

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Adult Day Health		
Other Service	Adult Day Care		
Other Service	Client Support Training & Wellness Education		
Other Service	Community Choice Guiding		
Other Service	Community Support: Goods and Services		
Other Service	Environmental Modifications		
Other Service	Home Delivered Meals		
Other Service	Skilled Nursing Services		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Transportation		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04050 adult day health

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Adult Day Health is a supervised daytime program providing nursing and rehabilitative therapy services to adults with medical or disabling conditions that require the intervention or services of a registered nurse, or a licensed speech therapist, occupational therapist, or physical therapist acting under the supervision of the participant's physician, when required. Services provided are specified in the participant's service plan and encompass both health and social services needed to ensure the optimal functioning of the participant.

Meals provided as part of the Adult Day Health services shall not constitute a full nutritional regime.

A skilled nursing or rehabilitative therapy service must be provided by staff operating within their scope of practice under Washington State law and regulation on each service day for which reimbursement is claimed.

Transportation between the participant's place of residence and the Adult Day Health site is included as a component of Adult Day Health services and is reflected in the rate paid to the Adult Day Health providers.

To ensure duplicate billing does not occur, The P1 system will have a conflict edit that will result if skilled nursing and transportation are authorized at the same time as Adult day health.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Center

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C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Adult Day Health Center

Provider Qualifications

License (*specify*):

N/A

Certificate (*specify*):

Certified under Washington Administrative Code which defines Adult Day Health Center employee requirements. (WAC 388-71-0702 through 388-71-0774)

Other Standard (*specify*):

The Adult Day Health Center must have a Core Provider Agreement with the State Medicaid Agency.

Minimum staffing requirements for adult day health centers include an administrator, program director, registered nurse, activity coordinator, a PT/OT or speech therapist, and a social worker. The administrator and program director may be the same person.

Employee qualifications are as follows:

The administrator must have a master's degree and at least one year of supervisory experience in health or social services setting (full-time equivalent), or a bachelor's degree and at least two years of supervisory experience in health or social services setting. The degree may be in nursing.

The program director must have a bachelor's degree in health, social services or related field with at least one year of supervisory experience (full-time equivalent) in health or social services setting. Upon approval by the department, an adult day health center may request an exception for an individual with an associate's or vocational degree in health, social services, or related field with four years of experience in a health or social service setting, of which two years must be in a supervisory position.

Therapists must have valid state credentials and one year of experience in a social or health setting.

Rehabilitative therapeutic assistants must be certified with valid state credentials, have at least one year of applicable experience and meet all statutory requirements.

A certified or registered nursing assistant must meet the requirements of RCW 18.88A.020.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging certify that all requirements outlined in Washington Administrative Code have been met.

Frequency of Verification:

Annually

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C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Day Care

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04060 adult day services (social model)

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Adult Day Care services provided in an adult day care center include provision of personal care; routine health monitoring with consultation from a registered nurse; general therapeutic activities; general health education; and supervision and/or protection for at least four hours a day but less than twenty-four hours a day in a group setting on a continuing, regularly scheduled basis.

Services also include: provision of recipient meals as long as meals do not replace nor be a substitute for a full day's nutritional regime; and programming and activities designed to meet participants' physical, social and emotional needs.

Adult Day Care shall be included in a participant's approved plan of care only when the participant: has mild to moderate dementia and/or is chronically ill or disabled; is socially isolated and/or confused; has significant risk factors when left alone during the day; needs assistance with personal care; and will benefit from an enriched socially supportive experience.

Personal care service hours are reduced 30 minutes for each hour of Adult Day Care service in order to avoid duplication of personal care services since it is assumed that some personal care tasks will be met by Adult Day Care services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Adult Day Care services may not be duplicative of any other waiver service.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care Center

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Adult Day Care

Provider Category:

Agency

Provider Type:

Adult Day Care Center

Provider Qualifications

License (*specify*):

N/A

Certificate (*specify*):

N/A

Other Standard (*specify*):

Must meet the requirements of WAC 388-71-0702 through 388-71-0774

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

1. Upon initial contracting
2. Annual review per WAC 388-71-0724(10)
3. Contract compliance monitoring every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Client Support Training & Wellness Education

HCBS Taxonomy:

Category 1:

13 Participant Training

Sub-Category 1:

13010 participant training

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Participant training needs are identified in the CARE assessment or in a professional evaluation.

