


DDCS & HCS Policy and Procedures Review
for Adult Family Home providers

Session 1: Programs and Eligibility

Developmental Disabilities Community Services &
Home and Community Services
Home and Community Living Administration


February 2026

1




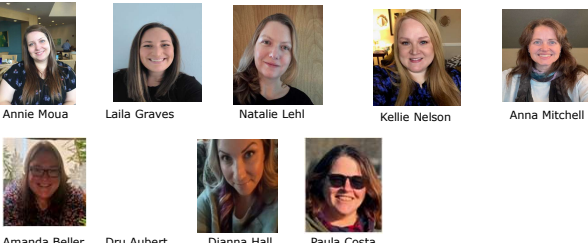
This training series will help you:

- Navigate access to support, care, and resources.
- Strengthen partnerships with DSHS.
- Partner with people needing care.



2


Presenters and Collaborators

Annie Moua Laila Graves Natalie Lehl Kellie Nelson Anna Mitchell



Amanda Beller Dru Aubert Dianna Hall Paula Costa

3


Housekeeping 

Participation -----

Download Handouts and Slides **Ask Questions!**





OR




Raise your hand


4

 **Objectives**


- Learn about Medicaid programs in residential settings.
- Learn how people qualify for services.
- Review the CARE assessment tool and Client Plans of Care.
- Learn what is included in case management services.
- Learn how to access support, care, and resources.




5

 **Medicaid Contract Benefits**

- ✓ Medicaid contracts promote aging in place; private pay clients can transition to Medicaid.
- ✓ Adult Family Home provider contract benefits include dedicated case management, reliable payments, free referrals, and client transition and stabilization resources.




6

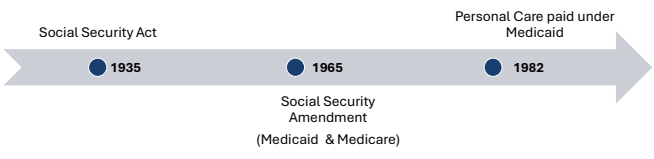


Overview of Medicaid Programs

7




Federal Health Insurance Programs




Washington State Department of Social and Health Services

8




Administration and Funding



Federal (CMS, CFR)

- Passes laws, makes rules, sets policy
- Federal match paid to state



State (RCW, WAC)

- Administers programs
- Must follow regulations
- Pays for services

9



Long-Term Services and Supports (LTSS)

- ✓ In order to receive Medicaid Long-Term Services and Supports (LTSS), an individual must be eligible both financially and functionally.
- ✓ Please keep in mind, each LTSS program has their own rules, limitations and approval processes.



10



Medicaid Programs

The official agreement with CMS describing the scope of the state's Medicaid Program and available services.

11



Medicaid Personal Care



Personal Care



Nursing Services



Nurse Delegation

12

 **Community First Choice (CFC) State Plan**


Personal Care


Nursing Services


Nurse Delegation


Assistive Technology


PERS (Limited)

13

 **Community First Choice (CFC) State Plan**


Personal Care


Nurse Delegation


Assistive Technology


PERS (Limited)


14

 **CFC Services (continued) Assistive Technology**

- Increases independence.
- Substitutes for human assistance.
- Is not solely for recreational purposes.
- Is the most cost-effective solution.




15

 **DSHS**


Case Study #1

Dwayne is 27 and has some hearing loss. He has learned to read lips when he cannot fully hear a speaker. He has tele-health appointments with his healthcare providers and has expressed that he would like to be more independent in his ability to communicate with them. He would also like to video chat with his sister in California. He enjoys watching cat videos on YouTube.

Could you think of a device that might be helpful for Dwayne?



16

 **DSHS**


Personal Emergency Response System

An electronic device that enables clients to get help in an emergency.


Adult Family Home clients may be eligible for a PERS unit with GPS if they have a documented history of:

- Short-term memory loss.
- Wandering.
- Being unaware of the need to ask for help.


