*
VEHICLES (CARS, BOATS, RV's, ETC.)	Title Registration Sales contracts
LAND, BUILDINGS, PROPERTY	Deed Tax statements Sales contracts
OTHER IMPORTANT INFORMATION	Financial Power of Attorney Legal Guardian Include the following for both: • Phone numbers • Addresses

*most commonly used document to verify financial eligibility

An ACES Coverage Group Guide that identifies the most common eligibility groups for MAC and TSOA can be found in the financial tile on the MTP Community WorkSpace. Below is a screen shot of the summary page of this document.

ELIGIBLE FOR MAC - NOT ELIGIBLE FOR TSOA			
Most common ACES coverage group	Description		Scope
N05	Adult 19-65 Medicaid Expansion coverage (ABP)		ABP
S01	A person who receives an SSI cash payment and medicaid		CN
S02	A person who does NOT get an SSI cash payment but is eligible for medicaid due to low income.		CN
Eligible for MAC - not common	Description		Scope
N01	MAGI Parent/Caretaker		CN
N02	MAGI Parent/Caretaker on 12 months transitional coverage		CN
S08	Healthcare for Workers with Disabilities (under 65 and working)		CN
S30	Breast & Cervical Cancer recipient (Women only)		CN
L32	Hospice SSI-related recipient		CN

ELIGIBLE FOR TSOA - NOT ELIGIBLE FOR MAC			
TSOA coverage group	Description		Scope
T02	Tailored Supports for Older Adults		N/A
Most common ACES coverage group	Description		Scope
S95/S99	Medically needy (with spenddown)		MN
S03	QMB - Qualified Medicare Beneficiary		MSP
S04	QDWI - Qualified Disabled Working Individual.		MSP
S05	SLMB - Specified Low-Income Medicare Beneficiary		MSP
Eligible for TSOA - unlikely	Description		Scope
P05	Family planning		FPSO
P06	Take charge family planning		FPSO

NOT ELIGIBLE FOR MAC OR TSOA (ONGOING) - NON CITIZENS			
ACES coverage group	Description		Scope
A01	Blind/disabled or 65+ non-citizen		MCS
A05	Temporary incapacity - non-citizen		MCS
L24	State-funded LTSS program		SFCN
N21	AEM - MAGI parent/caretaker - Emergency Related Services		ERSO
N25	AEM - MAGI new adult - Emergency Related Services Only		ERSO
S07	AEM - Alien Emergency Medical - Emergency Related Service		ERSO

LTSS IN-HOME COVERAGE GROUPS - USE CAUTION!			
ACES coverage group	Description	Participation?	Scope
L21	HCS waiver recipient with SSI cash and Apple Health	No	CN
L31	PACE recipient with SSI cash and Apple Health	No	CN
L41	Roads to Community Living recipient with SSI cash and Apple	No	CN
L51	Community First Choice recipient on SSI cash and Apple Health	No	CN
L22	HCS waiver - low income Apple Health, without SSI cash	Yes*	CN
L32	PACE recipients, on Apple Health, without SSI cash	Yes*	CN
L42	Roads to Community Living recipient on Apple Health, without	Yes*	CN
L52	Community First Choice recipient on Apple Health, without SSI	No	CN

* These groups usually pay towards cost of care but not always. Check ACES

Changes and reporting requirements for TSOA and MAC

Reporting requirements are different for each program.

TSOA recipients only report minimal changes per WAC 182-513-1650 (2):

(a) A change in residential or mailing address, including if the TSOA recipient moves out-of-state;
(b) When a person admits to an institution, as defined in WAC 182-500-0050, and is likely to reside there for thirty days or longer; or
(c) The person dies.

The only change for TSOA that must be reported within 30 days of the date of the change, is admitting into an institution (b).

Once a person is determined eligible for TSOA, they remain continuously eligible throughout the 12-month certification unless one of the following changes happens:

- The person no longer meets NFLOC;
- The person is no longer a WA state resident;
- The person moves into an institution (nursing facility);
- The person becomes eligible for CN or ABP Medicaid; or
- The person passes away.

More information can be found at: TSOA certification periods, change of circumstances, and renewals | Washington State Health Care Authority

MAC recipient must report changes within 30 days per the program they are receiving care under. MAC authorized under S-track and N-track have different reporting requirements.

If the care receiver is N-track, age 19-64 and not eligible for Medicare, they report changes to the Health Care Authority based on N-track MAGI rules:

- Income over the limit for their household size and expected to last over 30 days
- Address change
- Citizenship/Immigration Status change
- Change in Marital Status
- Moved out of state
- No asset test for N-track, no need to report resource changes if on N05, for example.

If the MAC recipient is receiving services under S-track, Example S02, they would report all changes mentioned above, including resources, within 30 days to Department of Social and Health Services - HCS.

More information can be found in the Washington Apple Health Manual at:
Changes of circumstances reporting requirement | Washington State Health Care Authority

Eligibility When in Hospital, Jail or Rehabilitation Facility

When a MAC or TSOA care receiver is in the hospital, jail or a rehabilitation facility for less than thirty (30) days, their financial eligibility is not impacted.

However, for TSOA recipients, if their stay in any of these locations is thirty (30) days or more, based on WAC 182-513-1650, the care receiver would no longer be financially eligible. The PBS worker would close the TSOA T02 coverage group. T02 can be reopened when the care receiver discharges home if the care receiver is not active on CN or ABP Medicaid and the T02 is still within the original certification period. If a CN or ABP Medicaid coverage is opened by the PBS, this typically is scheduled to end at the end of the month. The T02/3199 financial RAC cannot be screened in by the PBS until after the CN or ABP Medicaid is closed. If outside the original certification period, a new application would need to be submitted. However, if they were receiving Medicaid services while in a nursing facility, they wouldn't need to complete a new application as the financial worker would be able to do a program change in ACES.

MAC care receivers in a hospital, jail, or rehabilitation facility for thirty (30) days or more, depending on the Categorically Needy (CN) or Alternative Benefit Plan (ABP) Medicaid coverage group (Apple Health) they are enrolled with, will have different actions taken by PBS staff. It is important to check the care receiver's coverage in ACES or Barcode, prior to re-establishing services when the care receiver returns to their home and community-based setting.

Eligibility When Temporarily Out of the Country or Requesting to Put Paid Services on Hold temporarily

If the care receiver is temporarily out of the country or has requested to put their paid services on hold, but their intent is to return and re-engage in services, TSOA can stay open in ACES within their annual financial eligibility period. The intent to return is key. It is important to check the care receiver's financial coverage in ACES prior to re-establishing services to ensure financial RACs remain opened and unchanged.

When is a New Application Required

As care receiver and unpaid family caregiver's situations change; transitions in both functional and financial programs may occur. The below are some scenarios on when a new LTSS 18-005 application would not be needed:

- If the care receiver has transitioned to LTSS and would like to return to TSOA they wouldn't need another application. The PBS would complete a program change.
- If the TSOA coverage group has not been closed yet by the PBS, we wouldn't need a new application. Example: it's been 30 days, but the PBS hasn't been able to go in and close the program yet, or the PBS wasn't aware of the situation which resulted in the closure (example: 30+ days in an institutional status).
- Care receiver is active on a classic Medicaid program (S02, S95, S99) PBS could complete a program change, and no application would be required.

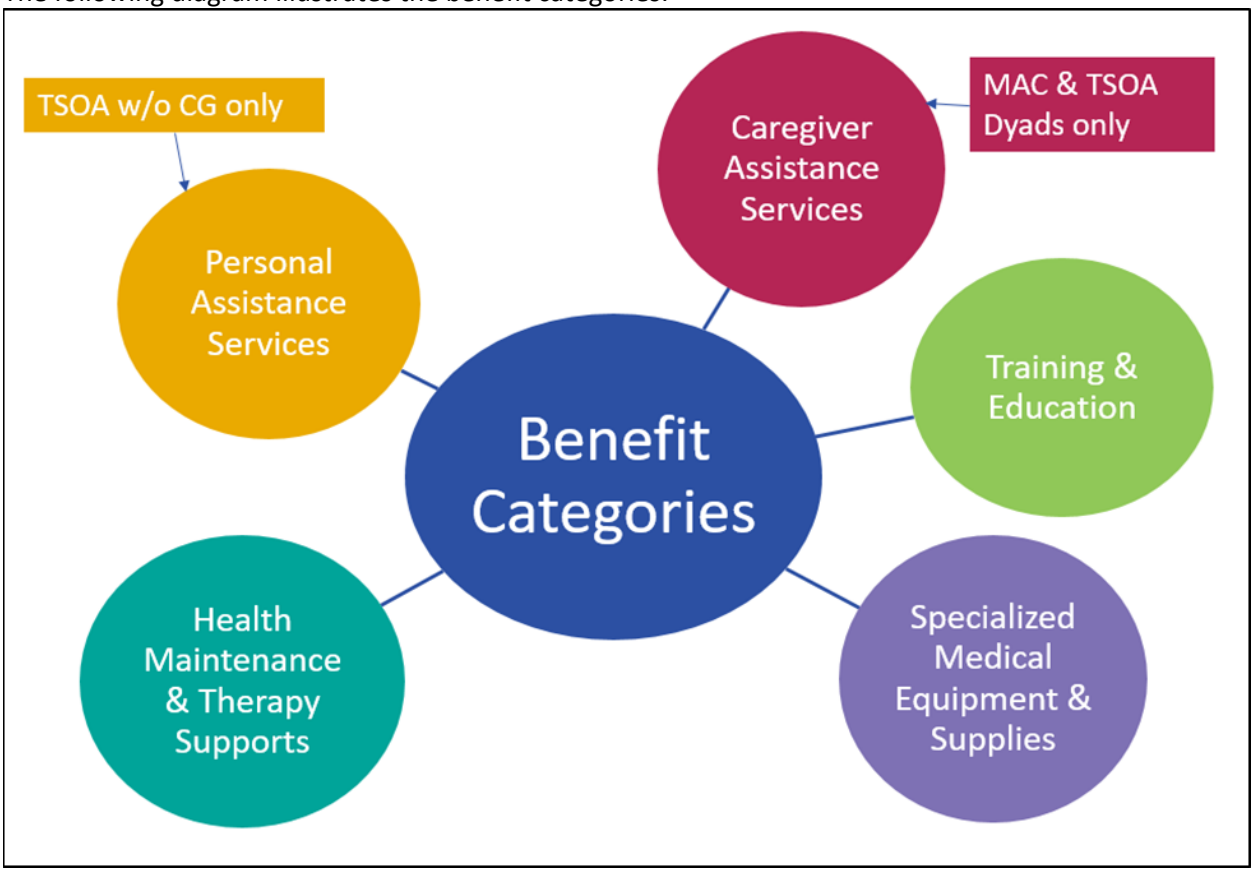
After the ACES Coverage group is closed, the PBS worker could use equal access (EA) rules to reinstate a care receiver within thirty (30) calendar days from when coverage ended, if the PBS is provided proof the care receiver is still qualified. An application or ER would only be needed if they are currently in an annual eligibility review month.

BENEFIT CATEGORIES, SERVICES AND STEPS

For MAC and TSOA programs there are five benefit categories and within each category are a selection of available services.

Benefit Categories

The following diagram illustrates the benefit categories:



- Personal Assistance Services (the orange circle) are available only for TSOA individuals who do not have an unpaid family caregiver.
- Caregiver Assistance Services (the red circle) are available for only MAC and TSOA dyads.
- Services within Training & Education, Specialized Medical Equipment & Supplies, and Health Maintenance & Therapy Supports are available for MAC and TSOA dyads and TSOA individuals.

Services

Network adequacy, mandatory for MAC and TSOA, requires that specific services be available in at least one location within each AAA planning and service area (PSA). The following contains a list of the types of services within each benefit category for MAC and TSOA. **Bolded** items in italics represent the categories used in the Centers for Medicare and Medicaid Services (CMS) Special Terms and Conditions (STCs) for MTP. Underlined subcategories and bulleted service details represent the language used in Family Caregiver Support, CLC- GetCare, and TCARE®. A purple * denotes services that may be received by a unpaid family caregiver and a care receiver. Additional services may be added to this list into the future.

Caregiver Assistance Services

Services that take the place of those typically performed by the unpaid caregiver in support of unmet needs the care receiver has for assistance with activities of daily living (ADLs) and instrumental (IADLs).

Caregiver Assistance Services are not available to TSOA individuals without an unpaid caregiver – see Personal Assistance

Respite

- Adult Day Care (where available)
- Adult Day Health (where available)
- Memory Care and Wellness Services
- Overnight Facility-Based Respite
- Overnight In-home Respite
- In-Home
- Nurse Delegation, in conjunction with respite care

Supplemental Services

- Transportation
- Home Safety Evaluation
- Housework and Errands in the Care Receivers Home*
- Yardwork
- Snow Removal
- Home Delivered Meals (HDM)*
    - Maximum limit of 2 meals per day (3rd meal can be requested via local ETR)
    - Meals may be provided for both the caregiver and the care receiver (up to 2 per day for each participant)

    Note: Unlike someone receiving HDM via traditional LTC, such as COPES, a care receiver or caregiver does not have to be homebound. The cost of the meals must be deducted from the care receivers step level benefit amount (no additional hourly deductions of personal care hours are needed).

- Bath Aide
- Home modifications and repairs
- Specialized Deep Cleaning
- Pest Eradication

- Community Choice Guiding Service

Training & Education

Services and supports to assist caregivers with gaining skills and knowledge to implement services and supports needed by the care receiver to remain at home or skills needed by the caregiver to remain in their role. Also available for TSOA individual care receivers as applicable.

Support Groups
- Online Support Group*
- Support Group*

Training/Consultation (Group Training; Health and Wellness Consultation; Consultation on Supported Decision Making; Financial or Legal Consultation)
- Occupational Therapist Consultation*
- Physical Therapy Consultation*
- Dementia Consultation/Training*
- Long Term Care Planning*
- Legal Services*
- Caregiver Conference
- Caregiver Consultation
- Family Caregiver Training/Education
- Powerful Tools for Caregivers
- Dietician Consultation*
- Chronic Disease Self-Management Program*
- Fall Prevention Workshop*
- Medication Management*
- STAR-C
- RDAD (Reducing Disease in Alzheimer's Disease)

Each AAA must have at least one service that provides:
1. Coping/skill building, and
2. Training to meet the needs of the care receiver)

Specialized Medical Equipment & Supplies

Goods and supplies needed by the care receiver.

Supplemental Services
- Personal Emergency Response Systems (PERS)
  - PERS is a monthly service with optional add-on services such as medication reminder, falls detection, or GPS locator.
- Assistive/Adaptive Equipment
- Durable Medical Equipment (DME)
  - Requires a health care provider's order/prescription in order for DME provider to claim for payment
- Care Supplies (such as incontinence supplies)

Health Maintenance & Therapy Supports

Clinical or therapeutic services that assist the care receiver to remain in their home or the caregiver to remain in their caregiving role and provide high quality care. Services are provided for the purpose of preventing further deterioration, improving or maintaining current level of functioning. Supports and services categorized here include those typically performed or provided by people with specialized skill, certification or licenses. Also available for TSOA individual care receivers as applicable.

Counseling*

- Must be short-term and solution oriented

Supplemental Services

- Adult Day Health (where available)
- Health promotion wellness service. This health promotion wellness service may be offered under Training/Consultation for example, Powerful Tools for Caregivers or Chronic Disease Self-Management Education (CDSME)
- Wellness Programs and Activities*
- Health promotion and wellness services such as Acupuncture* and Massage*
- RDAD (Reducing Disability in Alzheimer's Disease)
- Evidence-Based Exercise Programs*

Personal Assistance Services

Supports involving the labor of another person to help TSOA individual participants carry out everyday activities they are unable to perform independently. Services may be provided in the person's home or to access community resources.

- Personal Care
- Nurse Delegation, in conjunction with personal care
- Housework and Errands
- Yardwork
- Snow Removal
- Pest Eradication
- Specialized Deep Cleaning
- Community Choice Guide Services
- Adult Day Care
- Transportation
- Home Delivered Meals
    - Maximum limit of 2 meals per day (3rd meal can be requested via local ETR)

      Note: Unlike someone receiving HDM via traditional LTC, such as COPES, a care receiver does not have to be homebound. The cost of the meals are to be deducted from the care receivers step level benefit amount (no additional hourly deductions of personal care services should occur).
- Home Safety Evaluation
- Home modifications and repairs

Some of the services available through the MAC and TSOA programs are defined in WAC:

Adult Day Care: WAC 388-106-0800 through WAC 388-106-0805
Adult Day Health: WAC 388-106-1810 through WAC 388-106-1815
Nurse Delegation: WAC 246-840-910 to 960
Personal Care Services: WAC 388-106-0010

CMS requires in federal policy that Medicaid is the payer of last resort. Below is the general funding hierarchy used for ALTSA programs and services beginning with first payer:

- Private insurance
- Personal resources
- Medicare
- Medicaid
- Waiver funded programs (such as CFC, COPES, MAC, TSOA)
- State funded programs (such as Washington Roads)

Steps

Once a care receiver has been determined to be eligible, either presumptively or fully confirmed, services are provided at one of three different steps. The chart below lays out the steps and criteria for accessing services at each step. AAAs are responsible for tracking care receiver expenditures to prevent over-expenditures at any step.

Program	Step 1 Based on demographics & program eligibility; may receive under PE	Step 2 Based on demographics, program eligibility, & results of a TCARE® or GetCare Screening; may receive under PE	Step 3 Based on demographics, program eligibility, & results of a TCARE® or GetCare Assessment; may receive under PE
MAC/TSOA Dyads	$250 one-time only	$500 annually minus any expenditures at Step 1	Avg. $844 monthly not to exceed $5,064 in a six-month period*
TSOA Individual w/o CG	$250 one-time only	$500 annually minus any expenditures at Step 1	Avg. $844 monthly not to exceed $5,064 in a six-month period*

*as of 7/1/2024. The Step 3 benefit level formula uses the home care agency hourly rate in its calculation. Therefore, the Step 3 benefit level will change according to the rate determined by the rate setting board. Please see the "MAC-TSOA" tab on the HCS Rates website for the most current step 3 benefit level.

As is the policy for Family Caregiver Support Program, if someone had an initial risk score qualifying them for Step 3 benefit level and the next screening showed a lower risk score, we would not move them "down" to Step 2 benefit level. The lower risk score may be an indication that the Step 3 services are benefiting the participant.

A caregiver may provide services to multiple care receivers (such as an adult daughter caring for both her mother and her father). Each care receiver has a benefit level that can be used to support their

caregiver. However, the case worker needs to ensure that the funds for each care receiver is not duplicating services for their shared caregiver.

A care receiver may have more than one caregiver (such as a father that has two adult children sharing the caregiving tasks). However, the care receiver has only one benefit level that must be shared in order to provide the supports to both caregivers.

SCREENINGS AND ASSESSMENTS

Screenings and assessments for MAC and TSOA are completed in the CLC/ GetCare or the TCARE® system. Screenings must be completed at least every six months or more frequently if there is a change in the caregiver's or care receiver's condition.

- Example: Screening is completed January 15th. Next screening is due by July 31st.

If the six-month rescreen does not result in a change in the risk scores, then a six-month assessment is not required. However, both GetCare and TCARE® assessments must be completed at least annually or more frequently if there is a change in the caregiver's or care receiver's condition.

- Example: Assessment is completed January 15th. Annual assessment is due by January 31st the following year.

Assessments and Screenings may be completed outside of the care receiver's residence. For example, the assessment for the TSOA individual can be completed in the hospital or rehabilitation facility in preparation for discharge home. A benefit of doing so is facility staff may be present during the assessment to provide their feedback about the current support needs for the care receiver. Another benefit of doing the assessment and screening in an alternative setting is getting care planning started prior to discharging to expediate service delivery.

