HCBS Case Management 525-05-30-05

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Purpose

The purpose of HCBS Case Management is to assist a functionally impaired individual to achieve and maintain independent living, in the living arrangement of their choice, until it is no longer appropriate or reasonably possible to maintain or meet the individual's needs in that setting. In order to facilitate independent living, the HCBS Case Manager enables the elderly or disabled person and/or family to explore and understand options, make appropriate choices, solve problems, and provides a link between community resources, qualified service providers, and the client/applicant accessing needed services. The HCBS Case Manager also advocates for and promotes client-focused systems of service delivery, exercises an awareness of the larger target population in need, and exercises prudence in each referral to and/or linkage with resources and services, utilizing those services and resources effectively.

Standards for HCBS Case Managers

The service shall be performed by a social worker or agency that employs individuals licensed to practice social work in North Dakota and who has met all the requirements to be enrolled as either an Individual or Agency Qualified Service Provider in NDAC 75-03-23 and agreed to comply with policy.

1. Case Managers employed by a County Social Service Agency are eligible to receive payment for the service of Case Management and authorize services under the SPED and EXSPED Programs upon receiving a written notice from the HCBS Program Administration that an individual in the SPED or Expanded SPED Program Pool is authorized for services under the SPED or Expanded SPED Program.

2. Case Managers employed by a County Social Service Agency are eligible to receive payment for the service of Case Management under the HCBS or TD Waiver and authorize services if the individual is eligible for services under either waiver.

3. Individual Case Managers or an Agency who is enrolled as a QSP for the Service of Case Management are eligible to receive payment for the service of Case Management under the HCBS or TD Waiver and are eligible to authorize services for an individual, if the individual is eligible for services under either wavier.

Case file documentation must be maintained:

1. In a secure setting

2. On each individual in separate case files

Standards for Targeted Case Management (TCM) for persons in need of Long term Care.

- The service shall be performed by a social worker or agency that employs individuals licensed to practice social work in North Dakota. and who has met all the requirements to be enrolled as either an Individual or Agency Qualified Service Provider (QSP) or an Indian Tribe/Indian Tribal Organization who has met State Plan requirements and requirements to be enrolled as a QSP or Developmental Disabilities Program Manager (DDPM) who is a Qualified Mental Retardation Professionals (QMRP) or has one year experience as a DDPM with the Department.

The following enrolled provider types are eligible to receive payment for TCM

- Case Managers employed by a County Social Service Agency who have sufficient knowledge and experience relating to the availability of alternative long term care services for elderly and disabled individuals.

- Developmental Disabilities Program Manager (DDPM) who is a Qualified Mental Retardation Professionals (QMRP) or has one year experience as a DDPM with the Department

- An Individual Case Manager or Agency Case Manager that has sufficient knowledge and experience relating to the availability of alternative long term care services for elderly and disabled individuals.

- Indian Tribe or Indian Tribal Organization who has met the provider qualifications outlined in the North Dakota State Plan Amendment

The following enrolled provider types are eligible to receive payment for TCM and Authorize Service(s)

- Case Managers employed by a County Social Service Agency are eligible to approved services under SPED, EXSPED and Medicaid State Plan - Personal Care (MSP-PC), (see Chapter 535-05).

- DDPMs are eligible to approve services MSP-PC.

- If the client is a recipient of services funded by the SPED, Expanded SPED Programs, or MSP-PC the one case file will contain documentation of eligibility for TCM as well as for the service(s)

The following enrolled provider types are eligible to receive payment for single event TCM.

- County HCBS Case Managers, DDPMs, enrolled Individual or Agency Case Managers and enrolled Indian Tribe or Indian Tribal Organizations.

    - If the client requests a contact more than once every six months the Case Manager needs to obtain prior approval from a HCBS Program Administrator.

    - Indian Tribe or Indian Tribal Organizations are limited to providing TCM Services to enrolled tribal members.