Community First Choice




17

 **DSHS**


COPES Waiver



Offers wrap around supports




Receives Personal Care under CFC



Must access a Waiver Service each month


18

COPES Waiver Services 


@ Adult Family Homes -----




Adult Day Health




Client Support Training



Community Choice Guide



Skilled Nursing




Specialized Medical Equipment and Supplies






Wellness Education

19



Residential Support Waiver

- Available **only** in residential settings.
- Includes personal care.
- Designed to meet needs of a specific population.

20



Residential Support Waiver Services



Expanded Community Services

- Personal Care
- Medication Oversight
- Contracted Behavior Support
 - Person-Centered on-site training
 - Individualized Crisis Response and Behavior Support Plan



Specialized Behavior Support

- All ECS services
- Additional one-to-one staffing (6-8 hours/day)

21

Residential Waiver Services 

@ Adult Family Homes -----


Adult Day Health


Client Support Training



Community First Choice Services


Skilled Nursing & Nurse Delegation


Specialized Medical Equipment and Supplies


Wellness Education


22




Case Study #2

Velma is 77. She has a history of wandering, eloping and falls. The CARE Assessment indicates a diagnosis of Dementia. You found her outside your fence this morning near the road.

What options might be available to help Velma?



23



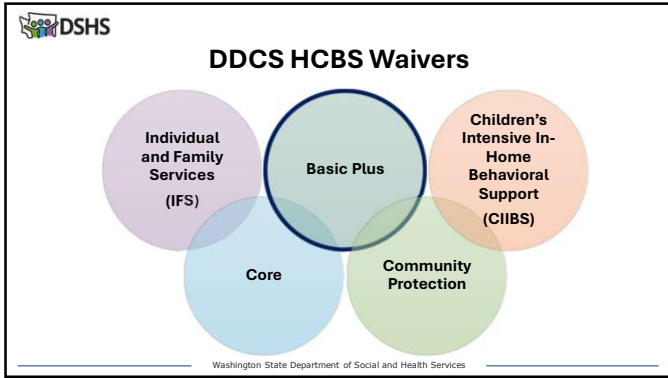
DDCS HCBS Waiver Eligibility Criteria*

The Individual:

- Meets DDCS eligibility criteria; and
- Has a disability according to criteria established in the Social Security Act; and
- Has gross income** that does not exceed 300% of the SSI benefit amount and resources under \$2,000; and
- Is assessed as meeting ICF/IID Level of Care; and
- Has waiver services that cost less than cost of institutional services; and
- Must receive at least one waiver service monthly (or monthly monitoring); and
- Agrees to receive HCBS services.

* WAC 388-845-0030
**Parental income not considered for minors

24



25

Basic Plus Waiver

Target Population: Individuals at high risk of losing community-based residence and institutionalization, designed to support a person in the family home, an AFH or in their own residence.

Most Popular Services for someone also in an AFH:

- Community Engagement:** introduce and connect clients to community supports, resources and activities to help the waiver participant fully access their community for daily living needs or to reduce social isolation.
- Individual Supported Employment:** Individual support to find & maintain a paid job.
- Life Skills:** Services to support a client to learn self-empowerment, safety awareness, social skills support, daily adaptive skills outside of scope of CFC skills acquisition, etc.

Category	Funding Amount
Employment Services	Determined by assessment
Aggregate Services	\$6,192/year
Emergency Assistance Funding	Up to \$6,000/year- must meet criteria in WAC 388-845-0810
Other	Limits determined by DDCS

Washington State Department of Social and Health Services

26

DSHS
WASHINGTON STATE
Department of Social and Health Services

Questions?