Client Support Training is provided in accordance with a therapeutic goal in the plan of care and includes for example, adjustment to serious impairment, maintenance/restoration of physical functioning, self management of chronic conditions, acquisition of skills to address minor depression, and development of skills to work with care providers including behavior management. Client support training is provided directly to the participant. Formal and informal care providers may participate in the training in order to continue to support the participant’s goal outside of the training environment.

Wellness Education provides accurate, accessible and actionable information designed to assist participants to achieve goals and address conditions identified during their person-centered planning process. Materials are personalized to each participant based on the participant’s assessment and person centered service plan. Each month, participants will be mailed printed information targeted to participant specific data identified in the participant’s comprehensive assessment.

Wellness Education materials assist participants to obtain, process, and understand information needed to manage and prevent chronic conditions. Easily understood information provides participants with usable tools for informed decision making and prepares participants for conversations with medical professionals. Wellness Education materials also assist participants to achieve community living goals by providing simple to understand information and specific action items. Topics may include strategies for engaging in the community, nutrition and diet, adaptive exercise, falls prevention, strength and balance activities, locating and seeking medical care, developing a social network, medication management, achieving employment goals, planning for emergencies, creating effective back-up systems and information related to other social determinants of health.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Providers may only train within the scope of their professional training skills and abilities.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Registered Nurse
Agency	Centers for Independent Living
Individual	Independent Living Provider
Individual	Human Service Professional
Agency	Wellness Education Vendor
Agency	Home Care Agency
Agency	Evidence Based Trainer
Individual	Licensed Practical Nurse
Individual	Chronic Disease Self Management Trainer
Agency	Physical Therapist
Individual	Physical Therapist
Agency	Board-Certified Music Therapist
Agency	Adult Day Health Center
Individual	Board-Certified Music Therapist
Agency	Community Mental Health Agency
Individual	Occupational Therapist
Agency	Occupational Therapist
Individual	Certified Dietician/Nutritionist
Agency	Home Health Agency
Individual	Evidence Based Trainer
Agency	Chronic Disease Self Management Trainer
Individual	Pharmacist
Agency	Community College

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C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Client Support Training & Wellness Education

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License (specify):

RN license under Chapter 18.79 RCW and Chapter 246-840 WAC

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Client Support Training & Wellness Education

Provider Category:

Individual

Provider Type:

Independent Living Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

A Bachelor's degree in social work or psychology with two years experience in the coordination or provision of independent living services; or two years experience in the coordination or provision of independent living services (e.g., housing, personal assistance services recruitment or management, independent living skills training, etc.) in a social service setting under qualified supervision; or four years personal experience with a disability.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Client Support Training & Wellness Education

Provider Category:

Individual

Provider Type:

Human Service Professional

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Bachelor's degree or higher in Psychology, Social Work, medical, or a related field with a minimum of two years experience providing services to aging or disabled populations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Wellness Education Vendor

Provider Qualifications

License (*specify*):

Appropriate license to do business in Washington State

Certificate (*specify*):

Other Standard (*specify*):

The provider must have the ability and resources to:

- Receive and manage client data in compliance with all applicable HIPPA regulations and ensure client confidentiality and privacy.
- Translate materials into the preferred language of the participant.
- Ensure that materials are targeted to the participant's assessment and person centered service plan.
- Manage content sent to participants to prevent duplication of materials.
- Identify any undeliverable client/representative addresses prior to each monthly mailing and manage any returned mail in a manner that ensures participants receive the monthly information.

Verification of Provider Qualifications

Entity Responsible for Verification:

AL TSA

Frequency of Verification:

Upon contract and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

Home Care Agency license under Chapter 70.127 RCW and Chapter 246-335 WAC

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Evidence Based Trainer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The trainer must have successfully completed all required professional development activities and be sanctioned or certified by the by credentialing entity which oversees the evidence based practice.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Client Support Training & Wellness Education

Provider Category:

Individual

Provider Type:

Licensed Practical Nurse

Provider Qualifications

License (specify):

Licensed under Chapter 18.79 RCW and Chapter 246-840 WAC

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Client Support Training & Wellness Education

Provider Category:

Individual

Provider Type:

Chronic Disease Self Management Trainer

Provider Qualifications

License (specify):

[Empty text box]

Certificate *(specify):*

Certification in an evidence based chronic disease self management training program such as the Stanford University Chronic Disease Self Management Program (CDSMP).