The TSOA individual care plan can be created with the services that are intended for the care receivers' home and community-based setting. Consent can be given by the care receiver and the care plan can be created while the care receiver is still in the facility. The start date of the care plan should be the discharge date or later (e.g., should not be a date when the care receiver is still in the facility). The important item to remember (CMS rule) is that the service enrollment/authorization must have a "from" date that is equal to or later than the discharge date. A face-to-face visit should occur after the care receivers discharge to view the living environment of the care receiver. The face-to-face visit does not need to occur prior to care plan creation and authorization of services but must be completed during the annual care plan period, best practice being within 30 days of discharge.

For dyads, the TCARE® assessment with the unpaid family caregiver may be completed when the care receiver is in the facility and preparing for discharge. In this situation, it may also be useful to have a facility staff provide feedback about the current support needs for the care receivers ADLs. For dyads, the care plan can also be completed with the unpaid family caregiver while the care receiver is still in the facility. The unpaid family caregiver would need to respond and select services based upon what supports the unpaid family caregiver will need once the care receiver returns home. Consent can be given by the caregiver and care receiver and the care plan can be started while the care receiver is still in

the facility. One face-to-face visit during the TCARE® assessment or consultation process is required before services can be authorized during the initial assessment/consultation process as well as during subsequent annual TCARE® reassessments/consultations. If the caregiver and care receiver live together, at least one home visit must occur in the home with both caregiver and care receiver present. This home visit allows the assessor to evaluate the living situation and must be completed before the care plan is created. When caregiver and care receiver don't live together, a home visit in the care receiver's home is strongly encouraged, though not required. Again, we still need to follow the CMS rule ensuring that the service enrollment/authorization must have a "from" date that is equal to or later than the discharge date.

GetCare

GetCare is the primary case management information system for MAC and TSOA. This system contains many elements necessary for implementing the MAC and TSOA programs including but not limited to:

- Demographic information for caregivers and care receivers
- Screening tool and assessment for TSOA individual without a caregiver
- Presumptive Eligibility assessment
- Annual NFLOC assessment

The GetCare Screening (TSOA without a CG Screening) is a process that gathers information about the individual without a caregiver in order to determine risk scores. The information gathered includes functional needs, fall risk, availability of informal support, memory and decision-making issues, and emotional well-being. The risk scores from the screening are used to determine if the individual will be referred for a TSOA without a CG Assessment.

The TSOA without a CG Assessment is a process that gathers information about an individual without a caregiver in the following areas: functional needs (All ADL's should utilize a 7-day look back period. All IADL's – essential shopping, housework, meal preparation, and medical transformation should use a 30 - day look back period. Medication management would be selecting the highest level of need (no 7 days look back period), diagnoses and conditions, behavioral health supports, oral health, and nutritional health needs. The assessment will assist the individual with choosing the Step 3 services that will address their assessed needs.

For TSOA without a caregiver care receivers, the TSOA Individual without a Caregiver Assessment may be completed remotely although best practice is to complete a face-to-face assessment. Assessments must be completed at least annually in a location convenient to the care receiver. One face-to-face visit must occur at least annually to view the living environment of the care receiver. The face-to-face visit does not need to occur prior to care plan creation but must be completed during the annual plan period.

TCARE®

The TCARE® process is based on the premise that providing the right service at the right time supports those unpaid family caregivers who are burdened by their caregiving responsibilities. TCARE® includes screening, assessment, consultation, and service planning elements that are designed to be utilized with

the Family Caregiver Support Program (FSCP), Medicaid Alternative Care (MAC), and Tailored Supports for Older Adults (TSOA) programs which are administered through the Area Agencies on Aging (AAA). The TCARE® process:

- Validates the family caregivers' feelings and experiences along their caregiving journey,
- Stimulates caregivers to reflect on their caregiving responsibilities through relevant and insightful questions,
- Provides structure to the interview between the assessor and the caregiver, and
- Identifies a broad range of support services available through public and private funding that address the specific stressors and burdens of the caregiver

There are several parts to the TCARE® process, two of which are the TCARE® Screening and the TCARE® Assessment. The TCARE® Screening can be conducted in a variety of settings: in person, by telephone, or through a self-screen form called the Personal Caregiver Survey. The scores from the screening determine whether the caregiver should be referred for the third part of the TCARE® protocol which is the TCARE® Assessment. The assessment includes all of the screening questions, as well as additional questions focused on both the caregiver's experience and the care receiver's situation. Some of the major areas covered in the assessment are care receiver behaviors, memory issues, ADLs, IADLs, Cognitive Performance questions and diagnoses/conditions. When the need for an assessment is indicated by the screening, the assessment and care plan must be completed within 30 calendar days of the screening.

For MAC and TSOA dyads, one face-to-face visit during the TCARE® assessment or consultation process is required before services can be authorized during the initial assessment/consultation process as well as during subsequent annual TCARE® reassessments/consultations. If the caregiver and care receiver live together, at least one home visit must occur in the home with both caregiver and care receiver present. This home visit allows the assessor to evaluate the living situation and must be completed before the care plan is created. When caregiver and care receiver don't live together, a home visit in the care receiver's home is strongly encouraged, though not required.

For complete details on the TCARE® process, see Chapter 17a of the LTC manual.

CARE PLANS AND SERVICE NOTICES

The Centers for Medicare and Medicaid Services (CMS) require that a care plan must be completed *prior* to authorizing services. Additionally, MAC and TSOA enrollees must receive a formal written notice of the services being authorized.

Step 1, 2, and 3 care plans

Care plans are created in GetCare for MAC & TSOA dyads and TSOA individuals who are receiving Step 1 or Step 2 services. TSOA individuals receiving Step 3 services will also have a GetCare care plan. MAC & TSOA dyads receiving Step 3 services will have a care plan developed in TCARE®.

PROGRAM	STEP 1:	STEP 2:	STEP 3:

MAC or TSOA dyad	Care plan in GetCare	Care plan in GetCare	Care plan in TCARE®
TSOA w/o a caregiver	Care plan in GetCare	Care plan in GetCare	Care plan in GetCare

The care plan includes paid and unpaid services addressing the identified needs of the caregiver and the care receiver. The care receiver must provide consent of the plan before services can be authorized. Verbal consent can be provided initially (and documented in the care plan) with written consent provided within 60 days of completing the plan. For MAC and TSOA dyads, the TCARE® care plan requires both the care receiver and caregiver verbal consent. The caregiver signature is best practice per FCSP policy. Written consent may be provided by secure email or other electronic means for Step 1 and Step 2 services per WAC 388-106-1980(3).

The care plan must be reviewed and updated at least annually. If there are no changes in the services/supports identified in the care plan during the 6-month rescreening process then a new care plan does not need to be created, if the 'Next Expected Care Plan Date' is in the future. The care plan should represent the services each dyad or individual has chosen to address the areas identified in their assessment and discussed during the person-centered conversation.

It is important that the care plan is locked, and verbal consent has been received from the care receiver before any service authorizations are created. There is an option to link service enrollments (linking is optional) in the GetCare care plan as a simple way to identify requested services into the plan or you can create an enrollment directly in the care plan. All paid services must be included in the care plan. Once the care plan is locked it cannot be edited.

For dyads who are receiving Step 3 services, workers will complete the Care Plan using the TCARE® process. If a caregiver has had a significant change or a change in their service needs at 6-month TCARE® screen, and/or requests to have a new assessment, a new assessment must be conducted, and a new care plan must be created that reflects the changing needs of the caregiver.

Unpaid services (services or referrals that do not require payment authorization through ProviderOne) still need to be captured on the care plan. If the care receiver is enrolled in MAC or TSOA and only receiving unpaid services such as a support group, they still need to have a locked care plan.

NOTE: If a service such as respite or personal care will be part of the care plan but you are waiting to find a home care agency with an available provider in order to complete the enrollment, you can add the service and select status of "pending" or you can identify the service in the care plan (i.e. Respite Paid Provider or Personal Care Paid Provider) and then document in the progress notes the search for a qualified provider is underway. There should be updates on the search, ongoingly documented in progress notes until the provider is found.

There are 4 different types of Care Plans in GetCare:

- Initial – select this for the first care plan created in GetCare
- 6 month – used only if you intend to create a new care plan based upon the 6-month rescreening process and outcome

- Annual – used for on-going care plans that are completed at least every 12 months
- Change in condition – use this option if changes to care plan (such as adding new services) are identified due to change in the care receiver or caregiver's condition outside of the annual care plan process

There are 4 different types of Care Plans in TCARE® as well:

- 6 month – used only if you intend to create a new care plan based upon the 6-month rescreening process and outcome.
- Annual – used for on-going care plans that are completed at least every 12 months.
- Review – rarely used in the care planning process as the other 3 types of care plans typically are used
- Other – use this option if changes to care plan (such as adding new services) are identified due to change in the care receiver or caregiver's condition outside of the annual care plan process.

The auto-populated due date for care plans falls on the last day of the month (6 or 12 months) from the date the care plan 'Type' indicates. For example, on 6/15/24 the care annual plan is created and the 'Expected Next Care Plan Date' is populated with date of 6/30/25. This date can be edited.

For the initial care plan, when moving from Presumptive Eligibility to Full RAC, you do not need to create a new care plan if the 'Expected Next Care Plan Date' is in the future unless there is a change in condition or if you are adding/deleting services in the care plan.

If there are no changes to the care plan during the 6-month re-screening process then a new care plan does not need to be created, if the 'Expected Next Care Plan Date' is in the future. If there is a change in condition of the caregiver or the care receiver resulting in a change to the care plan such as a new service being put in place or a service being removed, then a new assessment must be completed along with a new signed care plan.

Service Notices

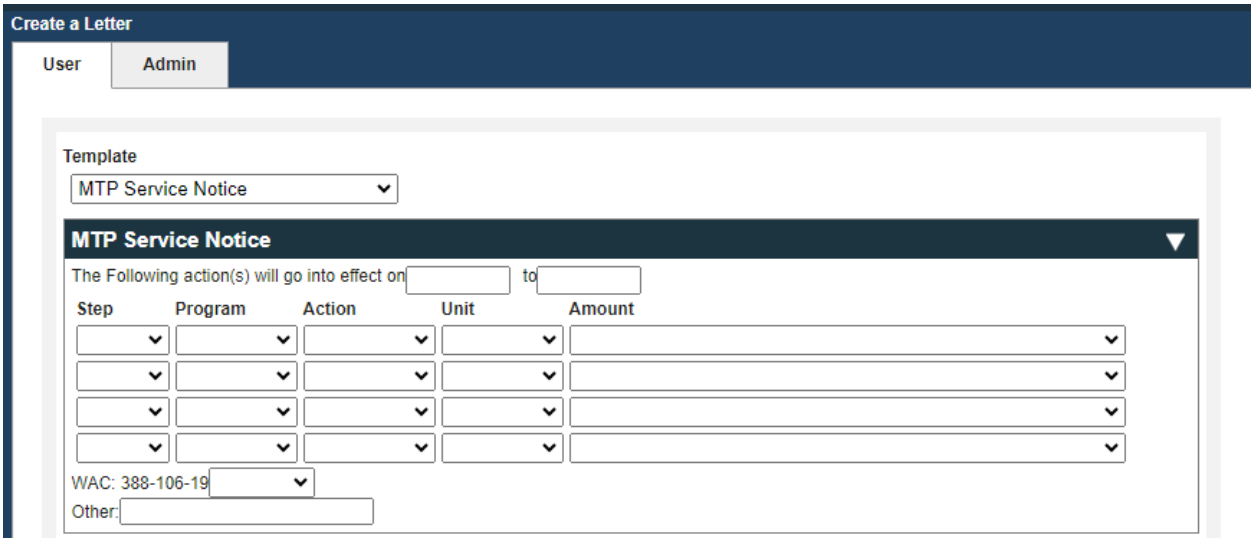
The purpose of the MTP Service Notice (DSHS 15-492) is to provide the care receiver with information about the amount of funding available for accessing goods and services under their specific benefit level (Step 1, 2 or 3). The notice also includes information about their administrative hearing rights if they disagree with the amount of funding approved or denied. Service notices are not required under presumptive eligibility (PE) but must be completed and sent to care receivers once they move out of PE into full eligibility. The service notice should be sent to the care receiver along with the care plan that needs to be signed.

Service notices must be sent to the care receiver at least (ten) 10 calendar days before the effective date of an adverse action such as denial, reduction, or termination. The service notice needs to describe what action is being taken and under what authority that action is being taken (the specific WAC reference).

Reminder: Ensure enough time is allowed for translations, when needed. The MTP English and Translated versions should be mailed to the Care Receiver together.

A MTP Service Notice (DSHS 15-492) also needs to be sent when the care receiver changes from one step/benefit level to another.

Approved (includes annuals/renewals and changes)	• Initial eligibility decision for full services • Continued eligibility/services when there is no change • A change in services from one step level to another Example: - Client was receiving Step 2 benefits and at the annual is now eligible for Step 3 benefit level.
Withdrawn	• Requests for services that are withdrawn by the client after the assessment was initiated and before services were initiated or authorized. Example: - Client went from PE to Full but never received any authorized services. If client, indicates they would like to withdraw then the action 'withdrawn' can be utilized.
Denied	• Not eligible for requested service/program and services were never initiated or authorized. Example: - Client was found to be eligible for Step 2 but is requesting services only offered under the Step 3 benefit package.
Terminated	• Services/program terminated Example: - Client was found to no longer be eligible for services at the annual NFLOC - Client started services but later requested to withdraw. As services had been provided, terminated would need to be used as the action.



Example: Care receiver was found to no longer be financially eligible. TSOA AAA Staff was notified via Barcode that the last day of financial eligibility will be 8/31/2024. MTP Service Notice should be sent out no later than 8/20/2024 (allowing at least 10 days' notice due to an adverse action). The following action date would be 8/31/2024. All RACs and Authorizations would need to be ended and not extend beyond 8/31/2024.

There is an instruction form providing guidance on how to correctly fill out the MTP Service Notice. It can be found on the DSHS forms page at https://forms.dshs.wa.lcl/formDetails.aspx?ID=38862 .

Translated versions of the Medicaid Transformation Project Service Notice DSHS 15-492 are available on the DSHS forms page. If needing a language, not available on the DSHS forms page, please contact Adrienne Cotton and Resa Lee-Bell. Any translated version of the MTP Service Notice (15-492) document must be stored in the client's GetCare electronic file cabinet.

RACS

Recipient Aid Categories (RACs) identify to the ProviderOne system under which program (MAC, TSOA, or other) the dyad or individual without an unpaid family caregiver is going to receive services either through presumptive eligibility or fully confirmed eligibility. Additionally, ProviderOne has been configured to know which services can be authorized under which RAC. Selecting the correct functional RAC is important so that data extracted from ProviderOne accurately reflects service provision and providers are correctly paid. The functional RAC must match the financial RAC that is sent from ACES to ProviderOne or an error will occur.

The functional RACs, also known as ALTSA RACs, indicate what program and related services the dyad or individual is eligible to receive. They are as follows:

RAC Title	RAC	RAC Description
Medicaid Alternative Care (MAC)	3170	Care receivers are Medicaid eligible
Medicaid Alternative Care : Presumptive Eligibility (Pre-MAC)	3171	Care receivers have time limited presumptive eligibility both financially and functionally
Tailored Supports for Older Adults (TSOA)	3175	Care receivers meet TSOA financial eligibility which allows for a higher income and resources than Medicaid
Tailored Supports for Older Adults: Presumptive Eligibility (Pre-TSOA)	3176	Care receivers have time limited presumptive eligibility both financially and functionally.
Tailored Supports for Older Adults No Unpaid Caregiver (TSOA-No-CGR)	3177	Care receiver does not have an unpaid caregiver, meets TSOA financial eligibility which allows for a higher income and resources than Medicaid.
Tailored Supports for Older Adults No Unpaid Caregiver: Presumptive Eligibility (Pre-TSOA-NO-CGR)	3178	Care receivers without an unpaid caregiver have time limited presumptive eligibility both financially and functionally.
Not Presumptively Eligible for MAC and TSOA (NOPE)	3190	Used when care receiver was: ○ initially enrolled as presumptively eligible for either MAC or TSOA; ○ received paid services; and ○ was later found to be ineligible. • • Once found ineligible for MAC or TSOA this RAC must be added to mirror the PE RAC dates to reprocess claims into the correct funding bucket in order to comply with federal reporting requirements.
State Only Adjustment of Payment (SOAP)	3490	This RAC should be used minimally and requires HQ pre-approval. This RAC is used only when a payment for services was made in error (the care receiver was not eligible to receive the services) and the payment

		must be made using state-only funds. The claim must be reprocessed by ProviderOne.

AAA staff must open the MAC/TSOA Service Enrollments section in GetCare and change the care receiver's RACs when they change from presumptive eligibility to fully confirmed eligibility or when adding the NOPE.

Typical RAC Timeframes

TSOA enrollees may or may not have financial eligibility at the time of their Presumptive Eligibility screening. Presumptive Eligibility TSOA RACs will begin on the date of the locked functional PE screening and end on the last day of the following month with one exception – if the care receiver submits a TSOA financial application within the PE period, the care receiver remains presumptively eligible until the HCS financial worker determines full financial eligibility.

MAC and TSOA Presumptive Eligibility (PE) and a locked care plan must be completed prior to any services being authorized.

If the TSOA care receiver did not previously have financial eligibility, the worker must wait to hear from HCS financial worker about their financial eligibility determination before moving the individual from PE to full eligibility. In this case, the full functional eligibility date spans one year from the date that the PE assessment was confirmed by HCS worker and may extend to the end of the month. For example:

- PE assessment NFLOC confirmed 10/29/24.
- Full financial eligibility confirmed 11/17/24.
- Full eligibility RAC start date = 12/01/2024; end date = 10/31/25.
- NFLOC reassessment must be completed WITHIN one year of initial PE or in this case, before 10/31/25.

MAC enrollees must have financial eligibility at the time of their Presumptive Eligibility screening. This means that functional eligibility confirmation is the last step in determining full eligibility for MAC care receivers. Due to this, MAC care receivers often do not have a PE RACs or the MAC PE RACs coverage dates are minimal. Full MAC eligibility will begin on the date functional eligibility is confirmed by HCS and end on the last day of the month one year later. Financial eligibility will be determined on a different cycle therefore Barcode and ACES should be monitored to ensure continued financial eligibility.

Managing RACs, Enrollments and Service Authorizations When Care Receiver is in Hospital, Rehabilitation Facility or Jail

If the care receiver is in the hospital, rehabilitation facility or jail for 30 days or less, you must do the following:

- Leave the functional RAC in place and do not change start or end dates
- Leave the enrollment in place and do not change start or end dates

- Change the end date of the P1 service authorization service line to match the date of admission into the hospital/facility. Notify paid providers and have services put on hold.
- If less than 30 days, The AAA staff should evaluate if there are any changes in the care receiver service needs and if so, complete a change in condition assessment and care plan.
- If the stay becomes longer than 30 days but the intent is still to return home with MAC or TSOA services, The AAA staff would need to complete the NFLOC, updated screening and assessment as well as a change in condition care plan prior to services being re-instated.
- AAA staff must lock the change of condition care plan prior to authorizing additional services.
- Verify care receiver remains active in ACES and Barcode
- Once the care plan is locked, the AAA Staff can create a new P1 service authorization line (no earlier than the date of discharge).

No services can be authorized (including services and supports being provided to the unpaid family caregiver, while the client is hospitalized, in a rehabilitation facility or in jail.

If the care receiver is in the hospital/facility for 30 days or more. The AAA staff would need to check the MAC or TSOA care receivers' financial eligibility coverage and communicate with financial as needed to ensure the appropriate financial RAC is opened prior to re-establishing paid services. The AAA Staff would then need to complete the NFLOC, updated screening and assessment as well as a new care plan prior to services being re-instated.