Washington State Department of Social and Health Services

27



Case Management Services



28




Client Support and Care Teams




Washington State Department of Social and Health Services

29

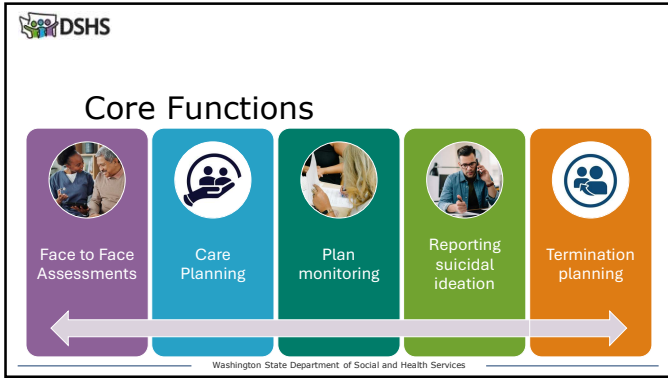


Case Managers

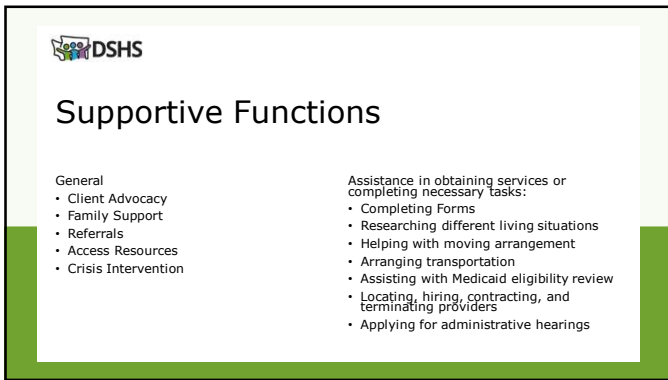
- Complete client CARE Assessments.
- Assist with:
 - Long-term services and supports eligibility reviews.
 - Coordinating needed goods or services.
- Authorize services and supports.
- Check-in on client and provider transitions.



30



31



32



33


 **DSHS**

CARE Web Application Tool

CARE has an internal set of rules that determine:

- Functional Eligibility for Long-Term Services and Supports
- Classification Group
- Benefit Level and Payment Rate

34


 **DSHS**

Foundational Differences

SLA vs. Support Assessment Comments

<p>SLA</p> <ul style="list-style-type: none"> • What support happened during a specific moment in time in the recent past? • What did that support look like? • Preferences. 	<p>Support Assessment</p> <ul style="list-style-type: none"> • What support could be in place to ensure the individual is successful in participating in the activity. • What would that support look like? • Preferences.
---	---

35

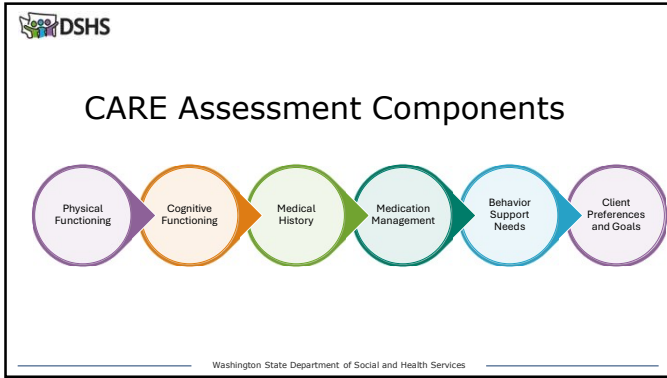
 **DSHS**

Look Back Period

SLA looks at specific moments in time.