Other Standard *(specify):*

[Empty text box]

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

PT license under 18.74 RCW

Certificate *(specify):*

[Empty text box]

Other Standard *(specify):*

[Empty text box]

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Client Support Training & Wellness Education

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License (specify):

PT license under Chapter 18.74 RCW

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Board-Certified Music Therapist

Provider Qualifications

License (specify):

Certificate (specify):

Music therapist- Board Certified (MT-BC) active credential.

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Initial contracting and every two years thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Adult Day Health Center

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Certified under Washington Administrative code which defines ADH Center employee requirements.
WAC 388-71-0702 through 388-71-0774.

Other Standard (*specify*):

The Adult Day Health Center must have a Core Provider Agreement with the State Medicaid Agency.

Minimum staffing requirements for adult day health centers include an administrator, program director, registered nurse, activity coordinator, a PT/OT or speech therapist, and a social worker. The administrator and program director may be the same person.

Employee qualifications are as follows:

The administrator must have a master's degree and at least one year of supervisory experience in health or social services setting (full-time equivalent), or a bachelor's degree and at least two years of supervisory experience in health or social services setting. The degree may be in nursing.

The program director must have a bachelor's degree in health, social services or related field with at least one year of supervisory experience (full-time equivalent) in health or social services setting. Upon approval by the department, an adult day health center may request an exception for an individual with an associate's or vocational degree in health, social services, or related field with four years of experience in a health or social service setting, of which two years must be in a supervisory position.

Therapists must have valid state credentials and one year of experience in a social or health setting.

Rehabilitative therapeutic assistants must be certified with valid state credentials, have at least one year of applicable experience and meet all statutory requirements.

A certified or registered nursing assistant must meet the requirements of RCW 18.88A.020.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agencies on Aging must certify that all requirements outlined in WAC have been met.

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Client Support Training & Wellness Education

Provider Category:

Individual

Provider Type:

Board-Certified Music Therapist

Provider Qualifications

License (specify):

Certificate (specify):

Music therapist- Board Certified (MT-BC) active credential.

Other Standard (specify):

[Empty text box]

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Community Mental Health Agency

Provider Qualifications

License (specify):

Licensed under WAC 388-877

Certificate (specify):

[Empty text box]

Other Standard (specify):

Capacity to provide services to individuals that do not meet access to care standards in the public mental health system

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Client Support Training & Wellness Education

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

OT license under Chapter 18.59 RCW

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

licensed under 18.59 RCW

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Client Support Training & Wellness Education

Provider Category:

Individual

Provider Type:

Certified Dietician/Nutritionist

Provider Qualifications

License (specify):

Certificate (specify):

Dietician and Nutritionist certificate under Chapter 18.138 RCW

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Home Health Agency license under Chapter 70.127 RCW and Chapter 246-335 WAC

Certificate (specify):

[Empty text box]

Other Standard *(specify):*

[Empty text box]

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Client Support Training & Wellness Education

Provider Category:

Individual

Provider Type:

Evidence Based Trainer

Provider Qualifications

License *(specify):*

[Empty text box]

Certificate *(specify):*

The trainer must have successfully completed all required professional development activities and be sanctioned or certified by the by credentialing entity which oversees the evidence based practice.

Other Standard *(specify):*

[Empty text box]

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Chronic Disease Self Management Trainer

Provider Qualifications

License (specify):

Public Health and Safety providers licensed under Chapter 70 RCW

Certificate (specify):

Other Standard (specify):

Individual Employee Qualification: Certification in an evidence based chronic disease self management training program such as the Stanford University Chronic Disease Self Management Program (CDSMP).