Managing RACs, Enrollments and Service Authorizations when there will be a temporary pause in services

If the MAC or TSOA care receiver is requesting to temporarily pause services, for 90 days or less (example: will be out of the country but the care receiver's intent is to return and re-engage in services), you must do the following:

- Ensure the duration of the pause will not span over a functional or financial eligibility review due date. If so, proceed with a voluntary disenrollment. Leave the functional RAC in place and do not change start or end dates
- Leave the enrollment in place and do not change start or end dates
- Notify paid providers and then change the end date of the P1 service authorization lines to match the date client is departing or is requesting to pause services
- The AAA staff would need to do the annual NFLOC upon client's return to determine that the care receiver still meets NFLOC. An updated screening, assessment and care plan would also need to be completed.
- Verify care receiver remains active in ACES and Barcode
- Once the care plan is locked. The AAA Staff can create a new P1 service authorization.

If the MAC or TSOA care receiver is requesting to temporarily pause services for 90 days or more, you must do the following:

- Notify care receiver that AAA Staff will be completing a voluntary disenrollment.
- Provide instructions/contact #'s for client to call when wanting/needing services in the future

- Complete closure steps (See Checklist)

If the client would like to re-engage services after being disenrolled, The AAA Staff should start the re-enrollment process similar to a new enrollee. The AAA Staff and HCS MTP staff would need to complete the Presumptive Eligibility (PE) screening. If care receiver is determined NFLOC on the PE. AAA Staff should verify client still is open on the appropriate financial coverage group. If so, CM can proceed with completion of the screening, assessment and care plan. Upon completion of the necessary items per step level (see Step Chart), services can be re-instated. If the client's financial coverage group was closed, AAA CM should notify PBS and may need to assist with a new application depending on the circumstances (please use link to determine if a new LTSS app is needed). If the client has received PE services in the last 24 months; no services can be authorized until the full financial determination is made. If the client has not received PE services in the last 24 months; the AAA Staff may enter the appropriate PE RAC and establish services as outlined in the care plan under PE until the full financial determination is made.

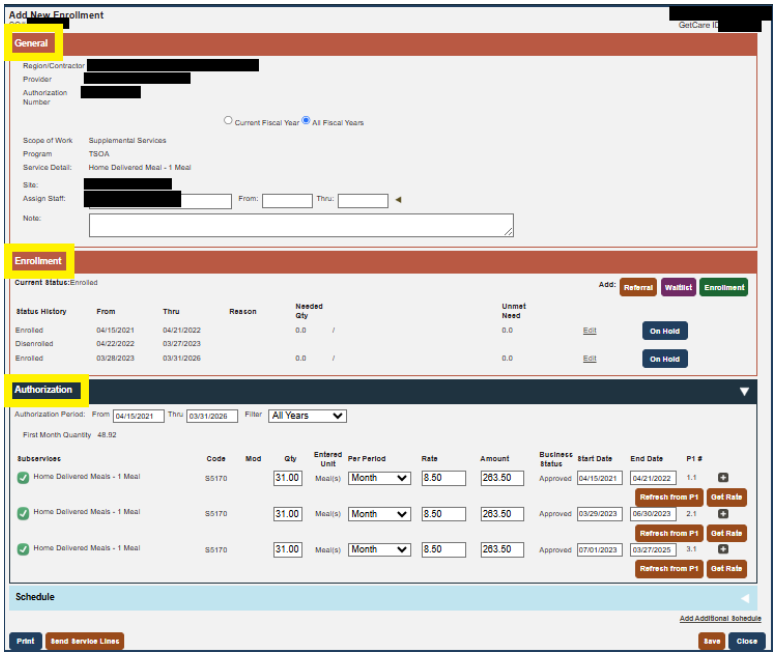
AUTHORIZATIONS

Authorizations for MAC and TSOA services will be completed by AAA staff through the GetCare system which interfaces with P1. Authorizations may be completed only after a P1 identification number has been obtained for the MAC or TSOA care receiver and the care plan has been completed and locked.

Prior to authorizing MAC or TSOA services, due to CMS rules, AAA staff must check for service coverage under Medicaid Apple Health, long-term care insurance, or other third parties such as private insurance. If the care receiver has LTC insurance, private insurance, Medicaid, Medicare or other federal/state programs that will cover the services requested under MAC or TSOA, then MAC or TSOA funds should not be authorized for those specific services. MAC or TSOA may be authorized for services that are not duplicative of services available under the other insurance benefit.

Note: Aid and attendant benefits through the Veterans Administration do not have an impact on the eligibility for MAC and TSOA services. The MAC or TSOA veteran can purchase additional in-home care services with their VA aid and attendant benefits, and it does not change the amount or type of services that can be purchased with MAC or TSOA funding. MTP should be the payor of last resort, by following that policy it prevents duplication and potential "stacking" or supplanting in services covered under private insurance, Medicare, state plan Medicaid, VAMC, or through other federal or state programs.

Each authorization in GetCare has several elements: General, Enrollment, and the Authorization section. The General Section is where the Region, Provider, Authorization Number, Program, and details on the services are entered. The Enrollment section outlines the enrolled and disenrolled status of the care receiver. The Authorization section is where services are entered with corresponding service codes rates, business status, and dates.



Providers being authorized in ProviderOne to deliver MAC and TSOA services must meet certain qualifications and be contracted through the ALTSA HQ or the local AAA prior to services being authorized. Each local AAA maintains a list of contracted, eligible providers for HCS and AAA.

As service lines are created in the authorization section, they are assigned a ProviderOne service line number and the ProviderOne systems confirms this is a service which can be covered under the services benefit package of the opened RAC. If a service is entered which is not configured with the appropriate RAC and error will occur.

Service authorizations created in GetCare for environmental modifications, Durable Medical Equipment (DME) and non-medical equipment and supplies should be entered in Reviewing status. Reviewing status allows the service line for these services to be submitted to ProviderOne, but not to be claimed or paid. After confirmation that the service is completed appropriately, the AAA staff can change the status of the authorization to "Approved" which will allow payment to be issued to the provider. A receipt in the GetCare Electronic File Cabinet (EFC) is also necessary.

More information on authorizations can be found in the GetCare MAC/TSOA Desk Manual in the Help Library.

Common Errors

Common errors refers to the process that occurs when ProviderOne does not recognize submitted information and stops the process of creating/modifying an authorization or allowing a claim to be made against an authorization. For MAC and TSOA, these stoppages will most commonly happen when an authorization header or a service line is submitted with information that conflicts with data that ProviderOne has already accepted. When such a stoppage occurs, ProviderOne will automatically

generate an error message letting the user know there is a problem. Each message is assigned a code by ProviderOne based upon the type of error that occurred. Below is a sample of common errors which occur in MAC and TSOA. For a more comprehensive list, please see the Get Care Help Library Common Issues and Error Codes, MTP Community Workspace, or the ProviderOne Social Services Appendix Common Errors Table.

MTP Related Error Codes in GetCare

GetCare users may see ProviderOne errors while working with authorizations for MAC & TSOA services. Here's a list of what the errors mean, what should be done, and by whom to resolve it.

Error	Error Description	Action Needed	By Whom
Address Errors Invalid	The care receiver's address is invalid	Review, correct, and complete steps to update ProviderOne	AAA Staff
AREP (authorized representative) Warnings	The collateral contact or caregiver with the role of "P1 Client Letters" has an invalid address	Review, correct, and complete steps to update ProviderOne	AAA Staff
02255	Client not eligible for date of service	No action needed; will resolve when full eligibility RAC is added	AAA Staff
30988	Financial Eligibility Requirement	Determine if error should be "forced" and if so, refer to ALTSA HQ for action*	AAA Staff and ALTSA HQ staff
40061	Unexpected error occurred, please contact system administrator (fatal error)	Review service lines to see if unresolved errors exist. If unable to determine source of the error, post error into Issue Manager entitled as "MTP authorization error" for review by AAA supervisor and escalation by local System Admin*	AAA Staff and System Admins / CARE Help Desk
40065	Proc/Svc Code service duration exceeds the maximum allowed duration limit (fatal error)	Review service limits on Service Code Data Sheet (SCDS) and modify, if necessary	AAA Staff

*The local system administrator will review the error with respective AAA staff and, if it is determined there is a valid issue, it will be posted to Issue Manager in GetCare. Escalated errors will be pulled by State System Administrator for review. Issues will be updated as to resolution, or the next steps needed for resolution. Issue Manager tickets once resolved should be closed by either the AAA staff or the system administrator.

More information related to ProviderOne common errors is available on the DSHS/ProviderOne website.

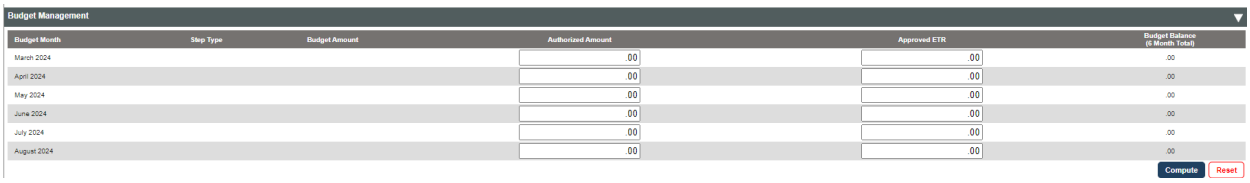
Tracking Benefit Expenditures

AAAs are responsible for tracking client expenditures to prevent over-expenditures based upon the step benefit levels identified in the table below:

Program	Step 1 Based on demographics & program eligibility; services may be received under PE	Step 2 Based on demographics, program eligibility, & results of a TCARE® or GetCare Screening; services may be received under PE	Step 3 Based on demographics, program eligibility, & results of a TCARE® or GetCare Assessment; services may be received under PE
MAC/TSOA Dyads	$250 one-time only	$500 annually minus any expenditures at Step 1	Avg. $844 monthly not to exceed $5064 in a six-month period*
TSOA Individual w/o CG	$250 one-time only	$500 annually minus any expenditures at Step 1	Avg. $844 monthly not to exceed $5064 in a six-month period*

*as of 7/1/2024. The Step 3 benefit level formula currently uses the home care agency hourly rate in it's calculation. Therefore, the Step 3 benefit level will change according to the rate determined by the rate setting board. Please see the "MAC-TSOA" tab on the HCS Rates website for the most current step 3 benefit level.

In the GetCare system, a budget management tool (calculator) is available to AAA staff to assist with managing the 6-month budget. It is located within the MAC/TSOA Service Enrollment section.



The 6-month budget period begins the month the PE assessment or annual NFLOC assessment is locked. Once the Initial or Annual care plan is locked, the 'Step Type', the related 'Budget Amounts' and 'Budget

Balance' will be automatically populate into the tool. Then as MTP services are authorized those will populate in the 'Authorized Amount' and will be subtracted from the 'Budget Balance'.

Authorizations for the Medicaid Unit Incentive (MUI), Pest Eradication, Specialized Deep Cleaning, and Nurse Delegation are funded by MTP's statewide aggregate funding and are not reflected in the 'Authorized Amount' or 'Budget Balance'.

Approved ETR amounts will populate into the 'Approved ETR' column and will calculate into the 'Budget Balance'.

PROVIDERS

In order to claim and be paid for services provided under MAC and TSOA programs, all providers, with the exception of Durable Medical Equipment (DME) providers, must have a DSHS signed contract, be registered or contracted in ACD (Agency Contracts Database), and be enrolled as a provider in ProviderOne. DME providers must have a core provider agreement with Health Care Authority (HCA) and be enrolled as a DME provider in ProviderOne.

All MAC and TSOA providers will be paid through the Health Care Authority's ProviderOne application, the Medicaid payment system.

When a service authorization is created and/or modified and sent to ProviderOne via GetCare, the provider will receive an Authorization Notice generated by ProviderOne. ProviderOne correspondence letters are sent when the following occur:

- A new authorization is created for a client/provider pair.
- An existing authorization service line is changed.
- A service line with a new service code is added.
- Adding or removing dates of service on a service line with an existing service code.
- Change in the amount of authorized units.
- Change in associated tasks.
- Change in the amount of client responsibility applied to the authorization service line.

Mailed ProviderOne correspondence will include the following:

- Names and ID's of provider and client
- Service Code, Modifier, Reason Code, Correspondence description
- Date ranges
- Number of units
- Dollar amount
- Client responsibility (Not applicable in the MAC and TSOA programs)
- Case worker name and phone number

A copy of the P1 Authorization Notice is also sent to the care receiver and for dyads to the unpaid family caregiver (ensure to select 'P1 Client letters' in the caregiver relationship role in GetCare). More information about ProviderOne correspondence can be found in the Social Services Authorization Manual.

Providers need to be added into GetCare with the appropriate ProviderOne number, Location Code and Service Sets. GetCare System Administrators should use Issue Manager in GetCare to request that new providers be entered once the provider has a signed contract in the ACD and been assigned a ProviderOne number.

In an effort in sustaining home care agency providers for MAC and TSOA programs, Community Partners in collaboration with ALTSA created the Medicaid Utilization Incentive (MUI) rate (originally referred to as the "MTP Capital Add-On Rate"). The MUI service line should accompany a personal care or respite care service line and can be claimed by a home care agency who has provided at least 15 minutes of personal care or respite care services in that month of service. If two home care agencies are being utilized, both would be eligible for the MUI as long as at least 15 minutes of personal care or respite care was provided, in that month of service, by each home care agency. If only housework and errands is authorized, the provider is not eligible for the MUI.

Documents Sent to Providers

Below is a table illustrating the specific documents that should be sent by the AAA staff to the provider:

Program	Service	Document
MAC and TSOA dyad • Step 1 and 2 • Step 3	Respite	• For step 1 and 2 - NFLOC assessment and care plan • For step 3 - TCARE® Respite Services Provider Assessment. If temporarily receiving out of home respite in an adult family home or assisted living facility you must also send the Respite Care Provider Addendum (DSHS 13-915).
TSOA Individual w/o CG • Step 3	Personal Care	• GetCare TSOA w/o CG assessment
MAC and TSOA dyad; TSOA individual w/o CG • Step 1 and 2 • Step 3	Adult Day Care Adult Day Health	• For step 1 and 2 – NFLOC assessment and care plan • For step 3 –GetCare TSOA w/o CG assessment or TCARE® Respite Services Provider Assessment
MAC and TSOA dyad • Step 2 and 3 TSOA individual • Step 2 only	Bath aide	• Dyads – send the TCARE® Respite Services Provider Assessment. • TSOA individuals – send the TSOA Individual w/o CG assessment.
MAC and TSOA dyad • Step 1, 2 and 3 TSOA Individual w/o CG	Nurse delegation	• Dyads – send the TCARE® Respite Services Provider Assessment. • TSOA individuals - GetCare TSOA w/o CG assessment

		• Copy of consent form (14-012) • ND Referral and Communication form (DSHS 01-212)

CONTRACTS

The Area Agencies on Aging (AAAs) will maintain a provider network to support the services available to MAC and TSOA enrollees. The AAAs also maintain the provider network for Family Caregiver Support Program (FCSP), traditional Medicaid programs such as CFC, MPC and COPES, and other supportive programs for older adults. MAC & TSOA programs for some services have specific MAC & TSOA contracts (example: Caregiver and Client Support or Behavior Support Services – MTP: Counseling) while other services are provided under already executed contracts held at the AAA (examples may include Personal Emergency Response Systems, Home Delivered Meals, Home Care Agencies, and Community Transition or Sustainability Services contracts). Most of the Medicaid and MAC/TSOA providers will have DSHS contracts executed and monitored by the AAAs. *(Please see the Benefit Categories/Services section for additional information about network adequacy).* When unpaid/no cost services are included in the care plan, a provider contract is usually not required.

Contracts in support of MAC and TSOA programs may be available via one of the following methods:

- Statewide contract through ALTSA HQ Contract unit
- Core Provider Agreement (CPA) with Health Care Authority (DME providers)
- AAA or DSHS existing contracts
- FCSP services contracts that have the necessary Medicaid language included and the contract has been registered in the Agency Contracts Database maintained by ALTSA.

The contracts that are executed and maintained by the contracts unit in ALTSA Headquarters are:

- Specialized Equipment and Supplies (SES)
- Nurse Delegation (ND)
- Assistive Technology (AT)
- Adult Family Home (AFH - Respite)
- Assisted Living Facilities (ALF - Respite)
- Nursing Facilities (Respite)

For more information about contracting and network adequacy requirements see MB H17-043. Refer providers who want more information about contracting to be a service provider to ALTSA's internet website.

CHECKLIST FOR CLOSING A MAC OR TSOA CASE

When a care receiver no longer wants or needs to be enrolled in the MAC or TSOA program it is important to complete several tasks in order to officially close the case. Completion of the tasks is especially important if the care receiver is transitioning to another ALSTA program like CFC or

CFC+COPES as it may impact the ability of the receiving case manager to add the new program RAC and create service authorizations for the new program.

The tasks to be completed include the following:

- Send a 14-443 to financial informing the Public Benefits Specialist (PBS) of the program end date and reason for closing case (such as withdrawing from services, moving to another program, passed away, etc.),
- Send MTP Service Notice (DSHS 15-492) to care receiver to provide formal notice of program/service termination (allow at least 10 days' notice for adverse actions, MTP Service Notice is not needed if the client passed away, as financial sends the condolence notification),
- Notify providers and change the end date of all service authorizations to match effective date of the MTP Service Notice or last date of service, if earlier
- Change the end date of the enrollment to match effective date of the MTP Service Notice (or date of death, when applicable)
- Change the end date of the functional RAC to reflect the last day of enrollment on the program
- Enter a progress note in CLC/ GetCare indicating reason for case closing

EXCEPTIONS TO RULE/POLICY

Before authorizing any exceptions to rule (ETR) or exceptions to policy (ETP), you must receive local or headquarters (HQ) approval, depending on the type of request. An ETR request means you are asking to make an exception to a rule (WAC). An ETP request means you are asking to make an exception to policy published in the LTC Manual or a management bulletin (MB).

CMS approved 1115 Waiver Policy and Procedures cannot be overridden with an ETP.

ETRs that require local approval include:

- Exceeding Step 2 benefit level of $500/annually up to $1,000
- A caregiver or TSOA individual who is in crisis and needs to be served with step 2 or 3 services without first completing a screening or assessment. A care plan must be completed prior to receiving services. The screening and/or assessment must be completed within 30 days if ongoing services are needed.
- Request for respite services in the rare instance when a dyad asks for respite services and the TCARE® assessment does not result in a recommendation for this service.
- When excess of 2 home delivered meals per day for the caregiver or care receiver is being requested (Excess of 62 meals per month for the caregiver or 62 meals per month for the care receiver is being requested).
- Exceeding Step 3 benefit level allowed in a six-month period for MAC and TSOA dyads
- For TSOA without a caregiver, when the six-month benefit level will be exceeded due to home delivered meals, PERS service (PERS service (install, monthly fee, and add-on features such as fall

detector, medication reminders, etc.), and requests to purchase Durable Medical Equipment (DME) and care supplies when the ETR request is $500 or less.

- Allowing Step 3 services when the assessment is only showing eligibility for Step 2 services.
- Annually, if a TSOA individual care receiver is also identified as a unpaid family caregiver for another MAC/TSOA care receiver.
- Exceeding $2,500 for Pest Eradication and Specialized Deep Cleaning.

NOTE:
ETRs may not be used to exceed the Step 1 benefit level of $250.

ETRs that require HCS HQ approval are:

- Exceeding Step 2 benefit level greater than $1,000
- For TSOA without a caregiver, exceeding Step 3 benefit level allowed in a six-month period for any items not outlined in the local ETR process.
- DME/Bathroom equipment for care receivers who have Medicaid Apple Health or Medicare benefits that may also cover the requested piece of bathroom equipment. See MB H24-067 for more details, tools and instructions.
- Home modifications and repairs exceeding $500 or when the modification or repairs will cause the MAC/TSOA dyad or TSOA individual to exceed their 6-month benefit level.
- Exception to Policy requests, if not specified under local approval.
- Community Choice Guiding Services – If costs will exceed Step 3 benefit level OR if initial 160 units/40 hours for first 3 months was not sufficient and additional 160 units/40 hours for additional 3 months is needed.