<p>Question to ask:</p> <p>What support actually occurred during the look back period and what did that support look like?</p>	<p>Core Look Back periods</p> <ul style="list-style-type: none"> • ADLs: 7 days • Incontinence questions: 14 days • IADLs: 30 days
---	--

36



37

Personal Care Services

[WAC 388-106-0100](#)

<p>Activities of Daily Living</p> <ul style="list-style-type: none"> • Bathing • Bed Mobility • Bladder/Bowel • Dressing • Eating • Locomotion/Walking • Medication Management • Personal Hygiene • Transfers 	<p>Instrumental ADLs</p> <ul style="list-style-type: none"> • Essential Shopping • Housework • Meal Prep • Medical Transportation • Wood Supply • Community Integration
---	--

38

Physical Function - definitions

- **Independent:** No help or staff oversight
- **Supervision:** Oversight (monitoring, standby), encouragement, or cueing.
- **Limited Assistance:** individual highly involved in activity, received physical help in guided maneuvering of limbs or other non-weight bearing assistance
- **Extensive Assistance:** While the individual performed part of activity over last seven days, help of following type(s) was provided:
 - Weight-bearing support
 - Full caregiver performance of activity during part (but not all) of the activity
- **Total dependence** - Full caregiver performance of the activity during entire seven-day period. Complete non-participation by individual in all aspects of the ADL definition.


Washington State Department of Social and Health Services

39

DSHS

CARE Assessment Coding

- Physical Functioning (ADL/IADL) – 7 day look back period
 - Independent
 - Supervision
 - Limited Assistance
 - Extensive Assistance
 - Total Dependence
- Two-person Assistance
- Medical History
- Medication Management – looks forward
- Behavior Support, needs and interventions – current/ 7 day look back past / last 5 years

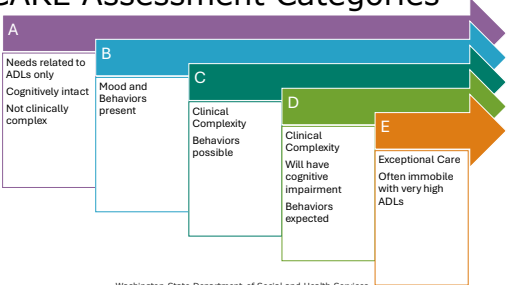


Washington State Department of Social and Health Services

40

DSHS

CARE Assessment Categories



A	B	C	D	E
Needs related to ADLs only Cognitively intact Not clinically complex	Mood and Behaviors present	Clinical Complexity Behaviors possible	Clinical Complexity Will have cognitive impairment Behaviors expected	Exceptional Care Often immobile with very high ADLs

Washington State Department of Social and Health Services

41


DSHS

Assessment and Care Planning

42

DSHS

Assessment Types



	Initial	Annual	Significant Change
Full Assessment	X	X	X
Determines Eligibility	X	X	X
Determines Benefit Level	X	X	X
Establishes Plan of Care	X		
Updates Plan of Care		X	X


Interim	
Shortened Assessment	X
Does not restart Plan period	X
Captures changes that do not involve client's condition	X
Changes in condition that do not change classification level	X

Washington State Department of Social and Health Services

43

DSHS

Significant Change Assessment



Request a significant change assessment when:

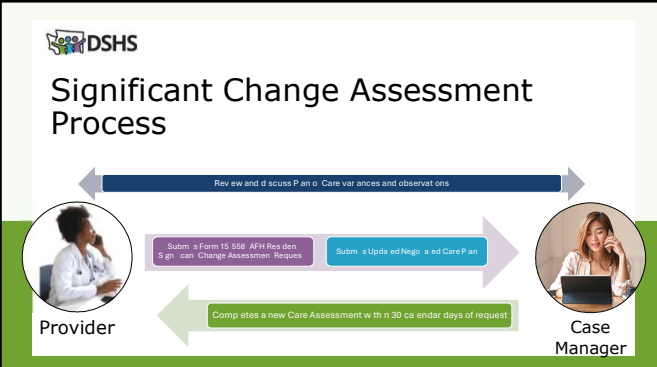
1. Your resident experiences a lasting change from their physical, mental or psychosocial baseline, **and**
2. The change is significant enough that the assessed plan of care does not match the current need.