    Targeted Case Management (TCM)

    The individual receiving TCM will meet the following criteria:

    1. Medicaid recipient.

    2. Not a recipient of HCBS (1915c Waiver) services.

    3. Not currently be covered under another case management/targeted case management system or payment does not duplicate payments made under other program's authorities for the same purpose..

    4. Lives in the community and desires to remain there; or be ready for discharge from a hospital within 7 days; or resides in a basic care facility; or reside in a nursing facility if it is anticipated that a discharge to alternative care is within six months.

    5. Case management services provided to individuals in Medical institutions transitioning to a community setting. Services will be made available for up to 180 consecutive days of the covered stay in the medical institution. The target group does not include individuals between the age of 22-64 who are served in Institutions for Mental Disease or inmates of public institutions.

    6. Has "long-term care need." Document the required "long-term care need" on the Application for Services, SFN 1047. The applicant or legal representative must provide a describable need that would delay or prevent institutionalization.

7. The applicant or referred individual must agree to a home visit and provide information in order for the assessment to be completed.

Activities of Targeted Case Management

1-Assessment/Reassessment

2-Care Plan Development

3-Referral and Related Activities,

4-Monitoring and Follow-up Activities

(Details outlined in section- HCBS Case Management - Service Activities, Standards of Performance, and Documentation of HCBS Case Management Activities)

- The focus or purpose of TCM is to identify what the person needs to remain in their home or community and be linked to those services and programs.

- An assessment must be completed and a Care Plan developed. The client's case file must contain documentation of eligibility for TCM. The HCBS Comprehensive Assessment must be entered into the SAMS Web Based System.

- Targeted case management is considered a "medical need" and thus included as a health care cost. Use of Medicaid funding for targeted case management may result in the recipient paying for/toward the cost of their case management. The client must be informed of that fact by noting Case Management Service and cost on the Individual Care Plan. Clients must also check and sign acknowledgment that if they are on Medicaid they may have a recipient liability. Payments from the Medicaid Program made on behalf of recipients 55 years or older are subject to estate recovery including for Targeted Case Management.

- If the only medical need is Targeted Case Management, then the SPED individual need not apply for Medical Assistance.

- The case record must include a HCBS Comprehensive Assessment (entered into the SAMs system or DDPMs current data system) and narrative which includes:

    - Name of the individual,

    - Dates of case management service,

    - Name of the case management provider/staff.

- Nature, content , units of case management service received, and whether goals specified in the plan are achieved
- Whether the individual has declined services in the care plan
- Coordination with other case managers,
- Timeline of obtaining services,
- Timeline for reevaluation of the plan

Limits:

Case management does not include direct delivery of services such as counseling, companionships, provision of medical care or service, transportation, escort, personal care, homemaker services, meal preparation, shopping or assisting with completion of applications and forms (this is not an all-inclusive list).

Case file documentation must be maintained:

1. In a secure setting
2. On each individual in separate case files

HCBS Case Management - Service Activities, Standards of Performance, and Documentation of HCBS Case Management Activities

HCBS Case Management Service consists of the service activities or components listed below.

1. Assessment of Needs - This component is completed initially and at least annually thereafter. At least one home visit is required during the assessment of needs process.

   Clients must be given a "Your Rights and Responsibilities" brochure DN 46 annually and verification must be noted on the SFN 1047 Application for Services by the client that a DN 46 was received note in narrative of annual date given.

   During the assessment process, when applicable, the information needed for submission to Dual Diagnosis Management (DDM) is obtained. The case management entity shall use the existing and

established procedures for requesting a level-of-care determination from (DDM).

For an adult (at least 18 years of age): Complete a comprehensive assessment and gather input from other knowledgeable persons as authorized by the applicant/client.

For a child (under 18 years of age): Complete a Social History (in lieu of the comprehensive assessment used for adults) AND submit the necessary documents to DDM for a level-of-care determination.