ETR Process

All ETR requests and approvals/denials for MAC and TSOA should be completed in the ETR/ETP section of GetCare.

Both local and ATLSA HQ ETR and ETP requests must include the following details:

1. Request description
    a. What item/service is being requested
    b. Justification for request
    c. Alternatives explored before considering ETR request
    d. Cost of the request (e.g., hours, dollars, quantity, etc.)
2. Start and end date of request
3. WAC # or policy to which the exception applies

Complete the Medicaid Transformation Project Notice of Action Exception to Rule DSHS form #05-255 in GetCare and save letter (the 'Save Letter' option will automatically save the document to the care

receivers GetCare Electronic File Cabinet). Then send to the care receiver informing them of the decision.

Detailed instructions for using the ETR/ETP functionality in GetCare can be found in the GetCare Desk Manual located in the GetCare Help Library.

Complaint Procedure for denial of initial ETRs

Initial ETRs do not have administrative hearing rights. However, care receivers do have the right to make a complaint to the Department. For complaints related to initial ETR decisions made by AAA at the field level, follow your AAA Grievance Policy.

Complaints related to initial ETR decisions made by HCS Headquarters will be reviewed as follows:

1. The care receiver may make a complaint in writing to the HCS or State Unit on Aging (SUA) Office Chief. The Office Chief will make a decision about the written complaint within ten days of the date it was received and send a letter informing the client of the decision and that the decision may be reviewed by the HCS Director at the client's request.
2. If the client makes a written request asking the HCS Director to review the Office Chief's decision, the Director will make a decision about the complaint within ten days of the date it was received and send a letter informing the client of the final decision.

When responding to a complaint it is important to address, at a minimum, the specific concern perceived by the client and explain how all of the pieces of information were reviewed (e.g. screening, assessment, any additional information provided in the complaint, or information from other relevant sources) in order to make a decision. The AAA staff may want to discuss the care plan with the care receiver in order to identify service gaps that may be addressed using other available resources.

COLLABORATION WITH ADULT PROTECTIVE SERVICES (APS)

AAA/MTP staff are considered Mandated Reporters of abuse, abandonment, neglect, and financial exploitation of vulnerable adults.

If information is reported to the AAA staff about a care receiver or other vulnerable adult and the person providing the information to the AAA staff indicates they have already made a report to APS, the AAA staff may consider the following to determine if they too, should make a report to APS:

- An additional report by the AAA staff is not required if verified that the report was made. This must be done by asking the reporter for a reporting confirmation or intake number or contacting APS to verify a report was made. These steps must be documented in the GetCare progress notes.
- A mandatory reporter takes a personal risk and a risk to the agency they work for if they choose not to make a report to APS and there is a negative outcome for the vulnerable adult that was not reported to APS.
- See Adult Protective Services policy and procedure and Chapter 74.34 RCW for detailed information about mandated reporting, including consequences of failure to report.

All APS and RCS information is subject to confidentiality laws:

- Do not disclose the existence of an APS or RCS report or investigation to anyone,
- APS documents should not be placed in the ECR,
- Contact your public disclosure coordinator when:
  - You receive a request for records or information about an APS or RCS report or investigation. Do not acknowledge the existence of an investigation.
  - Your client requests to review his/her services record that contains documented APS or RCS activity. All APS and RCS related information must be redacted.

After receiving the intake notice, AAA staff should go to the APS/RCS ribbon in GetCare and do the following:

- Review the intake details,
- Do not divulge this information to anyone,
- Collaborate with the APS or RCS investigator, if contacted,
- Allow the investigator to complete his/her work before contacting the client, unpaid caregiver or anyone else unless directed to do so by the investigator,
- Document all communications and coordination activities in a progress note.
  - Use the following criteria when documenting:
    - ✓ Keep all progress notes pertinent and succinct.
    - ✓ Do not cut and paste emails or documents involving APS or RCS information (e.g., an APS outcome notice) into the progress note.
    - ✓ Summarize activities and communications in a progress note and document if you placed a printed email or document in the electronic file cabinet (e.g., "Received email from [name of person] on this date. See electronic file cabinet.").

The APS or RCS investigator will contact the AAA staff if more information is needed during the investigation or if action is needed by the AAA staff during the investigation.

Refer to APS section on the ALTSA intranet site for more information.

DSHS FORMS AND NOTICES

The forms and notices below will be used for dyads and individuals enrolled in the MAC and TSOA programs.

All of these forms will be utilized by the AAA MTP staff. These forms can be accessed on the DSHS Internet forms site. Forms must be sent to care receivers in their primary language.

AAA staff will be able to complete the rest of the details in the form and save it in the care receiver's Electronic File Cabinet in GetCare. The case worker will then print the form/notice and provide it to the care receiver and obtain their signature (note that not all of the forms/notices require a signature).

TYPE	DSHS form #	PROGRAM	PURPOSE
Acknowledgement of Services	14-225	MAC	To document care receiver's choice to receive MAC services in the community rather than in a nursing facility. A signed copy must be scanned into the care receiver's electronic file cabinet in GetCare.
Medicaid Transformation Project Notice of Action Exception to Rule (ETR)	05-255	MAC & TSOA	To provide notification to the care receiver of an ETR approval/denial or notice that request for ETR was not initiated A completed copy of form must be scanned into the care receiver's electronic file cabinet in GetCare.
Consent	14-012	MAC & TSOA	To obtain consent from care receiver and caregiver to gather & share information for care planning purposes (Note: a separate consent form must be signed by the caregiver and by the care receiver.) A copy signed by the CR must be scanned into the care receiver's electronic file cabinet in GetCare. A copy signed by the CG must be scanned into the caregiver's electronic file cabinet in GetCare.
Your Rights & Responsibilities when You Receive MAC or TSOA Services Offered by ALTSA	16-247	MAC & TSOA	To inform care receiver of their rights and responsibilities when receiving services from ALTSA/AAA A signed copy must be scanned into the care receiver's electronic file cabinet in GetCare.

Medicaid Transformation Project Service Notice	15-492	MAC & TSOA	To inform care receiver of: • actions (approval, denial, reduction, and termination) taken regarding their services; and • Administrative Hearing rights A copy must be scanned into the care receiver's electronic file cabinet in GetCare. NOTE: You do not need to send a 15-492 when a client passes away. ACES/PBS sends out a condolence letter that includes termination of service language. AAA staff should send a 14-443 to financial when they become aware of a MAC or TSOA care receiver's death.
MTP TCARE® Information for Respite Care Service Providers	N/A	MAC & TSOA dyads	To provide necessary information about the care receiver's needs while receiving respite services.
Information for Respite Care Services Providers: Addendum to TCARE® Assessment (ALTSA)	13-915	MAC & TSOA dyads	To provide additional information, required by the facility's license, about the care receiver's needs during their respite stay in an adult family home or assisted living facility A completed copy of form must be scanned into the care receiver's electronic file cabinet in GetCare.
Housing Modification Property Release Agreement	27-147	MAC & TSOA	To be completed for modifications to the residence of individuals enrolled in an Aging and Long-Term Support Administration (ALTSA) program, including the installation of necessary equipment, that directly affects the interior or exterior of the dwelling.
Notice and Consent of Communication via Text or Unencrypted Email	27-156	MAC & TSOA	Have the care receiver and/or caregiver, when applicable, sign when they indicate they would like to receive communication by text messaging or via unencrypted email.

			Place signed copy in the care receiver's electronic file cabinet in GetCare.
Voter Registration (ABVR) forms	ABVR	MAC & TSOA	At least annually, during in-person visits, or when a change in address occurs. Continue to ask the care receiver if they would like to register to vote and if they need assistance with filling out the form. Use Agency Based Voter Registration (ABVR) forms and complete the voter registration section in GetCare.

The top eight languages available besides English are:

- Spanish
- Korean
- Somali
- Russian
- Laotian
- Cambodian
- Chinese
- Vietnamese

Instructions: Saving Documents and Forms to the GetCare Electronic File Cabinet.
To scan and send a document or form to the electronic file cabinet in GetCare:

- Scan signed document
- Email scanned document to AAA staff or other worker's email address
- Save email as title of document, name of client – follow internal security policy for PHI
- Open client record in GetCare
- Open electronic file cabinet in client's file
- Select "Browse"
- Select "Add attachment"
- Find the location of the file you saved
- Select appropriate file
- Select "Open"
- In GetCare, see the add attachment pop up and select "Save".

If care receivers do not return documents such as the Consent and Rights & Responsibilities form, this is not cause for terminating the client from the program. The AAA staff should use person-centered strategies to encourage the return of the signature and document their efforts in a Progress Notes. Documenting these efforts is an important component related to the Quality Assurance and CMS signature requirement if the signed document is never returned.

When the care receiver doesn't return the signed Consent form, services should continue but there may be certain entities to whom we cannot share information. However, the "covered entities" that are most important are typically covered under HIPAA and a signature is not required.

ADMINISTRATIVE HEARING (AKA FAIR HEARINGS)

Care receivers have the right to an administrative hearing when the department (HCS/AAA):

a. Sends a notice that approves, denies, reduces, or terminates a service or eligibility (at least 10 calendar days before the effective date of the action);
b. Determines a client received more benefit than they were eligible for and an overpayment was issued;
c. Reduces or terminates an ongoing service such as respite or in-home personal care that was initially approved through an ETR; and
d. Denies or terminates financial eligibility (Note: these hearings are facilitated by HCS financial staff).

Requesting an Administrative Hearing

Hearing requests must be made within a specific timeframe. The care receiver must request a hearing (aka as an appeal) to Office of Administrative Hearings (OAH) within 90 days of the date the service notice was received.

A care receiver or their representative may request a hearing in any of the following ways:

a. Verbal request. Department staff or their designee must notify OAH of any verbal request from the client, preferably in writing.

b. Written request (of any kind). Department staff or their designee must notify OAH of any written request that doesn't go directly to OAH.

c. The Request for Hearing form that accompanies every Service Notice (15-492). This form can be completed by the care receiver and mailed or faxed to OAH. The care receiver may also ask department staff or their designee to help them complete and submit the hearing request to OAH.

Administrative hearings related to financial eligibility decisions (full eligibility not PE) are handled by the financial staff.

Hearings related to decisions for services and functional eligibility (full eligibility not PE) are handled by AAA staff. Each AAA will designate who completes this work.

For more details about administrative hearings (AH), the AH process, and roles of the AAA staff/case manager and AH coordinator see Ch. 26 of the LTC Manual.

WAIT LIST

The state has client numbers and expenditure limits for each year of the 1115 demonstration waiver. It is possible that a wait list will be required if it appears that the limit will be reached. The renewal waiver, also deemed as MTP 2.0, has been approved from July 1, 2023 to June 30, 2028.

In the event that a wait list is implemented, the MAC and TSOA programs will stop conducting presumptive eligibility (PE) determinations. Dyads or individuals receiving services under presumptive eligibility established prior to implementation of the wait list will be able to continue receiving services until their PE period ends or their final eligibility determination is completed whichever comes first.

If additional funds become available, dyads or individuals may be removed from the wait list on a first come, first served basis.

During the time a wait list is in place, dyads or individuals should be referred to other options such as FCSP, local community resources, or other Medicaid long-term care services (CFC, MPC, New Freedom, Residential Support Waiver, COPES, etc.).

CONFLICT FREE CASE MANAGEMENT

Background

Federal requirements for the Community First Choice program, COPES, New Freedom, Residential Supports Waiver, and the Medicaid Transformation Project require Aging and Long-Term Support Administration (ALTSA) to ensure that conflict of interest safeguards are in place for all Medicaid participants. These safeguards outline provider qualifications, require a strategy for solving conflict and outline clear conflict-of-interest guidelines per Washington State MTP, Special Terms and Condition (STC) #52. Conflict of Interest, § 42 CFR 441.301(c)(1)(v)(vi), § 42 CFR 441.730, and § 441.555 (c).

In some areas of the state, it is challenging for ALTSA and Area Agencies on Aging (AAA) to recruit and enroll providers of evidence-based services or other services with a low demand such as support groups. This can be especially true when looking for culturally or linguistically appropriate providers or when serving a minute population spread across a vast frontier area or tribal reservation. Yet often these are the exact services that a participant needs and desires at the time they are assessed.

ALTSA and the AAAs are committed to providing needed services at the time and location that is right for the participant. Both entities acknowledge there may be occasions when safeguards are needed to protect participants from conflict of interest. This policy details the safeguards that must be in place when an AAA provides assessment and/or service planning and is the only qualified and willing entity available to be authorized to provide a home and community-based service.

Area Agency on Aging Requirements

AAA's must attest (see attached sample attestation form below) that they will adhere to the following conflict of interest policies:

1. The AAA will ensure that participants:
    a. As part of the assessment and authorization process, receive information about the full range of services available to the participant and not just the service furnished by the AAA; and
    b. Are supported in exercising their right to free choice of providers; and
    c. Are informed of their opportunity to identify other qualified and willing providers available in the participant's geographic area to provide the service.
2. The AAA's grievance resolution process must refer the participant to DSHS if they wish to dispute the assertion that there is not another qualified and willing entity available in the participant's geographic area to provide the service.
3. Where the AAA attests it is the only willing and qualified provider, the AAA must request ALTSA approval prior to authorizing service provision by an AAA employee. The approval shall be in effect as long as these policies are followed and until an alternative provider is identified. ALTSA will verify AAA is the only willing and qualified provider by:
    a. Reviewing the AAA provider recruitment efforts and results annually; and
    b. Confirming there is no available contracted provider in the State's contract database, ACD.
4. The development of the service plan is administratively separated, from the provision of authorized services. With the functions ideally accomplished by separate units.
5. Where service provision and/or assessment and service planning functions are provided by the same AAA employee because the only available qualified provider of the service is also the AAA staff/case manager who assists the client with service planning, supervision must be provided separately from the assessment and/or service planning functions. For this purpose, supervision means verifying that the requirements of this Conflict-of-Interest policy are being met as services are being delivered and that authorization levels are consistent with what is typical for the service.
6. That the AAA staff will remain unbiased and impartial during the development of the person-centered service plan.
7. That the AAA will include the service in its process for continuous recruitment and open enrollment of qualified providers required by Chapter 6 of the AAA policy and procedures manual.
8. That the AAA staff training includes these policies prior to providing services along with training on confidentiality, ethics and grievance procedures.

Aging and Long-Term Support Administration Requirements

ALTSA will provide oversight and monitoring of the conflict-of-interest safeguards for Medicaid participants when service provision and service planning are provided by the same AAA employee. The results of the activities will be reported to the State Medicaid Agency at the quarterly waiver management committee meeting. Monitoring and oversight activities will include an annual review of:

1. AAA compliance with these policies and adherence to the AAA attestation.

2. AAA efforts to enroll service providers.

3. A comparison of service utilization patterns where the AAA is the direct provider with utilization that is typical for comparable services provided by contracted providers.

4. A comparison of rates paid to the AAA with rates paid to contracted vendors for comparable services.

Conflict of interest attestation form.doc

QUALITY ASSURANCE

As part of the special terms and conditions with the 1115 demonstration waiver, the state developed a Quality Improvement System (QIS) which includes:

a. Performance measurement and reporting in accordance with the quality reporting and review standards outlined in Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waivers guidance issued March 12, 2014, and reporting timelines outlined in Revised Interim Procedural Guidance issued February 6, 2007.

   Performance measures should address the following areas:

   i. Identification of needs and goals, and access to services (Level of Care/Functional assessment and Person-Centered Plan of Care at least annually);
   ii. Services are delivered in accordance with the Person-Centered Plan of Care
   iii. Providers meet required qualifications;
   iv. Settings meet the home and community-based setting requirements for those services that could be authorized under 1915(c) and 1915(i);
   v. Number of substantiated incidents of neglect, exploitation or abuse and average time to resolution;
   vi. The State Medicaid Agency (SMA) retains authority and responsibility for program operations and oversight; and
   vii. Washington State Medicaid Transformation Project 2.0 Section 1115(a) Demonstration Approval Period: July 1, 2023 through June 30, 2028 Page 45 of 154 vii. The SMA

maintains financial accountability through payment of claims for services that are authorized and furnished to 1115 participants by qualified providers.

b. Ongoing quarterly/annual reporting that includes:
   i. Number of LTSS beneficiaries broken out by program (MAC and TSOA);
   ii. Number of new MAC and TSOA person-centered service plans;
   iii. Percent of MAC and TSOA level of care re-assessments annually; and
   iv. Number of people self-directing services under employer authority.

All MAC and TSOA AAA staff are eligible for a Quality Assurance review, regardless of length of employment. The ALTSA Social Service Quality Assurance unit will complete statewide monitoring using a statistically valid sample size when pulling cases for review.

During the annual Quality Assurance review, PSA's should complete the following:

i. Review any completed Initial Process Review and make corrections indicated for specific questions and their associated "no" responses.
ii. Correct the items identified in the Initial Process Review within 30-calendar days.
Note: AAA/HCS social service staff must lock any care plans and/or return any scanned copies of corrected documents required by the deadline to the ALTSA QA Lead. Original documents should still be sent to the Electronic File Cabinet.
iii. Correct items identified in the 30-day review by the 60-day due date.
iv. Any questions that did not meet or exceed the proficiency standard at the Initial Process Review and are not already being addressed in the HQ Proficiency Improvement Plan (PIP), will need to be included in each area's PIP.
v. E-mail PIPs, based on Initial Process Review findings, to headquarters within 30 calendar days of receiving the area Final Report.