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Client Support Training & Wellness Education

Provider Category:

Individual

Provider Type:

Pharmacist

Provider Qualifications

License (specify):

Licensed per Chapter 18.64 RCW and Chapter 246.863 WAC

Certificate (specify):

Other Standard (specify):

[Empty text box]

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Client Support Training & Wellness Education

Provider Category:

Agency

Provider Type:

Community College

Provider Qualifications

License (specify):

[Empty text box]

Certificate (specify):

[Empty text box]

Other Standard (specify):

Higher Education Institution conducting programs under Chapter 28B.50.020 RCW

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Choice Guiding

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17990 other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Community Choice Guiding services are necessary to establish or stabilize an individual in a community living arrangement in either a provider-operated setting or in a private residence. Waiver participants are eligible for Community Choice Guiding services when a participant’s community living situation is unstable and the participant is at risk of institutionalization as evidenced by any of the following:

- 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.

Services are provided in a manner that protects and promotes the participant’s health and welfare and is appropriate to the participant’s physical and psychological needs. Community Choice Guiding services include:

- 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.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Centers for Independent Living
Individual	Community Choice Guide Professional
Agency	Community Choice Guide Professional

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Community Choice Guiding

Provider Category:

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Community Choice Guiding

Provider Category:

Individual

Provider Type:

Community Choice Guide Professional

Provider Qualifications

License (specify):

Any applicable business license

Certificate (specify):

Other Standard (specify):

Bachelor's degree or higher in Psychology, Social Work, or other related field including a medical field, with a minimum of two years experience providing services to aging or disabled populations or A Bachelor's degree in social work or psychology with two years experience in the coordination or provision of independent living services (e.g., housing, personal assistance services recruitment or management, independent living skills training, etc.) in a social service setting under qualified supervision; or four years personal experience with a disability.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Community Choice Guiding

Provider Category:

Agency

Provider Type:

Community Choice Guide Professional

Provider Qualifications

License (specify):

Any applicable business license

Certificate (specify):

Other Standard (specify):

An agency that employs individuals to provide this service who meet the following qualifications: Bachelor's degree or higher in Psychology, Social Work, or other related field including a medical field, with a minimum of two years experience providing services to aging or disabled populations or A Bachelor's degree in social work or psychology with two years experience in the coordination or provision of independent living services (e.g., housing, personal assistance services recruitment or management, independent living skills training, etc.) in a social service setting under qualified supervision; or four years personal experience with a disability.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Support: Goods and Services

HCBS Taxonomy:

Category 1:

16 Community Transition Services

Sub-Category 1:

16010 community transition services

Category 2:

17 Other Services

Sub-Category 2:

17010 goods and services

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Continued):

Community support: Goods and Services are non-recurring set-up expenses for individuals that are not eligible for Community Transition Services provided under 1915(k) and who are transitioning from a provider operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and non-recurring cleaning prior to occupancy; (e) moving expenses; (f) necessary home accessibility adaptations; and, (g) activities to assess need, arrange for and procure needed/resources.

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.

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.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Vendor
Individual	Community Transition Service Provider
Individual	Community Vendor
Agency	Community Transition Service Professional
Agency	Centers for Independent Living

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Support: Goods and Services

Provider Category:

Provider Type:

Community Vendor

Provider Qualifications

License (*specify*):

Business licensing requirements per Title 308 WAC.
Based on service provided, a vendor may require a license through WA State Dept. of Agriculture per Chapter 15.58 RCW and Chapter 17.21 RCW

Certificate (*specify*):

Other Standard (*specify*):

Vendors will comply with standards that correlate to specific service type provided:
WA State Utilities and Transportation Commission (UTC) per Title 480 WAC, Title 80 RCW, Title 54 RCW, Chapter 480-15 WAC, Chapter 81.80 RCW
WA State Dept. of Labor and Industries: Chapter 18.27 RCW and Chapter 296-200A WAC
Additionally if the needed service is not one that is regulated, the State will ensure that such services are delivered as specified by waiver beneficiary and detailed in the plan of care.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Community Support: Goods and Services

Provider Category:

Individual

Provider Type:

Community Transition Service Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Bachelor's degree or higher in Psychology, Social Work, or other related field including a medical field, with a minimum of two years experience providing services to aging or disabled populations or A Bachelor's degree in social work or psychology with two years experience in the coordination or provision of independent living services (e.g., housing, personal assistance services recruitment or management, independent living skills training, etc.) in a social service setting under qualified supervision; or four years personal experience with a disability.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Community Support: Goods and Services