Prior approvals given for service combinations and service authorization requests that are continuing must be reviewed and re-approved by the HCBS Program Administrator on an annual basis.

The combination of a HCBS services and hospice service requires prior approval by a HCBS Program Administrator with the exception of intermittent Respite Care Service.

Clients who may be eligible for services under the ID/DD Waiver are referred to the Regional Development Disability Program Administrator. Case Manager must issue a formal denial if comprehensive assessment has been completed prior to referral.

2. Care Planning

Care Planning is a process that begins with assessing the client's needs. It includes the completion of the HCBS comprehensive assessment after which the case manager and client look at the needs and situations described in the comprehensive assessment and any other problems identified and work together to develop a plan for the client's care.

1. All needs are identified in the comprehensive assessment and the services authorized to meet those needs are identified on the ICP SFN 1467 or SNF 404. Additional information regarding needs and consumer choice will be outlined in the narratives in the HCBS comprehensive assessment;

2. For each functional impairment identified for which a service need has been authorized the narrative note must include: the reason the client is unable to complete the task, who is completing the task, number of

units, and time per week allocated for the task and the anticipated outcome;

c. For each ADL or IADL that is scored impaired and no services have been authorized the narrative note must include the reason the client is unable to complete the task and who is providing the service or how the need is being met;

d. Refer to the Authorization to Provide Services, SFN 1699 or Authorization to Provide Waiver Services SFN 404, to choose and discuss with the client the services and scope of the tasks (limits to the tasks) that can be provided. A written, signed recommendation for the task of vital signs provided by a nurse or higher credentialed medical provider must be on file outlining requirements for monitoring is required, and the frequency. For the task/activity of exercise a written recommendation and an outlined plan by a therapist for exercise must be on file.

e. The HCBS Case Manager shall review with the client or the client's representative the following information about qualified service providers (QSP) available to provide the service and endorsements required by the client:

    - Name, address and telephone number of Qualified Service Provider.
    - Whether Qualified Service Provider is an agency or individual.
    - The unit rate per Qualified Service Provider.
    - If applicable, limitations of the Qualified Service Providers available.
    - If applicable, endorsements for "specialized cares":
        - Global Endorsements (Only a provider who carries a global endorsement may provide these activities and tasks. Refer to the QSP list to determine which global endorsements the provider is approved to provide.) Global Endorsements include: Cognitive/Supervision, Exercises, Hoyer Lift/Mechanized Bath Chair, Indwelling Bladder Catheter, Medical Gases, Prosthesis/Orthotics/Adaptive Devices, Suppository, Ted Socks, and Temperature/Blood Pressure/Pulse/Respiration Rate.

- On the SFN 1699, Authorization to Provide Services, or on the SFN 404, Authorization to Provide Waiver Services, document the name of the agency or person who is to be contacted and provided the results of the client's blood pressure, pulse, rate of respiration, or temperature.

- Client Specific Endorsements (These activities and tasks may be provided only by a provider who has demonstrated competency and a Request for Client Specific Endorsement, SFN 830, is on file in the client's file. The provider must obtain documentation that a health care professional has verified the provider's training and competency specific to the client's need and provide a copy to the Case Management Entity. The Case Management Entity shall forward a copy of the SFN 830 to HCBS Program Administration. Client Specific Endorsements include: Apnea Monitoring, Jobst Stockings, Ostomy Care, Postural/Bronchial Drainage, Rik Bed Care (Specialty Beds).

f. Providers who can provide the required care and whom the client has selected will be listed on the ICP, SFN 1467 or the SFN 404. When a change in service provider occurs between case management contacts – the client or legal representative may contact the case manager requesting the change in provider. The contact and approval for the change in provider must be verified in the case managers documentation and noted on the ICP which is sent to the Department. A copy of the updated care plan must be sent to the client or legal representative. However, changes in services or the amount of service must be signed by the client or legal representative and approved.