RESOURCES

Related LTC Chapters

Chapter 4	Social Service Intake
Chapter 5	Case Management Chapter - Challenging Cases Protocol
Chapter 11	Consumer Directed Employer
Chapter 12	Adult Day Services
Chapter 13	Nurse Delegation
Chapter 15A	Communicating with Individuals with LEP & SD, Guidance for AAA Staff
Chapter 15B	Communicating with Individuals with LEP & SD Guidance for ALTSA and DDA Staff
Chapter 20	Transportation
Chapter 23	Quality Assurance and Improvement
Chapter 26	Administrative Hearings
Chapter 28	Medicaid Fraud
Chapter 30A	Intro to Medicaid Transformation Project

Related WACs

Functional WAC 388-106- 1900 thru 1990
Financial WAC – MAC 182-513-1600 and 1605, and 182-513-1660
Financial WAC – TSOA 182-513-1610 thru 1655, and 182-513-1660

Acronyms

AAA	Area Agency on Aging
ABP	Alternative Benefit Plan
ACD	Agency Contracts Database
ACES	Automated Client Eligibility System
ADLs	Activities of Daily Living
AFH	Adult Family Home
AH	Administrative Hearing
ALF	Assisted Living Facilities
ALTSA	Aging and Long-Term Support Administration
APS	Adult Protective Services
AREP	Authorized Representative
AT	Assistive Technology
CARE	Comprehensive Assessment Reporting and Evaluation
CDSME	Chronic Disease Self-Management Education
CFC	Community First Choice
CG	Caregiver
CLC	Community Living Connections
CM	Case Manager

CMS	Centers for Medicare and Medicaid Services
CN	Categorically Needy
COPES	Community Options Program Entry System
CPA	Core Provider Agreement
CR	Care Receiver
CS	Community Spouse
DME	Durable Medical Equipment
ECR	Electronic Case Record
EFC	Electronic Filing Cabinet
ER	Eligibility Review
ETP	Exception to the Policy
ETR	Exception to the Rule
FBR	Federal Benefit Rate
FCSP	Family Caregiver Support Program
GPS	Global Positioning System
HCA	Health Care Authority
HCS	Home and Community Services
HDM	Home Delivered Meals
HQ	Headquarters
IADLs	Instrumental Activities of Daily Living
ID	Identification
IP	Individual Provider
LTC	Long Term Care
LTSS	Long Term Services and Supports
MAC	Medicaid Alternative Care
MMIS	Medicaid Management Information System
MN	Medically Needy
MPC	Medicaid Personal Care
MSP	Medicare Savings Program
MTP	Medicaid Transformation Project
MUI	Medicaid Unit Incentive
ND	Nurse Delegation
NFLOC	Nursing Facility Level of CARE
NOPE	Not Presumptively Eligible for MAC and TSOA
OAH	Office of Administrative Hearings
P1	ProviderOne
PBS	Public Benefits Specialist
PE	Presumptive Eligibility
PERS	Personal Emergency Response Systems
PSA	Planning Service Area
RAC	Recipient Aid Category
RCS	Residential Care Services

RCW	Revised Code of Washington
RDAD	Reducing Disability in Alzheimer's Disease
RU	Reporting Unit
SCDS	Service Code Data Sheet
SES	Specialized Equipment and Supplies
SIPC	Spousal Impoverishment Protections Community
SOAP	State Only Adjustment of Payment
SSI	Supplemental Security Income
SSN	Social Security Number
STCs	Special Terms and Conditions
SUA	State Unit on Aging
TIVA2	Tracking Incidents of Vulnerable Adults
TSOA	Tailored Supports for Older Adults
WAC	Washington Administrative Code
WHO	Warm Hand Off

Outreach & Marketing Materials

MAC & TSOA Brochure
Publications, rack cards, poster

Other

For AAA Staff/MTP Case managers

ALTSA Intranet - HCS Medicaid Transformation Project
ProviderOne Social Services Authorization Manual for case managers
Service Code Data Sheets (SCDS) for ProviderOne authorizations
Health Care Authority – MTP Website
TCARE® – Caregiver Assessment and Planning

For Care receivers and Caregivers

ALTSA Internet – Caregiver Resources

For Potential Providers/Contractors

ALTSA internet – Potential Service Providers

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
12/2019	Debbie Johnson	1. Moved to new template 2. Incorporated QA section 3. Updated content 4. Added policy decisions from 2017 & 2018 MBs 5. Added policy info from Community WorkSpace 6. Modified policy related to sending DSHS 15-492 to GetCare electronic file cabinet rather than DMS	H19-0xx
4/2025	Resa Lee-Bell	1. Added policy decision from 2019-2024 MBs 2. Added policy info from Community WorkSpace 3. Added policy info from GetCare Help Library 4. Incorporated language from June 2023 CMS Approval/STC's 5. Added Acronyms 6. Style Formatting Update	H24-009 H23-093 H23-091 H23-057 H23-029 H21-079 H21-012 H20-033 H19-053 H19-049 H19-020

Initiative 3: Foundational Community Supports– Supported Employment

Chapter 30c describes the Supported Employment program offered through the Foundational Community Supports (FCS) of the Medicaid Transformation and the related rules, policy and procedures.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Supported Employment Team mailbox: SupportedEmployment@dshs.wa.gov

Michael Corcoran	Employment Unit Manager 360.725.2614	Michael.Corcoran@dshs.wa.gov
Jim Bischoff	HCS Region 1 Employment Specialist 360.870.4511	James.Bischoff@dshs.wa.gov
Sammy Bernardy	HCS Region 1 Employment Specialist 360.890.2910	samantha.bernardy@dshs.wa.gov
Ruby Pham	HCS Region 2 Employment Specialist 564.200.2264	Ruby.Pham@dshs.wa.gov
Muriel McAuliff	HCS Region 2 Employment Specialist 360.706.3047	muriel.mcauliff@dshs.wa.gov
Laura DeVol	HCS Region 3 Employment Specialist 360.870.4918	Laura.DeVol1@dshs.wa.gov
Katie Stettler	HCS Region 3 Employment Specialist 564.200.4238	katie.stettler1@dshs.wa.gov

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BACKGROUND

The Medicaid Transformation is an agreement between the State and the Centers for Medicare and Medicaid Services (CMS) that contains multiple initiatives. The intent of Foundational Community Supports (FCS) – Supported Employment (SE), is to support individuals in obtaining and retaining employment in support of their broader health goals. Evidence strongly suggests that individuals with disabilities who are employed experience increased health status, such as:

- Psychological benefits which lead to decreases in mental health symptoms, smoking, and other health factors
- Increased success in recovery and rehabilitation processes including mental health, substance use disorders, and even smoking cessation
- Reduced health care costs

Supported Employment services are designed to be person-centered and individualized one-to-one supports to individuals interested in employment in the community. FCS creates a system of services which will provide pre-employment and post-employment services to an individual at any point in their pathway to employment. The services are not time-limited but are intended to support the individual for as long as there is an identified need.

ADMINISTRATION OF FOUNDATIONAL COMMUNITY SUPPORTS

The FCS services are part of the Medicaid Transformation (MT). For more information on MT see Chapter 30a of the LTC Manual. The larger Demonstration, and FCS in particular, involves multiple state agencies of which ALTSA is one. Due to the multiple agencies involved, the state has set up a single, statewide Third-Party Administrator (TPA) for the FCS services, which includes Supported Employment services.

The TPA is a contracted, non-state entity that provides administrative oversight of the benefit programs and services. The TPA is responsible for:

- Provider network development and maintenance
- Client eligibility determination
- Service Authorizations for services to providers
- Distribution of reimbursement payments
- Encounter data tracking

Wellpoint has been contracted with the state through the Health Care Authority and will be functioning as the TPA for the duration of MT.

PROGRAM DESCRIPTION

Supported Employment services assist those individuals who want to work and meet FCS criteria to become employed in integrated community employment. Activities are intended to ensure successful employment outcomes through the utilization of collateral contacts, skills training, cueing, modeling and supervision as identified by the person-centered employment plan.

Individualized Supported Employment services include identifying career and occupational targets, developing ongoing relationships with prospective employers, assisting with the interviewing and hiring process, and once employed, support with maintaining employment. Coaching and skill-building of interpersonal relationships in the work setting as well as education for self-advocacy and support with the American with Disabilities Act are also included.

The focus is on obtaining competitive employment that reflects the interests and desires of the individual through:

- **Pre-employment services** — activities that assist an individual with obtaining employment.
- **Employment-sustaining services** — activities that support the individual in retaining and maintaining employment.

Pre-employment services support an individual's ability to prepare for and transition to competitive employment, including direct face-to-face contact with the client as well as collateral service.

Pre-employment services include the following:

- Prevocational/job-related discovery or assessment
- Person-centered employment planning
- Individualized job development and placement
- Job carving — defined as working with the client and employer to modify an existing job description so it contains one or more, but not all, of the tasks from the original job description when a potential applicant for a job is unable to perform all the duties identified in the job description
- Benefits education and planning — defined as counseling to assist the client in fully understanding the range of state and federal benefits he or she might be eligible for, the implications that work and earnings would have for continued receipt of these benefits, and the client's options for returning to work
- Transportation (only in conjunction with the delivery of an authorized service)

Employment-sustaining services include the following:

- Career advancement services — defined as services that expand opportunities for professional growth, assist with enrollment in higher education or credentialing and certificate programs to expand job skills or enhance career development, and assist the individual in monitoring his/her satisfaction with employment and determining the level of interest and opportunities for advancement with the current employer, and/or changing employers for career advancement
- Negotiation with employers — defined as services where a provider identifies and addresses job accommodations or assistive technology needs with the employer on behalf of the individual
- Job accommodations can include the following:
    - Adjusting work schedule to reduce exposure to triggering events (i.e., heavy traffic triggering symptoms of agoraphobia)
    - Providing a private area for individuals to take breaks if they experience an increase in symptoms
    - Access to a telephone to contact a support person if needed while at work
    - Adjusting job schedule to accommodate scheduled appointments
    - Small, frequent breaks as opposed to one long one
- Assistive technology can include the following:
    - Bedside alarms
    - Electronic medication reminders while at work or at home
    - Use of headset/iPod to block out internal or external distractions
- Job analysis — defined as gathering, evaluating and recording accurate, objective data about the characteristics of a particular job to ensure the specific matching of skills and amelioration of maladaptive behaviors.
- Job coaching
- Benefits education and planning — defined as counseling to assist the client in fully understanding the range of state and federal benefits he or she might be eligible for, the implications that work and earnings would have for continued receipt of these benefits, and the client's options for returning to work
- Transportation (only in conjunction with the delivery of an authorized service)
- Asset development — defined as services supporting clients' accrual of assets that have the potential to help clients improve their economic status, expand opportunities for community participation and positively impact their quality-of-life experience
    - Assets are defined as something with value owned by an individual, such as money in the bank, property and retirement accounts
- Follow along supports — defined as the ongoing supports necessary to assist an eligible client to sustain competitive work in an integrated setting of his or her choice.

- This service is provided for, or on behalf of, a client and can include communicating with the client's supervisor or manager, whether in the presence of the client or not (if authorized and appropriate). There is regular contact and follow-up with the client and employer to reinforce and stabilize job placement. Follow-along support and/or accommodations are negotiated with an employer prior to the client starting work or as circumstances arise.

Service providers will be engaged in individualized job development services that support individuals in searching for and securing a job in the community such as:

- Identifying and negotiating jobs.
- Building relationships with employers.
- Customized employment development, job analysis and job carving.
- Linking with community resources to support job search.

ELIGIBILITY, INTAKE, REFERRAL AND SERVICE DELIVERY FLOW

Eligibility determination is completed by the TPA, Wellpoint, based on criteria established by the state in agreement with the Centers for Medicare & Medicaid Services (CMS), the federal funding agency for MT. There are multiple sets of criteria for eligible clients, including an ALTSA specific set.

To be determined eligible for FCS Supported Employment services by the TPA, a client must meet the following criteria:

- Be aged 16 or older
- Eligible for Apple Health (Medicaid)
- Desire to obtain employment

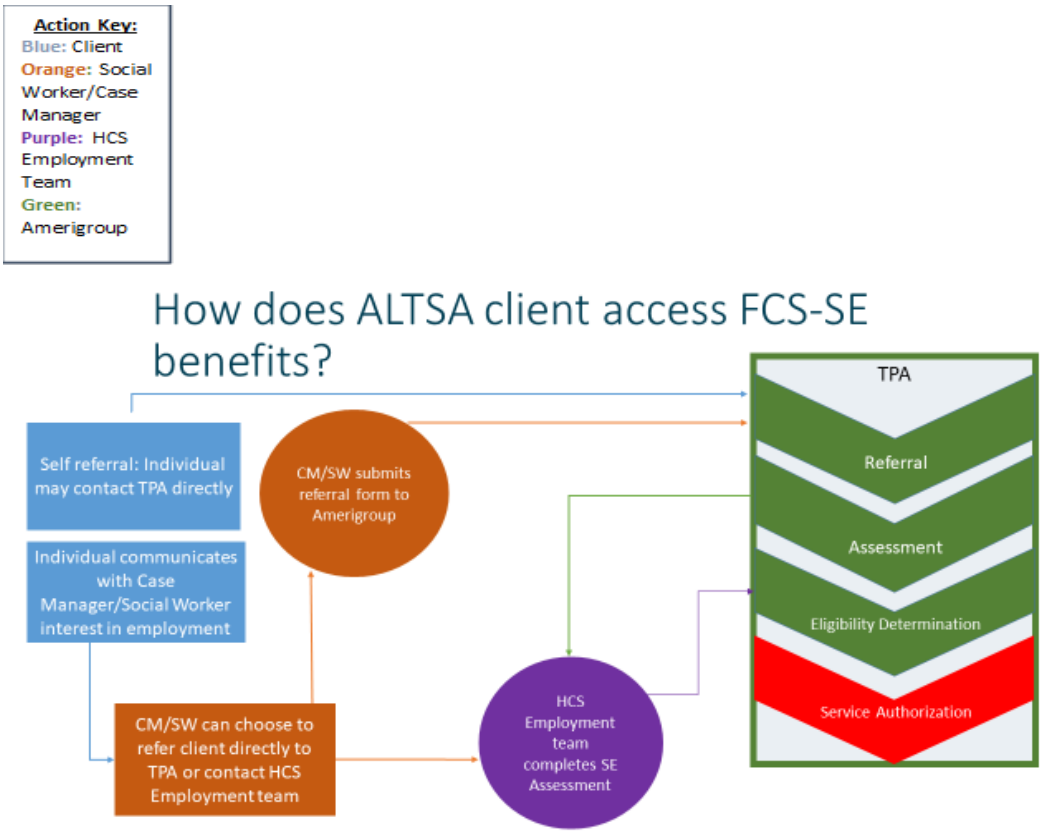
The client must also meet both the needs-based health and risk factor indicated below:

- **Health Factor:** An ALTSA client meets the necessary health needs criteria by being financially and functionally eligible with a current CARE assessment identifying the need for assistance with 3 Activities of Daily Living (ADLs) and/or hands-on assistance with at least one ADL, which may include body care

- **Risk Factor:** Meets the necessary risk factor criteria by having an inability to obtain or maintain employment resulting from age, physical disability, or traumatic brain injury (TBI).

A more detailed description of needs-based criteria for FCS may be found in the FCS Quick Reference Guide. Intake and service delivery flow consists of identifying an individual interested in employment, assessing them for eligibility, referring them to the TPA for eligibility determination and assignment to a local employment provider to begin services. The intake and referral process for an individual can take a

number of paths including self-directed referral or assistance from HCS/AAA field staff and/or the HCS Employment team (see image below).



The most effective and quickest referral process for the client is to communicate the client's interest to the HCS Employment team. This process assures that the client will have a complete eligibility determination packet assembled and submitted to the TPA and facilitate a more rapid eligibility determination and assignment to a provider.

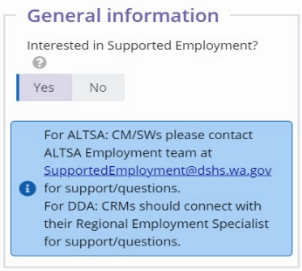
Ways to communicate a referral to the HCS Employment team:

- Contact the HCS Employment team through the SupportedEmployment@dshs.wa.gov email or 1-844-427-8256
- Contact one of the HCS Employment team directly through the contact information in the "Ask an Expert" section of this Chapter.

To indicate a client's interest in Supported Employment services in CARE:

- Select Client Details and go to their Profile Screen.

- Enter "Yes" to the Supported Employment question under General Information. A box will pop up with instructions on how to contact the ALTSA Employment team.
- Click on the link to SupportedEmployment@dshs.wa.gov and provide the client's name and one-piece identifying information, such as, ProviderOne number, ACES ID, or date of birth.



Clients may also be referred directly to TPA. Clients, their family or any support person, including HCS/AAA field staff, may contact the TPA directly through either phone or email to inquire about services and begin the assessment and eligibility determination process. Points of contact to begin the process are: phone – 1-800-451-2828; email – fcstpa@wellpoint.com.

More information for clients about the FCS services and how to apply can be found on Wellpoint's FCS website.

If a client is referred directly to TPA, the TPA will evaluate the individual for the eligibility criteria indicated above. For the needs-based health and risk factor criteria, the TPA will refer the client to an employment provider directly for supporting documentation and resubmission for a final eligibility determination.

Once a client is determined to be eligible for FCS services by the TPA, the TPA will assign the client to a local employment service provider and set up a Service Authorization in Provider One directly. Billing for services by providers will be through the TPA. The TPA will process billing and reimburse providers directly, then enter encounter data and billing information into Provider One directly.
HCS/AAA field staff and/or HCS Employment team will document each stage of the process from initial communication regarding FCS Supported Employment services with the client through the establishment of a Service Authorization with a provider in Provider One for FCS supported Employment services through Service Episode Records (SERs).

WHEN TO USE HOUSING & EMPLOYMENT STABILIZATION SERVICES FOR AN ALTSA CLIENT

Housing and Employment Stabilization Services should be used when an ALTSA client enrolled in Foundational Community Supports (FCS) Supported Employment requires additional assistance to

obtain/maintain their job and only qualifies for state funding. These services are designed to promote self-sufficiency and recovery by helping participants find and maintain stable housing and employment.

How To Authorize Housing and Employment Stabilization Services

1) The HCS/AAA CM will need to authorize a Contracted Provider (Community Choice Guide or GOSH Provider) to make payments or/and purchases on the behalf of the client.
2) The HCS/AAA CM will open RAC 3131- LTSS Housing Stabilization
3) Use Service Code SA294,U4 (Housing Subsidy-Purchasing) to authorize the necessary goods and services.
    - For "Start" enter the date you authorized the Contracted Provider to make payment on a client's behalf.
    - For "End", enter the date that falls two weeks after the start date. For example, start date is March 3, 2025, and the end date would be March 17, 2024.
    - For "# of Units" enter 1.
    - Unit type will be set to "Each".
    - For "Rate", enter the amount the Contractor was authorized to pay on behalf of the client.
    - Select reason code "Employment Stabilization"
    - For "Business status" select "Reviewing" status. Please do not put an authorization in "approved" status until you have received an invoice/receipt and the amount matches.
    - Once the invoice is received, update the start and end date, and verify the rate amount. If the rate doesn't match, please update the rate to match the invoice/receipt amount. Change "Business status" to "Approved".
4) When submitting an ETR, select "other" for both ETR/ETP category & type. Please note: an ETR will be required if the goods and services exceeds $5000
5) Submit the ETR to "Committee, Housing ETR" and email housingcommitteeetr@dshs.wa.gov to inform us about the ETR request.
6) Note in the Service Episode Record (SER) that the client is eligible for Housing & Employment Stabilization services and that you have Supervisory approval to authorize state only funds.
7) Complete a SER outlining the service you are authorizing and/or the items you are purchasing and how they are necessary for the client's service plan.
8) Receipts for all purchases must be included in the participant's electronic case record (ECR). Attach all receipts/bids to the Packet Cover Sheet: Social Services Packet Cover Sheet (DSHS Form 02-615)

How to Document Employment Stabilization Services in CARE:

Once the client is authorized for Employment Stabilization Services the HCS/AAA CM must:

- Add "Other" for Community Supports under Treatments
- On the Medical Screen in CARE, choose the Program "Other"
- Check "No" for Received in Last 14 days?
- Check "Yes" for Need
- Choose "Agency" for Provider
- Choose "PRN" for Frequency
- For Comments, type: *"Employment Stabilization item(s) as identified to assist with the client's [return to/stabilization in] independent living."*
- Add the Contracted Provider as a Paid Provider in the Care Planning section under the Supports Screen and assign the provider the task of "Other" (for Community Transition Services)

RESOURCES

For additional resources about the Foundational Community Supports (FCS) and Supported Employment program, please visit the following websites:

Office of Housing and Employment website: Office of Housing and Employment

MTP Community WorkSpace - Home

Medicaid Transformation Project (MTP) | Washington State Health Care Authority

HCS MTD intranet site for staff

Wellpoint TPA Provider Website with Resources

Wellpoint TPA Website for Clients

FCS Referral Form for Direct Referral to TPA

Supported Employment Assessment

FCS Quick Reference Guide

FCS Marketing Flyer - English

FCS Marketing Flyer - Spanish

Housing & Employment Stabilization Services Chart:

Housing Subsidy - Purchasing SA294u4

Housing & Employment Stabilization Services (H&ES) These state funded services are intended to fill specific gaps to provide transitional or stabilizing supports for clients, who have received a housing or Supported Employment resource or had their housing/employment coordinated through ALTSA to sustain community living.	
Who is eligible for state H&ES?	When an ALTSA client meets these qualifications: **1.** Received a housing resource or had their housing coordinated through ALTSA; **or** 2. Enrolled with Supported Employment or had their employment coordinated through ALTSA; **and** **3.** Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to your own home, or are living in the community and need stabilization services to remain there; **and** **4.** Do not have other programs, services, or resources to assist you with these costs; **and** 5. Are not eligible for federal funding
What is covered under state H&ES?	1. First month's rent, security deposits, safety deposits 2. Utility set-up fees or deposits 3. Health and safety assurances, such as pest eradication, allergen control, or non-recurring cleaning fees prior or upon return to the home. 4. Moving services 5. Background check/application fees 6. Non-recurring rental insurance required for lease up. 7. Furniture, essential furnishings, and basic items essential for basic living outside the institution.