Washington State Department of Social and Health Services

44

DSHS

Significant Change Assessment Process




```

    graph LR
      Review[Review and discuss Plan of Care variances and observations] --> Provider
      Provider -- "Submit Form 15-558 AFH Resident Significant Change Assessment Request" --> CaseManager
      CaseManager -- "Submit Updated Negotiated Care Plan" --> Review
      CaseManager -- "Completes a new Care Assessment within 30 calendar days of request" --> Provider
  
```

Provider

Case Manager


45



Understanding the Client Plan of Care

Service Plan, Care Plan, Person Centered Plan


46



Plan of Care, [Ch. 3](#)

The Plan of Care combines Assessment Details and Service Summary.

Purpose:
The documentation of person's strengths, preferences and goals, and to reflect services and paid and natural supports selected to meet identified needs.



Washington State Department of Social and Health Services

47




New Referrals



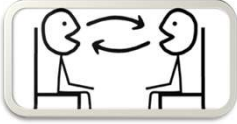
Read Visit Ask Determine

Washington State Department of Social and Health Services

48

 **DSHS**


Negotiated Care Plan



Plans are person-centered.

Plans include information from client, case manager, assessment and service summary.

49

 **DSHS**

Case Study: Vargas


Mrs. Vargas has been feeling unwell for several weeks, sleeping more and seeming confused. She was diagnosed with a UTI but has not returned to her baseline after taking the prescribed course of medication.

You notice it is taking additional caregiver time to help her dress in the mornings, and she is having more difficulty expressing her thoughts.

What steps do you take?




50

 **DSHS**
WASHINGTON STATE
Department of Social
and Health Services

Personal Care Exception to Rule (ETR)


2026
Jennifer Karlson & Kellie Nelson
ETR Program Coordinators

51

 **Learning Objectives**


- Personal Care & ETRs Definitions
- What ETRs are & are not
- Understand ETRs Are Not Automatic
- Know CARE Classifications
- Review the Assessment
- Explore wraparound services
- Who Can Request an ETR
- ETR Outcomes

52


 **Personal Care Defined**

"Personal care services"
Means 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.
[WAC 388-106-0010](#)

"The client's situation differs from the majority..." in clients classification group
[WAC 388-440-0001](#)



53

 **Where to Note the ETR for Personal Care**

ETRs are based on personal care needs being exceptional, different from the majority in the resident's CARE classification.	If a client has an ETR for personal care, it is based on their exceptional personal care needs.
The ETR does not outline how the ETR funds are to be spent.	You as the provider utilize the ETR funding to best care for our mutual resident. <i>This is noted in the negotiated service plan.</i>

Washington State Department of Social and Health Services

54

 **What ETRs Are Not**

Residential personal care Exception to Rule is not a negotiation.


- The rate is bargained for; the only path is to demonstrate exceptional care needs.

ETRs are not approved for contracted services.

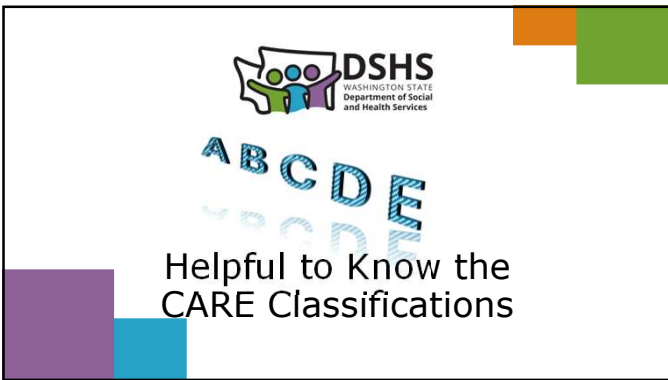
- Private room (Centers for Medicare and Medicaid Services; "CMS")
- Contracted or specialized services (42 CFR 431.958)




55

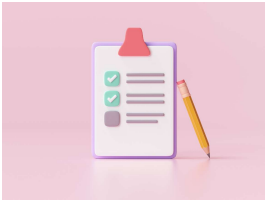
 **Helpful to Know the CARE Classifications**