Provider Category:

Individual

Provider Type:

Community Vendor

Provider Qualifications

License (specify):

Business licensing requirements per Title 308 WAC.
Based on service provided, a vendor may require a license through WA State Dept. of Agriculture per Chapter 15.58 RCW and Chapter 17.21 RCW

Certificate (specify):

Other Standard (specify):

Vendors will comply with standards that correlate to specific service type provided:
WA State Utilities and Transportation Commission (UTC) per Title 480 WAC, Title 80 RCW, Title 54 RCW, Chapter 480-15 WAC, Chapter 81.80 RCW
WA State Dept. of Labor and Industries: Chapter 18.27 RCW and Chapter 296-200A WAC
Additionally if the needed service is not one that is regulated, the State will ensure that such services are delivered as specified by waiver beneficiary and detailed in the plan of care.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Community Support: Goods and Services

Provider Category:

Agency

Provider Type:

Community Transition Service Professional

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

An agency that employs individuals to provide this service who meet the following qualifications: Bachelor's degree or higher in Psychology, Social Work, or other related field including a medical field, with a minimum of two years experience providing services to aging or disabled populations or A Bachelor's degree in social work or psychology with two years experience in the coordination or provision of independent living services (e.g., housing, personal assistance services recruitment or management, independent living skills training, etc.) in a social service setting under qualified supervision; or four years personal experience with a disability.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon Initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Community Support: Goods and Services

Provider Category:

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications

License (*specify*):

Certificate (specify):

Other Standard (specify):

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Modifications

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):**Category 4:****Sub-Category 4:**

Those physical modifications to the private residence of the participant or the participant's family, identified by the participant's service plan, that are necessary to ensure the health, welfare, and safety of the participant or that enable the participant to function with greater independence in the home. Such modifications include the installation of ramps, grab-bars, widening of doorways, modifications of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those modifications or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant.

Environmental modifications include the performance of necessary assessments to determine the types of modifications that are necessary. Home modifications may be authorized up to 180 days in advance of the community transition of an institutionalized person.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Modifications that add to the total square footage of the home are excluded from this benefit except when necessary to complete the modification (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Environmental modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

Home modification begun while a person is institutionalized is not considered complete until the date the person leaves the institution and enters the waiver.

Service Delivery Method (*check each that applies*):**Participant-directed as specified in Appendix E****Provider managed****Specify whether the service may be provided by** (*check each that applies*):**Legally Responsible Person****Relative****Legal Guardian****Provider Specifications:**

Provider Category	Provider Type Title
Individual	Home Modifications Contractor
Individual	Volunteer

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Environmental Modifications****Provider Category:****Provider Type:**

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Meet the standards of Chapter 18.27 RCW Registration of Contractors

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Environmental Modifications

Provider Category:

Individual

Provider Type:

Volunteer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must sign confidentiality statement
Must have knowledge of building codes as applicable to the specific task
Cost must be less than \$500 per Chapter 18.27.090(9) RCW (Volunteers are reimbursed for costs of supplies and materials but are not reimbursed for labor).

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:

06 Home Delivered Meals

Sub-Category 1:

06010 home delivered meals

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Home delivered meal services provide nutritional balanced meals delivered to the participant's home. Services may be delivered by mail or may include an additional face to face contact to monitor the client's well-being and safety.

These meals shall not replace nor be a substitute for a full day's nutritional regimen but shall provide at least one-third (1/3) of the current recommended dietary allowance as established by the Food and Nutrition Board of 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.

Home delivered meals are provided to an individual at home and included in the approved plan of care only when the participant is homebound, unable to prepare the meal and there is no other person, paid or unpaid, to prepare the meal. Receiving a meal is more cost effective than having a personal care provider prepare the meal. When a participant'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.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service is provided only as identified in the participant's CARE assessment and service plan. No more than one meal per day is reimbursed under the waiver.

Participant must be home bound, unable to prepare the meal, and there is no other person paid or unpaid to prepare the meal.