	8. The provision of goods that increase independence or substitute for human assistance to the extent that expenditures would have been made for human assistance, such as purchasing a microwave. 9. Cellphone 10. Household items 11. Bus pass 12. Food 13. Food Handlers card 14. Identification card 15. Clothes (interview clothes, first set of uniforms to begin work) 16. Etc.
What is not covered under fed state H&ES?	1. recreational or diversional items such as television, cable or DVD players. 2. Assistive Technology
When do I need a provider contract?	1. A contracted provider (Community Choice Guide or GOSH SHP) will need to be authorized to complete purchases or/and payments on the behalf of the client.
How do I authorize state H&ES?	1. Open RAC 3131-LTSS Housing Stabilization 2. Use Service Code SA294,U4 to authorize the necessary goods and services. • Select the appropriate reason code. Options are "In-Home Community Stabilization or Employment Stabilization" 3. Note in the Service Episode Record (SER) that the client is eligible for LTSS Housing Stabilization services and that you have Supervisory approval to authorize state only funds. 4. Complete a SER outlining the service you are authorizing and/or the items you are purchasing and how they are necessary for the client's service plan. 5. Receipts for all purchases must be included in the participant's electronic case record (ECR). Attach all receipts/bids to the Packet Cover Sheet: Social Services Packet Cover Sheet (DSHS Form 02-615)
When do I authorize this service?	When an ALTSA client meets these qualifications: 1. Received a housing resource or had their housing coordinated through ALTSA; **or** 2. Enrolled with FCS Supported Employment or had their employment coordinated through ALTSA; **and**

	3. Are transitioning from a hospital, nursing facility, licensed assisted living facility, enhanced services facility, or adult family home to your own home, or are living in the community and need stabilization services to remain there; **and** 4. Do not have other programs, services, or resources to assist you with these costs; **and** 5. Are not eligible for federal funding
Are ETRs allowed for state H&ES?	**Yes.** 1. An ETR will be required if the total amount of goods & services exceeds $5000. 2. Select "other" for both ETR/ETP category & type. 3. Submit the ETR to "Committee, Housing ETR" and email housingcommitteeetr@dshs.wa.gov to inform us about the ETR requested. • Note: If the amount Exceeds $2500, this will generate an error message in CARE and will require the HCS/AAA CM to reach out to the Supported Employment Specialist to force the error.

Forms:

FCS Referral Form for Direct Referral to TPA

Related WACs:

FCS WACs

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
10/2018	Michael Corcoran	Initial publication	
6/2022	Michael Corcoran	Updated information	
5/2023	Michael Corcoran	Updated information	
6/2024	Michael Corcoran	Updated Information	
4/2025	Michael Corcoran	Updated chapter format. Added information about SA294,U4- Housing and Employment Stabilization	

		Services. Added information on How to document Employment stabilization services in CARE. Added a chart demonstrating SA294,U4.	

Foundational Community Supports- Supportive Housing

Chapter 30d describes Supportive Housing, a collaborative wraparound service for individuals with complex needs. These services are available in one of two ways for ALTSA recipients: Foundational Community Supports (FCS), or the Governor's Opportunity for Supportive Housing (GOSH). This chapter describes program eligibility, service areas, referral process and case coordination for Foundational Community Supports – Supportive Housing services. For more information on GOSH, please see Long-Term Care Manual Chapter 6A: Altsa Subsidies & GOSH Services.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Whitney Joy Howard Housing Integration Unit Manager
360.791.2358 whitney.howard@dshs.wa.gov

Stephen Miller Supportive Housing Unit Manager
564.200.3510 stephen.miller@dshs.wa.gov

For additional information please visit our website: Office of Housing and Employment

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BACKGROUND

Supportive Housing (SH) is a philosophy and a program that is rooted in the belief that no one should have to prove "housing readiness" to be housed. The service is an evidence-based practice with decades of research, as well as personal and professional stories that highlight the success of community living paired with intensive, personalized supports. A person is supported in the process of securing community-based, affordable housing of their choice along with individualized support to assist them with stabilization and self-identified goals. SH adheres to the principles of Housing First, Harm Reduction, Trauma Informed Care, Motivational Interviewing, Person Centered Planning, and Strengths-Based Approach. Program participation, medication adherence, and abstinence are not required to keep one's housing.

SH services are available in two ways for ALTSA recipients:

- Individuals who are currently residing in the community may be eligible for Supportive Housing services under Healthier Washington Medicaid Transformation: Foundational Community Supports (FCS) - Supportive Housing services.
- Individuals with challenging or complex needs who are currently residing at Eastern or Western State Hospital or are able to be diverted from these institutions may access Supportive Housing Services through the Governor's Opportunity for Supportive Housing (GOSH). For more information about GOSH, see chapter 6A.

SH provides dedicated housing support to people with complex needs wishing to live independently. The service provides wraparound support, which means facilitating cross-sector coordination of all services the person needs, including Long-Term Services and Supports (LTSS), mental health, substance use disorder, physical disabilities, developmental disabilities, and legal and/or financial issues. Supportive Housing services may be an option for individuals who want to live independently and have a history of unsuccessful housing episodes without coordinated, focused support services. ALTSA seeks to provide person-centered, responsive, low barrier services for these individuals.

Contracted Supportive Housing Providers (SHP), service capacity and service areas are continuously expanding across the state. The ALTSA Supportive Housing Program Managers maintain the list of contracted SHPs. To find your Region's Supportive Housing Program Manager, please see the ALTSA Housing Regional Map.

Supportive Housing Services: Pre-Tenancy

These specialty services provide assistance and support to aid an eligible individual's successful transition to independent housing. Supportive Housing Pre-Tenancy services may include, but are not limited to the following:

- Facilitating a cross-sector system of care.
- Locating and arranging independent, accessible housing, including working with local housing authorities and other community resource providers when applicable.

- When relevant, liaising with and among the individual, institutional facility staff, case managers, housing providers, medical personnel, legal representatives, formal caregivers, family members, informal supports and any other involved parties.
- Educating individual on tenant rights, expectations and responsibilities.
- Assisting individual with filling out forms and obtaining needed documentation to aid in maintaining successful community living (forms may include initial and renewal voucher forms, lease agreements, etc.).
- Assisting individual in developing a basic household budget.
- Creating individualized Crisis Plan that is shared with cross sector team.

Supportive Housing Services: Tenancy

Once a Supportive Housing client has secured independent housing, signed a lease and moved into independent housing, they are considered a Supportive Housing tenant for the purposes of WAC 388-106-1710. These specialty services provide assistance and support to ensure the eligible individual's maintenance of independent housing. Supportive Housing Tenancy services may include, but are not limited to the following:

- Necessary assistance to support the individual's community living, including assistance in settling disputes with landlords and/or neighbors.
- Working with an individual to identify a broad range of life goals and providing support to meet the goals documented on the goal and service plan. This housing support plan is created with the client and the Supportive Housing Provider.
- Assisting individual with locating and arranging transportation resources to effectively connect with community resources.
- Facilitating connections to engage and enhance community integration activities.
- Educating individual on accessing community settings or health services.
- Personal skill development for individual and/or caregivers related to the individual's care plan.
- Connecting with emergency resources to avoid utility shut-off and/or eviction.

FOUNDATIONAL COMMUNITY SUPPORTS: SUPPORTIVE HOUSING

In 2017, Washington State and the Centers for Medicare and Medicaid Services (CMS) finalized an agreement for a five-year Medicaid Transformation Project (MTP) to improve the state's health care systems, provide better health care, and control costs. In 2021, CMS approved a one-year extension. On June 30, 2023, **CMS renewed MTP for an additional five years, beginning on July 1, 2023 and running through June 30, 2028.** By renewing MTP, our state can continue to develop innovative projects, activities, and services that improve Apple Health (Medicaid). . To read the approval letter from CMS, please see here. To learn more about MTP 2.0, please see HCA's MTP renewal website. You can also read the full waiver renewal application.

The research is clear—unemployment and job insecurity, homelessness, and unstable housing contribute to poor health. Homelessness is traumatic and cyclical; it puts people at risk for physical and mental health conditions and substance use disorders. Similarly, evidence links unemployment to poor physical and mental health outcomes, even in the absence of pre-existing conditions. Foundational

Community Supports (FCS)—part of Washington's federally authorized Medicaid Transformation project—addresses these factors with targeted benefits for Supportive Housing and Supported Employment.

In 2018, FCS began providing targeted Supportive Housing and Supported Employment services for eligible Medicaid beneficiaries in Washington State.

For more information regarding ALTSA FCS Supported Employment benefits, please see LTC Manual Chapter 30c.

Eligibility

To receive Foundational Community Supports – Supportive Housing services, an individual must:

1) Be 18 or older Medicaid-eligible
2) Must meet at least ***one*** assessed health needs-based criteria:
   a) Mental health need where there is need for improvement, stabilization or prevention of deterioration of functioning resulting from the presence of a mental illness (receiving services through a Managed Care Organization under the Behavioral Health Services Only (BHSO) plans or the Fully Integrated Managed Care (FIMC) plans).
   b) Need for outpatient substance use disorder (SUD) treatment (receiving services through the Behavioral Health Services Only (BHSO) plans or the Fully Integrated Managed Care (FIMC) plans).
   c) Need for assistance with three or more activities of daily living (ADL) (receiving long-term care [LTC] services).
   d) Need for hands-on assistance with one or more ADL (receiving LTC services).
   e) Complex physical health need, which is a long continuing or indefinite physical condition requiring improvement, stabilization or prevention of deterioration of functioning For ALTSA clients to receive Supportive Housing services through FCS, an individual must meet ALTSA Functional and Financial Eligibility.
3) Must meet at least ***one*** of the following Risk Factors:
   - More than one institutional contact in the past 12 months or one 90+ day stay in an institutional setting in the past 12 months
   - More than one adult residential care* stay in the past 12 months
   - Three or more in-home caregivers in the past 12 months
   - HUD definition Chronic Homeless as verified through the homeless service system
   - PRISM score of 1.5 or higher**

ALTSA Supportive Housing Program Managers can assist in submitting referrals for ALTSA clients meeting the above eligibility criteria.

*Adult residential care settings may include:

- Long-Term Services and Supports settings such as Adult Family Home, Assisted Living, Enhanced Adult Residential Center, Enhanced Service Facility, and
- Behavioral Health Settings such as Evaluation and Treatment Centers, Detoxification Centers, Inpatient Substance Use Treatment Facility.

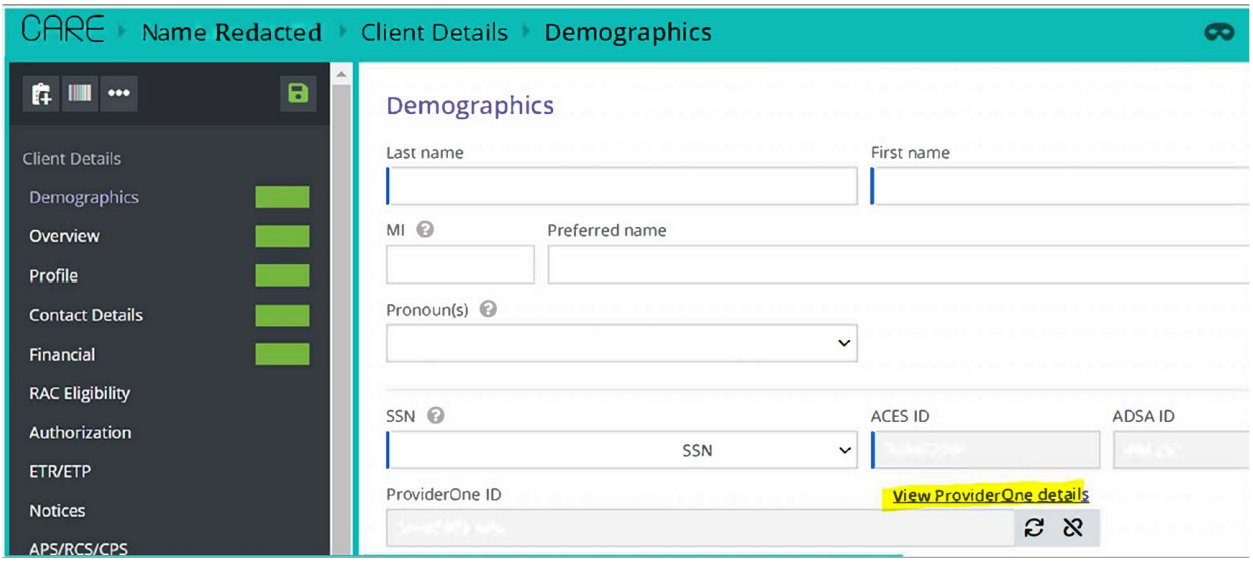
**ALTSA Supportive Housing Program Managers can verify PRISM scores for LTSS clients.

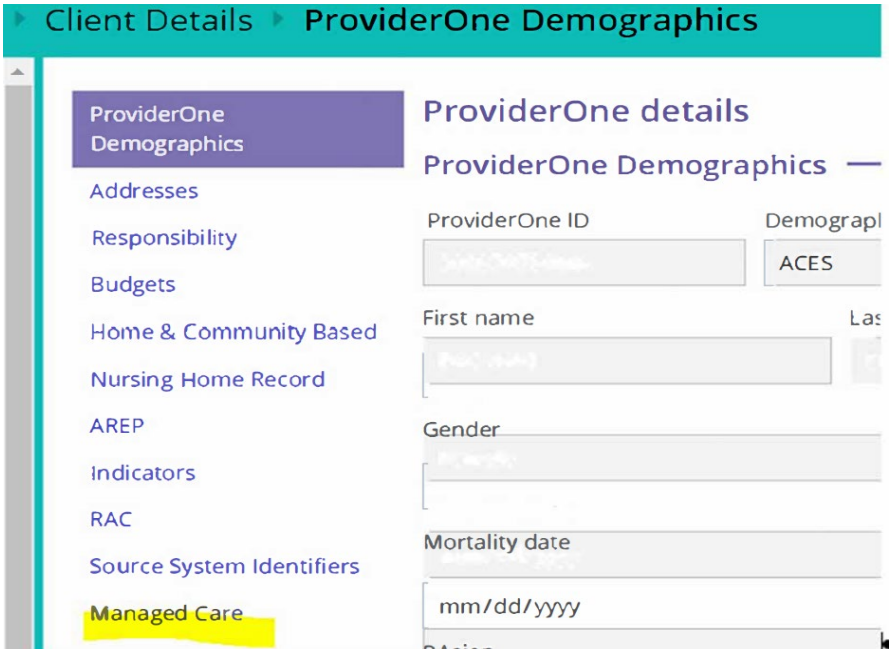
Note:

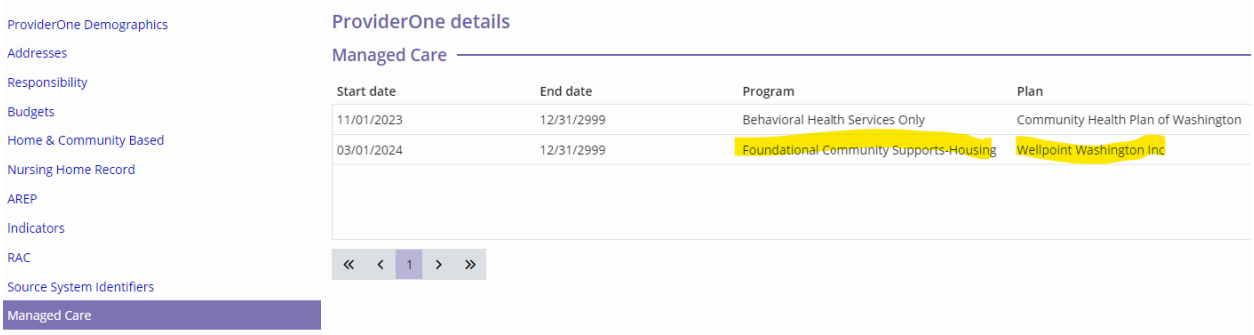
- A CARE assessment determines ALTSA functional eligibility. Functional eligibility is defined in WAC 388-106-0210, 388-106-0277, 388-106-0310, 388-106-0338, or 388-106-1410
- Healthcare Authority WACs pertaining to FCS: 182-559-100 to 182-559-600
- Long Term Care WAC: 388-106-1700 to 388-106-1765

How can I tell if my client is enrolled in FCS-SH?

- Open the client's file in CARE Web
- Go to Client Details
- Go to the Demographics screen
- Click the "View ProviderOne Details" link
- From the "ProviderOne Demographics" screen, click on "Managed Care"
- Look for Program to contain "Foundational Community Supports-Housing" with Wellpoint Washington Inc listed as the plan







The above client is currently enrolled in Supportive Housing through Foundational Community Supports beginning 03/21/2024. Service authorization periods are 6 months but can be reauthorized by the provider if the client still wants/needs the service and is active on Medicaid.

FCS-SH Referral Process

1. When case managers identify a client who could benefit from these services, speak with them about Supportive Housing services and get a verbal confirmation that they would like to be referred for these services.
2. Potential client, AAA/HCS Case Manager or ALTSA contracted provider contacts ALTSA Supportive Housing Program Manager, who will facilitate eligibility determination and, with client's verbal consent, make referral to Wellpoint.
    a. Referrals can be made directly to Wellpoint by a potential client, AAA/HCS Case Manager or Wellpoint FCS contracted provider.
    b. For direct referrals please see Wellpoint's FCS Provider website.

3. All referrals go through Wellpoint to determine eligibility, for service authorization and assignment to a SHP.
4. If eligible for FCS, Wellpoint refers client to SHP.
5. SHP accepts or declines referral
    a. If SHP declines referral, Wellpoint will find another SHP to accept the referral.

Regardless of whether the individual is an ALTSA recipient, anybody can make a referral for FCS. To contact Wellpoint directly about Foundational Community Supports, call 1-844-451-2828 or email FCSTPA@wellpoint.com. To contact an ALTSA Supportive Housing Program Manager, call 1-844-704-6786 or email SupportiveHousing@dshs.wa.gov
To file an appeal or grievance with Wellpoint, call 1-844-451-2828 or email FCSTPA@wellpoint.com

Note: Individuals on the Residential Support Waiver setting who wish to transition to an independent living setting with supports **may** be referred to Supportive Housing services.

FCS-SH Client Accepted

1. ALTSA Supportive Housing Program Manager will email/connect the LTSS case manager with the SHP to coordinate continuity of care.
2. LTSS case manager should schedule time with the SHP to discuss client needs, CM role, SHP role and assist SHP connect with client.
    - As referenced in Chapter 3, page 3.17, LTSS case manager should share the plan of care with the SHP.
    - ALTSA Supportive Housing Program Manager is available to participate in meeting.
    - Best practice would be to coordinate regular check-ins between LTSS and SHP.
3. Once client is authorized for Supportive Housing, the case manager must:
    - Add Supportive Housing Provider to Collateral Contacts screen.
    - Add Supportive Housing under Treatments.
    - Add Supportive Housing Provider as an Unpaid Provider in the Supports screen of the Care Plan and assign the task of "Supportive Housing".
    - Use the Purpose Code “Housing” for any SERs related to FCS-SH.
4. SHP works with client to pursue independent housing and support client in maintaining independent housing.
5. LTSS case manager should work with client and SHP to identify any LTSS goods, services and/or supports client might need authorized to transition into or sustain independent housing.

Reimbursements

Community Transition and Sustainability Services are available to provide transitional or stabilizing supports for ALTSA clients to sustain community living. With prior approval from the AAA/HCS CM or ALTSA Supportive Housing Program Manager, an ALTSA contracted provider, such as a Community Choice Guide (CCG) or Governor’s Opportunity for Supportive Housing (GOSH) provider, is reimbursed for the authorized purchases after it is verified the individual received the goods or service. Based on an

individual's eligibility, the following services could be reimbursed: Shopping for necessary household goods/items or paying for rental deposit, tenant background screening to aid housing search, utility hookup fees, or rent/emergency rental assistance service.
Additionally, starting in May 2022, Wellpoint launched the Transition Assistance Program (TAP) for FCS-SH enrollees. TAP is a time-limited, flexible funding assistance that covers housing-related fees, including move-in costs, first and last month's rent, deposits, and non-refundable fees. For more information on TAP please see the Transition Assistance Program section on Wellpoint's FCS Provider webpage.