ABCDE




56

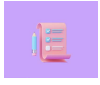
 **Prior to ETR submittal Review the assessment**



57


 **Review Assessment**

- Provider review(s) ensure the information is captured with descriptions
- If you find yourself stating the client has significantly declined in health/behavior or has a new condition(s), you can request a Significant Change Assessment.
- **Detail information** you have noted that is not in the Assessment Details with additional information of what you are seeing with client to help in discussion with Case Manager



Washington State Department of Social and Health Services


58

 **Review for details – Gathering more Information**

- Utilize comments to describe in detail what is different, unusual, exceptional about the care the client needs.
- Paint the picture.
- Describe how caregivers are assisting the client on ADLs.
- If no comments, committee can only assume that the selections and drop downs cover the client’s needs.

Washington State Department of Social and Health Services

59

 **Explore Wraparound Services**

- ETRs cannot be used to replicate contract services **or** while a contract is being pursued.
- Specialized Dementia Care (SDC)
- Specialized Dementia Care Plus (SDCP)
- CBHS/1915i
- Residential Support Waiver (RSW) services
 - Expanded Community Services (ECS)
 - Specialized Behavior Supports (SBS)
 - Enhanced Services Facility (ESF)
 - Community Stability Supports (CSS) > Tiers

Washington State Department of Social and Health Services

60




ETRs Last Resort

- Other options have been explored:
 - RSW
 - CBHS/1915i
 - Equipment
- **We pursue an ETR only** if the client is exceptional from others in the same classification.




61




Details Matter


Would additional services be appropriate for client? Give more detail:

- "Resident needs assistance with eating due to tremors," describe how and how often caregivers are assisting.
- "Resident has tremored all day every day, caregiver must assist feeding every meal, every bite, every day"

Avoid words describing frequency:
"Resident is frequently incontinent." 

Use concrete numbers:
"Resident is incontinent 10 times daily." 

62




ETRs Are Not Automatic

2-person
Requiring a 2-person assist is not automatically exceptional.


Overnight care
AFH's provide 24-hour care. It is reasonable that clients may need something overnight; it's not exceptional for clients to get up and go to the bathroom several times a night.

1:1
If AFH is stating they need 1:1 for a client, open the discussion with reviewing our contracted services. Is this setting appropriate for the client?


In-home is not a 24-hour care setting
Has there been consideration to splitting of shifts to optimize hours?




63

 **How to Request an ETR**

- Contact the case manager
- Review the assessment details




- Other resources to aid client
 - Equipment
 - Assistive technology
 - RSW services
 - RCS Behavior Support Team



- Give details of why you are requesting an ETR

Washington State Department of Social and Health Services


64

 **ETR Outcomes**


<p>Denied</p> <ul style="list-style-type: none"> • The client did not look exceptional from client's classification. • Lack of information. 	<p>Approved</p> <ul style="list-style-type: none"> • ETR fully approved as submitted. • The ETR and assessment demonstrate an exceptional need in the classification of the client. 	<p>Partially Approved</p> <ul style="list-style-type: none"> • Committee saw some of what the ETR described in the assessment.
--	--	--

If you have questions, contact the Case Manager

65

 **Resources**

- [Chapter 3](#) - Assessment and Care Planning
- [Chapter 7f](#) - Residential Support Waiver
- [Chapter 8](#) - Residential Services




ETR Program Coordinators:


- Kellie Nelson DDCS
- Jennifer Karlson HCS/LTC

WACs:


- [WAC 388-440](#)
- [WAC 388-440-0001](#)
- [WAC 388-440-0005](#)
- [Blank Residential Algorithm Exhibit template, effective 03-01-2021](#)
- [CARE ETR/ETP](#)