Service Delivery Method *(check each that applies):*

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by *(check each that applies):*

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Food Service Vendor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Food Service Vendor

Provider Qualifications

License *(specify):*

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

Services listed in the service plan must be within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in the State. Skilled nursing services under the waiver differ from skilled nursing 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. The waiver skilled nursing service is used for treatment of chronic, stable, long-term conditions that cannot be delegated or self-directed.

The services under the waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Skilled Nursing services may not be duplicative of any other waiver service.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Individual	Licensed Practical Nurse
Individual	Registered Nurse

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Skilled Nursing Services

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Licensed under Chapter 70.127 RCW

Certificate (specify):

Other Standard (specify):

Individual RNs and LPNs employed by the agency must be licensed under Chapter 18.79 RCW and Chapter 246-840 WAC.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Skilled Nursing Services

Provider Category:

Individual

Provider Type:

Licensed Pratical Nurse

Provider Qualifications

License (specify):

Licensed under Chapter 18.79 RCW and Chapter 246-840 WAC

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Skilled Nursing Services

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

Licensed under Chapter 18.79 RCW and Chapter 246-840 WAC

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:

14 Equipment, Technology, and Modifications

Sub-Category 2:

14032 supplies

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

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

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

This service also includes maintenance and upkeep of items covered under the service and training for the participant/caregivers in the operation and maintenance of the item. Training may not duplicate training provided in other waiver services.

The services under the waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service provided only as identified in the participant's CARE assessment and service plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the participant.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medical Equipment and Supply Contractor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Provider Type:

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Must have a Core Provider Agreement with the State Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency

Frequency of Verification:

Upon purchase of specialized equipment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

HCBS Taxonomy:

Category 1:

15 Non-Medical Transportation

Sub-Category 1:

15010 non-medical transportation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

Service offered in order to enable participants 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 does not replace them. Transportation services under the waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge should be utilized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies):*

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by *(check each that applies):*

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Taxi
Individual	Volunteer
Individual	Individual
Agency	Public Transit

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Individual

Provider Type:

Taxi

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Standards are the same as those applied to vendors who provide access to State Plan medical services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Transportation

Provider Category:

Individual

Provider Type:

Volunteer

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Standards are the same as those applied to vendors who provide access to state plan medical services. Volunteers receive reimbursement for gas mileage.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Transportation

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Standards are the same as those applied to vendors who provide access to State Plan medical services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Transportation

Provider Category:

Agency

Provider Type:

Public Transit

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Standards are the same as those applied to vendors who provide access to State Plan medical services.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency
Area Agency on Aging

Frequency of Verification:

Upon initial contracting and every two years thereafter

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

Not applicable - Case management is not furnished as a distinct activity to waiver participants.

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*

As an administrative activity. *Complete item C-1-c.*

As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Case management is provided by State case managers and Area Agency on Aging case managers as an administrative function.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

The DSHS Background Check Central Unit is responsible for conducting the background check.

The types of positions for which such investigations must be conducted:

- case manager, LPN, RN, nursing assistant, certified dietician, physical therapist, occupational therapist, and any waiver contractor who has unsupervised access to a vulnerable adult.

The scope of such investigations (e.g., state, national):

- The State's background check includes a comprehensive criminal history information including aliases, as well as information about the persons who are on a state registry for findings of abuse, neglect, abandonment, or exploitation against a minor or vulnerable adult (state).
- Completion of a national finger-print based background check (national)

The process for ensuring that mandatory investigations have been conducted:

- the entity originally requesting the background check receives a letter outlining the findings of the background check from BCCU. This letter is used to determine whether a potential provider is cleared for contracting. Contracts cannot be executed and providers cannot be paid without evidence of complete background check which includes abuse registry screening, and finger-print based check.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The DSHS Background Check Central Unit maintains the abuse registry and conducts screenings against the registry.

Case managers, LPNs, RNs, nursing assistants, certified dieticians, physical therapists, occupational therapists, and all other waiver contractors who have unsupervised access to vulnerable adults.

The entity originally requesting the background check receives a letter outlining the findings of the background check from BCCU. This letter is used to determine whether a potential provider is cleared for contracting. Contracts cannot be executed and providers cannot be paid without evidence of complete background check which includes abuse registry screening, and finger-print based check.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.

Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix C: Participant Services

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of **extraordinary care** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Self-directed

Agency-operated

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

The state does not make payment to relatives/legal guardians for furnishing waiver services.

The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

Other policy.

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The state establishes qualifications and offers the opportunity for any willing provider to demonstrate qualifications and enroll at any time through an application process managed by the Area Agencies on Aging. Provider enrollment information and forms are continuously available for provider enrollment via ALTSA's internet website. Providers who meet qualifications and are willing to contract will be contracted to serve waiver participants in the specified geographic areas covered by the waiver. Access problems identified will be addressed through enrollment of additional providers.

The State fully complies with open enrollment requirements for Wellness Education providers in that it:

- Establishes a provider application for Wellness Education that identifies specific provider requirements and service description
- Provides a Medicaid provider agreement template
- Posts the application and sample Medicaid provider agreement on ALTSA's internet website where other waiver service provider applications are posted
- Applications from potential providers are reviewed by program management staff in ALTSA headquarters.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

- a. Sub-Assurance:** *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The number and percent of service providers who require licensure and/or certification who meet contract standards, prior to furnishing waiver services, as delegated by the SMA N = All waiver service providers who require licensure or certification that initially meet contract standards D = All waiver service providers, with initial contracts, that require licensure and/or certification

Data Source (Select one):

Other

If 'Other' is selected, specify:

Contracts Administrative Data

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Percent of waiver service providers who require licensure and/or certification that continue to meet contract standards at the time of contract renewal as delegated by the State Medicaid Agency N = All waiver service providers who require licensure and/or certification that meet contract standards at contract renewal D = All contracted waiver providers who were required to have contract renewals

Data Source (Select one):

Other

If 'Other' is selected, specify:

Contracts administrative data

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify:	Annually	Stratified Describe Group:

	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The number and percent of non-licensed/non-certified providers that meet waiver requirements prior to providing waiver services requirements, as delegated by the SMA. N = Number of contracted individual providers that meet contracting requirements D = Number of contracted providers

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1025 1264 1111" type="text"/>
Other Specify: <input data-bbox="408 1249 647 1335" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1249 1264 1335" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1473 1264 1559" type="text"/>
	Other Specify: <input data-bbox="718 1697 954 1783" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The number and percent of waiver service providers that meet training requirements, as delegated by the State Medicaid Agency
 $N = \text{Number of waiver service providers that meet training requirements}$
 $D = \text{Number of waiver service providers}$

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCA monitoring tools used by AAAs

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="AAAs"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text" value="12 direct service worker files or 7% whichever is higher."/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Other Specify: <input type="text"/>

Performance Measure:

The number and percent of adult day health facilities that have met training requirements, as delegated by the State Medicaid Agency
N = Number of adult day health facilities that met training requirements
D = Number of adult day health facilities reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 30px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 30px;" type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

-Contracts for all waiver providers are maintained in a central database. Contract status is updated on a daily basis.

Other waiver service contracts (Home delivered meals, Environmental Modifications, Skilled Nursing, etc.) are monitored by AAAs which is verified by the State.

A home visit is conducted within required timelines for an initial transfer to in-home case management to ensure the plan of care is in place, services are being implemented, the provider is adhering to requirements, and no further changes are needed.

Face-to-face monitoring and verification occurs at the annual review and/or if there is a significant change. A minimum number of other contacts is specified based on the level of case management to verify that the plan is being appropriately implemented.

- Waiver providers are monitored by the Area Agencies on Aging (AAA). Reports are provided to the operating agency (AL TSA) annually. Comprehensive contract monitoring is conducted every other year. On alternate years, a focus monitoring is conducted. The operating agency reviews reports on an ongoing basis that are provided by the AAA to verify that monitoring and remediation of providers are occurring.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

AAAs provide technical assistance if standards are not met for waiver provider contracts they manage. Failure to make required changes can lead to contract termination. Identified issues often determine where additional policy clarification is required or training is needed.

Case managers terminate payments and may request termination of contracts if qualifications are not sustained.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">AAAs</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

Not applicable- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

Other Type of Limit. The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Washington's Statewide Settings Transition Plan received Final approval on October 24, 2017.