Community Choice Guides and FCS-SH Providers

Community Choice Guides (CCG) and FCS-SH Providers have similar pre-tenancy duties, such as housing search, identifying housing resources, independent skills development, and landlord relations. State Supportive Housing services do not include transition funds to pay for items such as background checks, application fees, security deposits or furniture. Therefore, when there are no individual or other community resources available, LTSS case managers should authorize Community Transition or Housing & Employment Stabilization Services to supplement the services provided by CCGs and/or FCS-SH Providers. Please see the reference tools document for assistance in determining the appropriate funding source.

Who authorizes a CCG and FCS-SH Providers?

CCGs are authorized in CARE by HCS and/or AAA staff per ALTSA policy.
FCS-SH Providers are contracted and authorized by Third Party Administrator Wellpoint. These authorizations are not in CARE.

When is it OK to have both a CCG and FCS-SH authorized?

CCGs and FCS-SH Providers can work simultaneously with a client as long as there are clearly defined and separate tasks. For example, a FCS-SH Provider could assist with independent housing search and paperwork/applications, while the CCG could assist with purchasing and residential facility search.

When is it *not* OK to have both a CCG and FCS-SH authorized?

When both CCG and FCS-SH Providers are assisting a client with the same tasks, such as housing search, it is a duplication of service. It is important to note that not all FCS-SH referrals come from ALTSA Supportive Housing Program Managers. Referrals can come from many sources, including providers, community partners, and clients themselves. Clients may already be enrolled in FCS Supportive Housing at the time of LTSS intake/assessment.

Can FCS-SH Providers be reimbursed directly without authorizing a CCG?

Supportive Housing Providers that are contracted directly with DSHS through ALTSA's Governor's Opportunity for Supportive Housing (GOSH) service or through CCG contracts may complete purchasing for items pre-approved by the case manager and be reimbursed through ProviderOne. However, if a Supportive Housing Provider through Foundational Community Supports is not dually-contracted with DSHS through a GOSH or CCG contract, they will not be able to purchase items directly and be reimbursed. In these cases, a case manager will need to authorize a CCG to make a purchase on behalf of a client. Foundational Community Supports SHPs are authorized via Wellpoint to provide services. The

FCS-SHP will bill Wellpoint for the services and submit the invoice/receipt for reimbursement to the HCS/AAA case manager. The FCS-SHP would not be authorized through HCS to provide a service, as they are already authorized via FCS to provide services and this would be a duplication of service to be doubly authorized.

-

Please consult your Regional Supportive Housing Program Manager if you are not sure if a FCS-SH Provider is contracted directly with DSHS.

How is this funded?

Foundational Community Supports is part of the Healthier Washington Medicaid Transformation (MT). MT is a six-year demonstration waiver funded 100% by the federal Centers for Medicare and Medicaid Services through 2022. On July 15, 2022, the State submitted a waiver renewal application for MTP to CMS. If CMS approves the application, MTP will continue for an additional five years – from 2023 – 2027.

Note: There is no participation required for clients receiving FCS - Supportive Housing services.

Can a DDA services recipient receive FCS-SH Services?

An individual receiving DDA services may be eligible for FCS Supportive Housing services. Such individuals must be found to meet an eligible health need and a risk factor. Individuals dually eligible for DDA and ALTSA services are eligible for FCS through the long-term care eligibility pathway if they also meet a risk factor. Individuals only receiving DDA services could also be found eligible with a mental health diagnosis/substance abuse disorder or experiencing homelessness with a disability determined by a coordinated entry assessment and an accompanying risk factor. Please refer to Wellpoint for specific eligibility questions. They can be reached directly by phone: 1-844-451-2828 or email FCSTPA@wellpoint.com.

What about Contracting?

Wellpoint Washington Inc. was awarded the contract providing the Third-Party Administrator services for FCS. Providers interested in contracting for FCS should contact Wellpoint directly by phone: 1-844-451-2828 or email FCSTPA@wellpoint.com.

SUPPORTIVE HOUSING AND CASE COORDINATION

How do SH services and Long-Term Services and Supports (personal care, client training, community transition services, etc.) complement each other?

SHPs will need to coordinate closely with case managers to ensure all necessary LTSS services are authorized. Clients who are eligible for LTSS may receive MPC, CFC, CFC + COPES, RCL and RSW services while receiving Supportive Housing services.

I. Based on the LTSS program the client is eligible for, Community Supports: Goods and Services may be considered.
   a. LTC Manual Chapter 7b discusses the Community First Choice (CFC) Community Transition Services (CTS) and its eligibility parameters
   b. As for Community Transition and Sustainability Services (CTSS), dependent on client's eligibility and the situation, see:
      i. LTC Manual Chapter 6D for coverage under Housing & Employment Stabilization Services
      ii. LTC Manual Chapter 7d for COPES eligibility
      iii. LTC Manual Chapter 29 for coverage under RCL
   c. ALTSA Supportive Housing Program Managers are available to answer questions regarding accessing these resources.

II. The SHP should be in contact with the case manager as well as the ALTSA Supportive Housing Program Manager to provide updates. The case manager should document communication as a service episode record (SER).

III. In partnership with the SHP, any purchases made on behalf of the individual to assist with community transition and sustainability as well as any subsequent reimbursement processing will be completed per regional policy. Any ETRs necessary for these goods and services will be completed per regional policy.

IV. If the individual is eligible for long term services based primarily on a psychiatric condition and the criteria indicated in LTC Manual Chapter 7h, the case manager will follow the process as outlined in LTC Manual Chapter 7h for requesting funding from the MCO to cover the client's personal care.

If someone receiving Supportive Housing services "refuses" or declines personal care, do I need to close the case for all services?

No, you do not need to close the case for all services if a client "refuses" or declines personal care. No authority or regulation states that a case must be closed if the individual does not receive personal care. Individuals eligible for ALTSA Supportive Housing services may struggle with obtaining or maintaining a caregiver. Certain individuals may have behavioral health challenges, and/or struggle with homelessness. Services other than Personal Care, such as Supportive Housing, may allow providers to assertively engage with clients and work with them to decide which services or interventions could enable them to reach or maintain stability. During the period of time when a client is adjusting to the idea of utilizing services, it is important to keep the case open.
Before closing out a case, consider the following:

- Certain community settings, client choice, or other situations may create a care plan where Personal Care is not feasible. Has the possibility of setting up personal care in a non-traditional setting (e.g., shelter or hygiene station) been explored?
- Other ALTSA services may be authorized in order to move an assessment to current and provide an official start date for services. Some examples of these services could be: GOSH, Wellness Newsletter, PERS, Behavioral Supports, DME, Skilled Nursing, Client Training, etc. As a reminder, per Management Bulletin H18-056, AAA's are paid to case manage clients with *any* open authorization for LTSS.
- What supports do the collateral contacts (including formal and informal supports) report the client is utilizing? These supports should be captured in CARE.
- Medication Management is a "look forward" screen. Will the client benefit from ongoing medication management assistance?
- What support services, outside of caregiving, will the client benefit from in order to stabilize community living?
- Has the case been staffed with an ALTSA Supportive Housing Program Manager?

Note: If you believe you must close a case, please see requirements to do so in the Challenging Cases Protocol.

RESOURCES

Housing Team Contacts can be found on the **RCL Housing Resources Website.**

Office of Housing and Employment website: Office of Housing and Employment

Brochures and Videos

WAWP-CD-049507-24 FCS QRF_CMAP.docx

Foundational Community Supports - Supportive Housing (FCS-SH)

WAWA_WLP_CAID_TransitionAssistanceProgramQRG.pdf

Services Now Available in COPES and New Reason Codes.pdf

Related RCWS and WACs:

The following rules and policy support case management functions:

RCW 74.38.010	Legislative Recognition – Public Policy
RCW 74.38.040(1)	Scope and Extent of Community-Based Services Program
RCW 74.39.005(7)	Long-term Care Service Options - Purpose
RCW 74.39A.040(3)(c)	Department Assessment of and Assistance to Hospital Patients in Need of Long-term Care
RCW 74.42.057	Notification Regarding Resident likely to Become Medicaid Eligible

RCW 74.42.058	Department Case Management Services
RCW 74.39A.090	Discharge Planning-Contracts for Case Management Services and Reassessment and Reauthorization – Assessment of Case Management Roles and Quality of In-Home Care Services – Plan of Care Model Language
RCW 74.39A.095	Case Management Services – Agency on Aging Oversight Plan of Care – Termination Contract – Rejection of Individual Provider Contract
RCW 70.41.310	Long-term care -- Program information to be provided to hospitals -- Information on options to be provided to patients.

WAC 388-106-1700 to WAC 388-106-1765

Forms:

Behavioral Health Personal Care Request for MCO Funding DSHS form 13-712

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
10/2018		Established	
01/2019		Edits to section on when a client declines personal care that that the case may remain open to receive supportive housing services or subsidy.	
08/2019		Edits for clarity on program services.	
06/2020		Edits to update FCS and GOSH sections for clarity on program services and for formatting.	
8/2020		Hyperlinks added for LTC Manual Chapters 5b and 9b; updated FCS-SH and GOSH procedural steps.	
10/2020		Updated GOSH Pre-Tenancy Service Code, provided clarification around SHPM vs CM responsibility in "GOSH Client Accepted" section and updated link for DSHS form 13-712	
02/2021		Rearranged chapter sections; Moved section on Governor's Opportunity for Supportive Housing (GOSH) from Chapter 30d to Chapter 5b: Housing Resources for ALTSA Clients; Clarified FCS-SH Eligibility criteria; Added clarification that there is no participation for Supportive	

		Housing services; Added section on verifying if client is already enrolled in FCS-SH; Added clarification around Community Choice Guides and FCS-SH Providers.	
05/2021		Updated hyperlink in Chapter Section for Supportive Housing and Case Coordination	
02/2022		Updated hyperlinks, Updated Medicaid Transformation Project end date to December 31, 2022 to include the approved extension year, clarified some language throughout the Chapter	
08/2022		Updated "Foundational Community Supports: History" section to include information on the five-year waiver renewal application the State submitted to CMS; updated "How can I tell if my client is enrolled in FCS-SH?" section to CAREWeb version.	
08/2023		Updated with information on MTP 2.0 renewal and new end date. Reference to FCS-SH Transition Assistance Program added under Reimbursements section.	
08/2024		Updated page numbers, table of contents, and replaced Amerigroup with Wellpoint. Added additional info regarding FCS-SH with DSHS (CCG/GOSH) contracts. Added Office of Housing Website link	

Long-Term Services and Supports Presumptive Eligibility (LTSS PE)

Chapter 30e describes LTSS PE as part of the 1115 Medicaid Transformation Project waiver. LTSS PE will establish presumptive eligibility for individuals in need of long-term services and supports under Medicaid state plan and 1915(c) waiver authorities and Medicaid medical coverage and will be implemented in three phases.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Rhonda Widhalm LTSS PE Policy Program Manager
360.725.2525 rhonda.widhalm1@dshs.wa.gov

If you have questions or need clarification about the 1115 Waiver:

Anne Moua Medicaid Unit Manager
509.590.3909 anne.moua@dshs.wa.gov

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LONG-TERM SERVICES AND SUPPORTS PRESUMPTIVE ELIGIBILITY (LTSS PE) OVERVIEW

What is LTSS PE?

Approved under the 1115 waiver called Medicaid Transformation Project (MTP), Long-Term Services and Supports Presumptive Eligibility (LTSS PE) is package of services that allows the state to *waive* certain Medicaid requirements. LTSS PE provides individuals an opportunity for expedited access to both home and community-based services in their own home and Medicaid (Apple Health) medical coverage benefits while full functional and financial eligibility are being determined.

The LTSS PE assessment will be used in CARE to gather preliminary information for LTSS PE eligibility. For PE-eligible recipients, ALTSA/HCS will provide a limited benefit package during the PE period, through phases, for individuals residing in their own home and who plan to enroll in one of the following Washington State programs:

- Medicaid Personal Care (MPC)
- Community First Choice (CFC)
- CFC + Community Options Program Entry System (COPES)

Services included in the limited benefit package are described in subsequent sections. Rules governing LTSS PE can be found in WAC 388-106-1800 thru 388-106-1855 ~~WAC 182-533~~.

Who is an LTSS PE Client?

LTSS PE is a service option for clients who meet the below criteria:

1. Specific to Phase 1:
   - Will be discharging or diverting from an acute care hospital or a community psychiatric hospital; or
   - Have discharged or diverted from an acute care hospital or community psychiatric hospital in the last 30 days; and
2. Required in Phase 1 & 2
   - Live in your own home as defined in WAC 388-106-0010; and
   - Are not receiving any other Medicaid funded long-term services and supports.

An LTSS PE recipient can receive LTSS Medicaid Personal Care (MPC) PE or LTSS Nursing Facility Level of Care (NFLOC) PE services.

To be eligible for LTSS MPC PE, the above criteria noted in (1) or (2) for LTSS PE will be met in addition to the following requirements:

- Functional eligibility requirements as defined in WAC 388-106-0210; and
- Financial eligibility requirements as defined in WAC 182-513-1225.

To be eligible for LTSS NFLOC PE services, the above criteria noted in (1) or (2) for LTSS PE will be met in addition to the following requirements:

- Functional eligibility requirements as defined in WAC 388-106-0355(1)(a), (b), (c), or (d); an. d
- Financial eligibility requirements as defined in WAC 182-513-1315.

When will LTSS PE Start?

LTSS PE will be rolled out statewide in phases. Phase 1 began December 2023. In the Summer of 2025, Phase 2 is anticipated to expand and LTSS PE services will be offered to applicants who choose to receive services in their own home. Phase 3 is under review by CMS and if approved, will roll out statewide at a later date. Additional details will be provided at that time.

Where will LTSS PE Services be Provided?

LTSS PE services will be provided in home and community-based settings. To be eligible to receive LTSS PE services, the client must live in their own home as defined in WAC 388-106-0010. Examples of own home include:

- In an apartment building that the client rents from.
- In an established home residence that the client owns.
- In a relative's established home residence.
- In the home of another where rent is not charged.
- In a motel, where the client pays an established weekly/monthly rate of pay to reside (i.e., rent).

Why LTSS PE?

The goal of LTSS PE is to provide individuals with expedited access to home and community-based services. By doing so, LTSS PE will provide services to assist clients to live as independently as possible in their home.

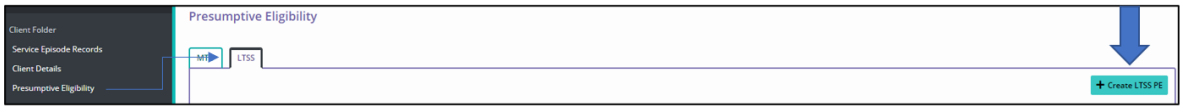
LTSS PE allows individuals to access to Medicaid Apple Health medical coverage and a reduced package of services while full functional and financial eligibility is being determined. Individuals already determined financially eligible for Medicaid state plan medical benefits will only require a functional LTSS PE determination.

DETERMINING ELIGIBILITY FOR LTSS PE

ALTSA HCS Social Service Specialist (SSS) staff will use the LTSS PE assessment in CARE to gather preliminary information that will determine both financial and functional LTSS PE for applicants. Similarly to MAC & TSOA PE screenings, the LTSS PE assessment may be conducted telephonically. To determine full functional eligibility, the CARE assessment will continue to be conducted via an in-person interview process. See Chapter 3 on *Assessment and Care Planning* for more information on the functions of an assessment.

Accessing the LTSS PE Assessment in CARE Web

The LTSS PE assessment can be accessed via the *Client Folder* > *Presumptive Eligibility* > *LTSS* tab > *+ Create LTSS PE*:



The LTSS PE assessment will have three (3) sections, Financial, Functional, and Care Plan. Each section of the assessment is dynamic, meaning, once all required fields in the Financial section have been completed, the PE assessment will display the Financial indicator as Eligible or Ineligible. When displayed as Eligible, then the LTSS PE Functional section will enable. When the Functional section is displayed as Eligible, then the LTSS PE Care Plan will enable to complete the assessment.

LTSS PE Financial Eligibility Overview

LTSS PE applicants who plan to enroll in either CFC, CFC+COPES, or MPC program are either already financially eligible for Medicaid state plan medical benefits or will self-attest to financial eligibility. When self-attestation is done, the below criteria must be met to establish LTSS PE financial eligibility:

Financial Eligibility for LTSS NFLOC or MPC PE is met when the:

Applicant is a current recipient of:

- Categorically Needy (CN); **or**
- Alternative Benefit Plan (ABP) Medicaid coverage.

Applicant is financially eligible for LTSS NFLOC PE when #1-#4 **and** either #5 **or** #6 apply:

1. Has Washington State residency; **and**
2. Is a U.S. citizen, U.S. national, or eligible immigrant.
3. Social Security Number (SSN); **and**
4. Is Aged, Blind, or Self-Attests to Disability; **and**
5. If *single*: the single individual's non-excluded monthly income is equal to or less than the Categorically Needy Income Level (CNIL), and the individual's separate non-excluded resources are at or below $2,000; **or**
6. If *married*: for a married couple with a non-institutional spouse, the individual's non-excluded income is equal to or less than the CNIL with spousal impoverishment protections, and that non-excluded resources (calculated as of the first point at which the individual is deemed to have the status of an "institutionalized spouse") are at or below a combination of $2,000, plus the current state Community Spouse Resource Allowance, based on the individual's self-attested statement of their household resources.

If the applicant attested to resources over the allowable limits both as a single person or married person, they do not meet the criteria for LTSS PE services. They can still pursue LTSS services; however, through our traditional avenues.

Defining "Resources"

A "resource" is any cash, other personal property, or real property that an applicant, recipient or other financially responsible person owns, can to convert to cash (if not already cash), and has the legal right to use for support and maintenance (see WAC 182-512-0200). Any asset that does not meet this criterion is not a resource. Resources examples: checking accounts, stocks, bonds, annuities, pensions, vacation property, multiple cars, and cash in a safe.

A "countable resource" is something that meets the definition of a resource, is not excluded as a resource, and is available to convert into cash (if not already cash). A resource that ordinarily cannot be converted to cash within 20 working days is considered unavailable as long as a reasonable effort is being made to convert the resource to cash (WAC 182-512-0250). A person may provide evidence showing that a resource is unavailable. A resource is not counted if the person shows sufficient evidence that the resource is unavailable.

An "excludable resource" can be:

- The home, household goods, certain other property (WAC 182-512-0350).
- One vehicle used for transportation (WAC 182-512-0400).
- Life insurance up to $1,500, but the rule can get complex (WAC 182-512-0450).
- Burial fund up to $1,500, but the rule can get complex (WAC 182-512-0500).
- Other resources excluded by federal law (WAC 182-512-0550).
- Certain American Indian or Alaska Native resources (WAC 182-512-0770:).

HCA Form #19-0054 Certification of Potentially Disabling Condition

Clients must be determined Aged, Blind, or Disabled. If the client is not determined Aged, Blind, or Disabled, and there is no open S02, S95, or S99 ACES code open for a first-time client, then the HCA #19-0054 form is required for LTSS PE financial eligibility. The #19-0054 form will be needed before the LTSS PE period is over and full financial and functional eligibility is determined. SSS staff will support the client to have this form completed by a licensed medical professional (as described in WAC 388-449-0010) to confirm a disabling condition for the client on long-term services and supports.

The #19-0054 form would not be required for clients 65 years and older or already active on a DSHS Classic Medical program (S01, S02, S95, S99 ACES code) because they would have already been determined Aged, Blind or Disabled in order to be active on a DSHS Classic Medical.

Scenario 1
Q: Do I need to get a 19-0054 presumptive disability form when the client is already receiving Medicaid coverage at the time LTSS PE is requested?