66

 **Questions?**




67

 **Knowledge Check**

1. Which classification would have the highest personal care needs:
 - a. E Medium
 - b. C Low
 - c. A High

2. An individual must be determined both Functionally and Financially eligible for Medicaid services? True/False


68



3. What is included in the client's Plan of Care (multiple selections):
 - a. Client's preferences
 - b. Personal care needs
 - c. Service Summary and Assessment Details
 - d. Details about a client's entire medical and social history

4. A Medicaid client may receive Nurse Delegation services in an Adult Family Home? True/False


69

 **DSHS**

- When might you talk to the case manager about a Significant Change Assessment?
 - They have regular lunch outings with a family member.
 - They request craft supplies be available in the home.
 - They are not interested in group activities.
 - The client needed additional support with walking during the last two weeks.
- What should you do before admitting a new resident into your home?
 - Ask the Case Manager if they are a good fit for your home.
 - Visit the client's childhood home.
 - Read only the Service Summary.
 - Determine if you can meet the client's needs.


Washington State Department of Social and Health Services

70

 **DSHS** **ACRONYMS**

ADL Activities of Daily Living	HCS Home and Community Services
AFH Adult Family Home	IADL Instrumental Activities of Daily Living
AL TSA Aging and Long-Term Support Administration	LTSS Long-Term Services and Supports
APS Adult Protective Services	MPC Medicaid Personal Care
CM Case Manager	ODHH Office of Deaf and Head of Hearing
CARE Comprehensive Assessment Reporting Evaluation	PERS Personal Emergency Response System
CFC Community First Choice	QA Quality Assurance
COPE S Community Options Program Entry System	RCS Residential Care Services
DDCS Developmental Disabilities Community Services	RSW Residential Support Waiver
DSHS Department of Social and Health Services	SHDD State Hospital Discharge and Diversion
ETR Exception to Rule	
HCLA Home and Community Living Administration	


71

 **DSHS**

Washington
Administrative
Code (WAC)

- Long-Term Care Services [Chapter 388-106 WAC](#)
- Community First Choice (CFC)
 - [WAC 388-106-0270](#) CFC Services
 - [WAC 388-106-0272](#) CFC Eligibility
 - [WAC 388-106-0271](#) Skills Acquisition Training
 - [WAC 388-106-0273](#) PERS add-on services
 - [WAC 388-106-0274](#) Assistive Technology
 - [WAC 388-106-0275](#) Community Transition Services
- Medicaid Personal Care (MPC)
 - [WAC 388-106-0200](#) MPC Services
 - [WAC 388-106-0310](#) MPC Eligibility
- Community Options Program Entry System (COPE S)
 - [WAC 388-106-0305](#) COPE S Services (residential setting)
 - [WAC 388-106-0310](#) COPE S Eligibility
- Residential Support Waiver (RSW)
 - [WAC 388-106-0336](#) Residential Support Waiver Services
 - [WAC 388-106-0338](#) RSW Eligibility


72

 **Washington Administrative Code (WAC)**

- CARE Assessments
 - [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 388-106-0075](#) How are personal care services assessed in CARE?
- CARE Classifications
 - [WAC 388-106-0085](#) Classification group criteria
 - [WAC 388-106-0090](#) How does CARE measure cognitive performance?
 - [WAC 388-106-0095](#) How does CARE measure clinical complexity?
 - [WAC 388-106-0100](#) How does CARE measure moods and behaviors?
 - [WAC 388-106-0105](#) How does CARE measure Activities of Daily Living?
 - [WAC 388-106-0110](#) How does CARE evaluate for Exceptional Care (E)?
 - [WAC 388-106-0115](#) What criteria is used to determine classification for residential facilities?

Washington State Department of Social and Health Services

73

 **Thank you for all you do!**

Did you know we now have a website for AFH providers – AFH Corner
Save this link [DDCS HCS AFH Corner website](#)

[AFH Policy and Procedure Training Series](#) - Survey

74