A: No, for clients who are already Medicaid eligible (On MAGI or classic Medicaid coverage) and functionally eligible for LTSS PE services, no 19-0054 form is required. Proceed with opening LTSS PE services if the client is functionally eligible.

Scenario 2
Q: If the client is already Medicaid eligible under MAGI and receiving LTSS PE services and is found to need waiver services when the full assessment is completed, do I still need to get the 19-0054?

A: No, you don't need to have the 19-0054 form completed. You will need to communicate with financial and let them know waiver services are required so they can request an application and start the NGMA process (see Chapter 7h) to get disability approved following existing processes. If eligible, the client can be approved for CFC only. You can end LTSS PE services and authorize CFC services pending the eligibility determination for waiver services. Once a disability has been determined, the client may move to CFC + COPES if needed.

Scenario 3
Q: If the client is not already Medicaid eligible (under any program) and is determined financially and functionally eligible for LTSS PE services, do I need to get the 19-0054 form?

A: Yes. Under the terms of the 1115 waiver, a person applying for COPES or CFC may self-attest to disability status. If the client self-attests to having a disability, we must get the 19-0054 form completed by their health care professional to confirm presumptive disability status.

LTSS PE Client Responsibility / Participation / Cost of Care

A client financially eligible for a CN or ABP Medicaid coverage program does not pay toward the cost of care in an in-home setting.

1. Clients receiving LTSS MPC PE services do not pay toward the cost of care for those services.
2. Clients receiving LTSS NFLOC PE services **may** need to pay toward the cost of care as outlined (see WAC 182-515-1509).

To calculate Client Responsibility, SSS staff will use the LTSS PE Participation Calculator to enter/complete:

1. Client's gross earned income (income a client receives when being employed)
2. Client's gross unearned income (such as a pension, SSA income, VA income, etc.)
3. Client Has a Payee? (Check box Yes or No options)
4. Does client pay a guardianship fee? (Check box Yes or No options)
5. Medical Deductions (such as old medical bills, premiums, out-of-pocket expenses, etc.)

Post-Eligibility Treatment of Income (PETI)

LTSS PE applicants are subject to Post-Eligibility Treatment of Income (PETI) based on self-attested available income and allowable deductions, including a Personal Needs Allowance (PNA) during the LTSS PE period. The cost of care applied during the PE period will not be adjusted when full eligibility is determined. If applicable, an updated PETI will be applied the first of the month following determination, based on completion of the client's final financial and functional eligibility determinations.

Estate Recovery

LTSS PE applicants are subject to Medicaid estate recovery rules. Estate recovery is the department's process of recouping the cost of Medicaid and long-term services and supports benefit payments from

the estate of the deceased client. Information on estate recovery will be provided to an LTSS PE-eligible client via the LTSS PE Approval Notice.

LTSS PE Functional Eligibility

LTSS PE functional eligibility rules will follow the same eligibility rules used when determining MPC or NFLOC full functional eligibility through an assessment:

- WAC 388-106-0355 (1)(a), (b), (c), and (d), Am I eligible for nursing facility care services; **and**
- WAC 388-106-0210, Am I eligible for Medicaid Personal Care (MPC) services?

LTSS PE applicants who self-attest and plan to enroll in either Washington State's CFC, CFC+COPES, or MPC program will be screened to determine if they appear to meet MPC eligibility, NFLOC eligibility, or ineligibility. The LTSS PE assessment in CARE captures the individual's self-attestation.

Full Financial or Functional Eligibility are Already Determined, can LTSS PE be Accessed?

Most often, full financial and full functional eligibility determinations for LTSS will be done concurrently.

If the client received a full functional CARE assessment and financial eligibility is not yet determined, the LTSS PE functional assessment cannot be retroactively accessed during the interim. Consider Fast Track, a process that allows the authorization of HCS services prior to a financial eligibility determination, when staff can reasonably conclude that the applicant will be financially eligible. See Chapter 7a, *Financial Eligibility for Core Programs* for an overview on Fast Track.

Note: A client cannot access Fast Track when accessing LTSS PE.

If the client meets full financial eligibility for Medicaid state plan medical benefits but did not yet receive a CARE assessment to determine full functional eligibility, then the LTSS PE functional assessment can be accessed (given the circumstances that the client has an established home setting).

LTSS PE NOTICES

LTSS PE has three forms:

1. The "Long-Term Services and Supports Presumptive Eligibility Approval Notice" (LTSS PE Approval Notice) is used when the client is determined LTSS MPC PE or LTSS NFLOC PE eligible. The notice informs the client of eligibility, and that once a final determination is made, the client may be eligible for different services, more or fewer monthly personal care hours, or be determined not eligible for any services. The notice informs the client of next action steps to make a full financial and functional determination, inform the client of their rights and responsibilities, and estate recovery. SSS staff should review with the client and obtain the client/authorized representative's signature.
2. The "Long-Term Services and Supports Presumptive Eligibility Denial Notice" (LTSS PE Denial Notice) is used when the client is determined ineligible for LTSS MPC PE or LTSS NFLOC PE. The notice informs the client of the reason(s) for ineligibility and informs them of their rights.

3. The "Presumptive Eligibility Care Plan," is used as the plan of care, to be signed by the client, SSS staff/assessor, and the paid provider responsible for implementing the plan of care.

SSS staff should continue to include the Consent Form (DSHS Form #14-012) and obtain client/authorized representative's signature.

PERIOD OF PRESUMPTIVE ELIGIBILITY

The period of LTSS PE is the duration of time that begins on the date that an applicant is determined LTSS presumptively eligible and ends with the earlier date of:

- The date the decision was made on the client's application (see WAC 388-106-0010);
- The date the client was determined by a CARE assessment to not meet functional eligibility (see WAC 388-106-0355 or 388-106-0210); **or**
- If the client did not submit an application, then the LTSS PE period and all LTSS PE services will end on the last day of the month following the month in which the client's LTSS PE services were authorized.

SSS staff should discuss with the client that LTSS PE is not a final eligibility decision. LTSS PE services are temporary, unless the client takes action to apply for LTSS, respond to functional determination (CARE assessment), and respond to a financial determination (telephone interview and providing necessary verifications after review of the submitted application). SSS staff may explain that once a final determination is made, the client may be eligible for different services, more or fewer monthly personal care hours, or be determined not eligible for any services.

Initially, the LTSS PE period end will end on the last day of the month following the month in which the client's LTSS PE services were authorized. For example, when a client is found LTSS presumptively eligible in October, then initially, the LTSS PE period will end the last day of November.

Ideally, a Medicaid application should be submitted within 10 days from the LTSS PE assessment completion date. But, in the instance when the client does not submit their application at all, then LTSS PE services will end the last day of following month that LTSS PE was determined.

When an application is submitted, then the LTSS PE period can be maintained and extended beyond the initial end date set, until the earlier date of an ineligible decision was made on the client's application or the date the client was determined by a CARE assessment to not meet functional eligibility.

LTSS PE Notices & Financial Ineligibility

When the client submits their application, the Public Benefits Specialist (PBS) will determine a client to be financially eligible or ineligible. When determined financially ineligible, the PBS sends a denial letter to the client. SSS staff do not need to send additional notice following the PBS worker's financial ineligibility notice, in order to close services. Best practice is that the SSS will contact the client and let them know that services will end the date the decision was made on client's application. The LTSS PE Denial Notice applies to *initial* denial of LTSS PE services before a LTSS PE period were to begin, and therefore, would

not be used for this purpose. The LTSS PE Approval Notice serves as the notice for when LTSS PE services will be initially end-dated to inform the client that once a final determination is made, they may be eligible for different services, more or fewer monthly personal care hours, or be determined not eligible for any services.

LTSS Presumptive Eligibility Limitation

Applicants who are approved for LTSS PE and receive services during the LTSS PE period will be allowed only one (1) LTSS PE period every 24 months. This will be calculated from the time the previous LTSS PE ended. Applicants who are approved for LTSS PE during Phase 1 but did not receive services during the LTSS PE period could reapply for an LTSS PE assessment when discharging/diverting from an appropriate setting or have discharged/diverted in the last 30 days, returned to their established home setting, and are not receiving any other Medicaid funded LTSS.

IDENTIFYING LTSS PE SERVICE OPTIONS

Once the LTSS PE assessment completed in CARE indicates LTSS MPC PE or LTSS NFLOC PE functional and financial eligibility, the client provides verbal consent and approval for their LTSS PE plan of care, and the client's choice of care provider meets DSHS qualifications (*see WAC 388-71-0510*), the client may receive a combination of LTSS PE services.

Clients may receive LTSS PE services in their own home (*see WAC 388-106-0010*). Clients may also receive LTSS PE services while they are out of their home accessing the community or working while:

1. Within Washington State; **or**
2. In a recognized out-of-state bordering city (*see WAC 182-501-0175*).

Services offered and the client's choice of services under this benefit cannot duplicate services covered under private insurance, Medicare, state plan Medicaid, or through other federal or state programs.

- LTSS PE services may not supplement the reimbursement rate from other resources.
- ETRs are not allowed for LTSS PE services (*see WAC 388-106-1855*).
- Applicants do not have an administrative hearing right to LTSS PE eligibility or services (*see WAC 388-106-1850*).

LTSS MPC PE Service Option (WAC 388-106-1820)

The LTSS MPC PE benefits include up to 34 hours of authorized personal care services per month.

LTSS NFLOC PE Service Options (WAC 388-106-1810)

1. Personal care services, up to 103 hours authorized per month.
2. Nurse Delegation.
3. Personal Emergency Response System (PERS).

4. Home Delivered Meals (HDM). When authorizing Home Delivered Meals (HDM), there is no deduction of personal care hours for each meal.
5. Specialized Medical Equipment and Supplies.
6. Assistive/Adaptive Technology and Equipment.
7. Community Transition or Sustainability Services (CTSS): Goods and services which are nonrecurring set-up items and services to assist with expenses to move from an acute care hospital or diversion from a psychiatric hospital stay to an in-home setting and may include:
    i. Security deposits that are required to lease an apartment or home;
    ii. Activities to assess need, arrange for, and obtain needed resources, including essential household furnishings;
    iii. Set-up fees or deposits for utility or services access, including telephone, electricity, heating, water, and garbage;
    iv. Services necessary for your health and safety such as pest eradication, and one-time cleaning prior to occupancy;
    v. Moving expenses; and
    vi. Minor home accessibility modifications necessary for hospital discharge.
8. Community Choice Guide (CCG): Specialty services which provide assistance and support to ensure an individual's successful transition to the community and/or maintenance of independent living.
9. Supportive Housing.

> **"Isn't a person experiencing homelessness ineligible for Presumptive Eligibility?"**
> GOSH clients are eligible to utilize the Motel for Interim Stay Transition (MIST) program. MIST can be authorized for up to 6 months. If the ALTSA client qualifies for presumptive eligibility, desires GOSH, and has no safe place to stay or resources to pay for a place, the HCS/AAA case manager can utilize MIST. When a GOSH recipients are paired with MIST, they are not considered homeless and can then access the PE benefits.

DEVELOPING THE LTSS PE PLAN OF CARE

- After the LTSS PE is completed in CARE, a brief plan of care will be generated based on the level of care (LTSS MPC PE or LTSS NFLOC PE) and services selected. Before identifying and authorizing a service indicated in the client's LTSS PE plan of care, the client must have verbally approved the plan of care. Utilizing voice signature would replace the need to obtain verbal approval prior to obtaining the signature. See attachment in Appendix. Contact the client to obtain verbal approval for the LTSS PE plan of care.
    - In CARE, use Service Episode Record (SER) Purpose code, *Plan Approval*, to document verbal approval.
    - Review with the client and send the LTSS PE Approval Notice, LTSS PE Care Plan, and Consent Form (DSHS Form 14-012).
- Work with the client to identify qualified providers and authorize payment for services consistent with the procedures for other programs like CFC, COPES, or MPC.
- Send plan of care to home care agency or CDWA per client's choice.
- If discharging from a hospital at the time of the LTSS PE assessment, use the designation "Discharged with HCS services pending" for Phase 1.

Social Services Communication to Public Benefits Specialist (PBS)

When SSS staff complete the LTSS PE assessment in CARE, SSS staff will communicate eligibility with financial/PBS team. SSS staff will email (1115PresumptiveEligibility@dshs.wa.gov) the PBS team of the LTSS PE program start date, regardless if the client has an ACES ID or not. If the client is not assigned an ACES ID, SSS staff should request an ACES ID be established. The PBS team will respond that the email and requested information was received.

When the client has an ACES ID, SSS staff will also submit an 14-443 communication via Barcode to inform the PBS team of the LTSS PE program start date. Check "LTSS Presumptive Eligibility (PE)" as a program option, and identify the LTSS MPC PE or LTSS NFLOC PE program start date.

Email address (1115PresumptiveEligibility@dshs.wa.gov) is specific to LTSS PE only and should not be used for Medicaid Alternative Care (MAC) or Tailored Supports for Older Adults (TSOA) inquiries or needs.

IMPLEMENTING THE PLAN OF CARE

Prior to authorizing services in CARE, all services must be indicated in the client's LTSS PE plan of care, and the paid supports must be qualified:

- Home care agencies or service vendors: ensure the home care agency or service vendors of LTSS PE services are qualified and contracted through the local Area Agency on Aging (AAA). Each local AAA maintains a list of contracted, eligible providers for HCS and AAA.
- CDWA Individual Provider (IP): clients may also choose personal care services be provided by one or more CDWA Individual Providers (IPs), as defined in WAC 388-115-0503.

LTSS PE Program RACs

Before authorizing an LTSS PE service, a RAC must be established. The RAC start date must be on or after the LTSS PE assessment was completed/locked in CARE. When establishing services to implement the plan of care, the RAC end date must not be greater than the initial LTSS PE period. The initial LTSS PE period end will end on the last day of the month following the month in which the client's LTSS PE was determined. For instance, when a client is found LTSS presumptively eligible in October, then initially, the LTSS PE period will end the last day of the following month, being the last day in November.

LTSS PE has two program RACs:

- LTSS MPC PE RAC: 3209
- LTSS NFLOC PE RAC: 3208

Authorizing Service(s)

The LTSS NFLOC PE or LTSS MPC PE service authorization(s) start date may begin when:

- Verbal approval and consent are obtained from the client/authorized representative for the LTSS PE plan of care,
- LTSS NFLOC PE or LTSS MPC PE assessment is completed and locked, and
- The appropriate RAC is determined.

The service authorization end date must not exceed the LTSS PE RAC end date.

Example: The LTSS PE assessment determined the client was eligible for LTSS PE MPC services on August 19, and the client's verbal approval and consent to services was obtained this same date. Client submitted their Medicaid application on September 21, and continued to receive LTSS PE MPC services. The SSS conducts an *Initial* CARE Assessment on October 1. The Public Benefits Specialist determined full financial eligibility on October 5. The SSS obtains verbal plan approval for the CARE Assessment on October 15.

LTSS MPC PE RAC start date = 08/19
LTSS MPC PE RAC end date = 10/14 *(authorized hours used under PE up till the 14th then end LTSS PE. There is no carryover of unused hours)*
Full Eligibility RAC start date = 10/15 *(If the client is eligible for a core program (MPC/CFC/CFC+COPES), the client will be authorized the full benefit of that program to include the personal care hours for the remainder of that month and each month thereafter through the plan period.)*
Full Eligibility RAC end date = 10/31 of the following year (to match the assessment Plan Period End date)

What if the LTSS PE Client is Hospitalized?

Service authorizations should be adjusted as applicable, when the service intended for the home setting cannot be provided in the client's own home (due to reasons such as a hospitalization/admit). This includes long-term care services provided by CDWA Individual Providers (IPs) and/or home care agencies, who may be authorized to provide services to clients in the client's own home but cannot while the client is not home (such as a hospitalization/admit). Applicable home care agencies are ones licensed under chapter 70.127 RCW and chapter 246-335 WAC and contracted with the department. If the client does go to the hospital or SNF on a short-term basis, authorizations should be suspended under LTSS PE. If the client is staying longer than 14 days, close LTSS PE services and notify the PBS.

Scenario: Client on the LTSS PE S02 workaround enters a skilled nursing facility (SNF) during the LTSS PE period.

Once the client is in the SNF 14 days, social services will end the LTSS PE service authorization(s) and notify the PBS that client is in the SNF and the date LTSS PE services will be ending.

PBS will close the S02. S02 will continue through the end of the month if closure completed prior to 10-day notice deadline. PBS will suppress the termination letter.

If the PBS closes the S02 after 10-day notice deadline, the system will still show a paid through date through the following month.

If the client discharges from the SNF prior to the 30th day, a short stay letter can be issued off the S02 LTSS PE AU for an admission under 30 days.

Notify the HCS SW/CM the client has discharged from the SNF.

ADDRESSING A WAITLIST FOR LTSS PE APPLICANTS

Should program expenditures or enrollment exceed funding availability, a statewide wait list will be implemented. If a wait list for LTSS NFLOC PE or LTSS MPC PE is implemented:

1. LTSS PE assessments will be put on hold; **and**
2. If additional funding becomes available, LTSS NFLOC PE or LTSS MPC PE applicants on the wait list will be considered on a first come first serve basis. This will be based on the applicant's request date for LTSS NFLOC PE or LTSS MPC PE.

RESOURCES

Related WACs

Chapter 388-106 on Long-Term Services and Supports WAC Sections can be found here.

WAC 388-106-1800	What definitions apply to LTSS PE?
WAC 388-106-1805	Am I eligible for LTSS NFLOC PE services?
WAC 388-106-1810	What services may I receive under LTSS NFLOC PE?
WAC 388-106-1815	Am I eligible for LTSS MPC PE Services?
WAC 388-106-1820	What services may I receive under LTSS MPC PE?
WAC 388-106-1825	Who can provide long-term care services when I am eligible for LTSS NFLOC or LTSS MPC PE services?
WAC 388-106-1830	When will the department authorize my LTSS NFLOC or LTSS MPC PE services?
WAC 388-106-1835	When do LTSS NFLOC PE or LTSS MPC PE services end?
WAC 388-106-1840	Where can I receive LTSS NFLOC PE or LTSS MPC PE services?
WAC 388-106-1845	What do I pay for if I receive LTSS NFLOC PE or LTSS MPC PE services?
WAC 388-106-1850	Do I have a right to an administrative hearing on LTSS NFLOC PE or LTSS MPC PE determinations?
WAC 388-106-1855	Can an exception to rule (ETR) be granted for eligibility or service determinations?
WAC 388-449-0010	What evidence do we consider to determine disability?

Acronyms

A complete list of Washington State DSHS acronyms can be found here.

AAA	Area Agency on Aging
ABP	Alternative Benefit Plan
ALTSA	Aging and Long-Term Support Administration
CARE	Comprehensive Assessment Reporting Evaluation
CCG	Community Choice Guide
CDWA	Consumer Direct of Washington
CN	Categorically Needy
COPES	Community Options Program Entry System
DSHS	Department of Social and Health Services
ETR	Exception to Rule
HCA	Health Care Authority
HCBS	Home and Community Based Services
HCS	Home and Community Services
HQ	Headquarters
LTSS	Long-Term Services and Supports
MPC	Medicaid Personal Care
PBS	Public Benefit Specialist
RCW	Revised Code of Washington
SER	Service Episode Record
SME	Specialized Medical Equipment
SSS	Social Service Specialist
WAC	Washington Administration Code

Revision History

DATE	MADE BY	CHANGE(S)	MB #
4/2025	Rhonda Widhalm	• Language clarification • Improved guidance	
11/08/24	Rhonda Widhalm	Language clarification	H24-062
7/30/24	Rhonda Widhalm	Language clarification	H24-044
12/2023	Dru Aubert	Initial Draft	H23-081

Appendix

HCA Form #19-0054 Certification of Potentially Disabling Condition

19-0054-hospital-certification-disabling

Voice signature instructions

Voice Signature Chapter 30E Attachr

GOSH and Supportive Housing

GOSH and
Supportive Housing