g. The service, amount of each service to be provided, the costs of providing the selected services, the specific time-period, and the source(s) of payment are recorded on the ICP, SFN 1467 or SFN 404, and Authorization to Provide Service, SFN 1699 or the Person Centered Plan of Care SFN 404. Clients must be made aware of funding caps and documentation must verify that the client has been informed of the service limits when developing the care plan at a minimum of every 6 months. If an individual's needs exceed the service limit, they would be issued a denial notice and would have the right to appeal.

h. Contingency plans;

- Contingency planning must occur if the QSP selected is an individual rather than an agency. The backup provider or plan must be listed on the SFN 1467 or on the SFN 404.

i. The case manager shall review with all clients or the client's representative the client stated goal. The goal must be recorded on the ICP, SFN 1467 or Risk Assessment as part of the Person Centered Plan of Care SFN 404 and described in the narrative section of the comprehensive assessment on an annual and 6 month basis.

j. For Medicaid Waiver Only: Complete SFN 1597, Explanation of Client Choice.

k. For Medicaid Wavier Only: New clients who are eligible for the Affordable Care Act Benefit must be given Affordable Care Act Benefit letter and a copy of the letter must be sent to the Department (includes a client whose waiver service closed and reopened).

l. The final step in Care Planning is to review the completed SFN 1467, Individual Care Plan, or the completed Person Centered Plan of Care SFN 404 with the client/legally responsible party and obtain required agreements/acknowledgments and signatures. See the instructions for completing the Person Centered Plan of Care SFN 404 or Individual Care Plan, SFN 1467.

m. When services are reduced, you must provide the client or their legal representative with a completed SFN 1647.

Interim care plans are limited to clients who receive services though the HCBS Medicaid Waiver and require services immediately, or who are affected by a natural disaster or other emergency. An interim care plan may be developed for a client, who is on Medicaid, has an approved LOC Determination that was completed within the previous 90 days, and the case manager is unable to complete an immediate visit. When services are needed immediately the case manager will need to complete a face-to-face visit and complete an assessment within 10 working days of the request. During natural disasters or other emergencies a face- to- face visit must be made within 60 days of the request. Prior approval from the Department is required.

- Example 1: A client who is currently in a Nursing Home, has a LOC in place, and is on Medicaid, plans to return home and the Case manager is unable to see the client on the day of transfer home. An interim care plan could be written and services could begin however a face-to-face visit would need to be completed within 10 days.

- Example 2: A current client has a LOC in place, is on Medicaid but because of flooding their residence is not accessible, an interim care plan could be written so services could continue for up to 60 days before a face-to-face visit is required.

Medicaid eligibility redetermination is completed by Economic Assistance. A client who is receiving service through the HCBS Waiver is required to be eligible for Medicaid. If in the redetermination process it is determined the client is not eligible for Medicaid, payment for services stops the day Economic Assistance sends the termination notice. If the client has an established ICP and Authorization and the termination is overturned, waiver services could be paid during that period of time.

3. Implementing the Individual Care Plan or Person Centered Plan of Care - The Case Manager assures that services are implemented and existing services continued, as identified in the Individual Care Plan or the Person Centered Plan of Care. This activity includes contacting the QSP and issuance of an Authorization for Service(s) SFN 1699 or Authorization to Provide Waiver Services SFN 404 to be delivered. Refer to instructions for completing the Authorization To Provide Services, SFN 1699 or the Person Centered Plan of Care SFN 404.

4. Monitoring - Service monitoring is an important aspect of case management and involves the case manager's periodic review of the quality and the quantity of services provided to service recipients. The Case Manager monitors the client's progress/condition and the services provided to the client. As monitoring reveals new information to the Case Manager, regarding formal and informal supports, the care plan may need to be reassessed and appropriate changes implemented. The case management entity is responsible to monitor the service plan and participant health and welfare. If the client's care needs cannot be met by the care plan and health, welfare, and safety requirements cannot be assured; case management must initiate applicable changes or terminate services. If the case is closed, the client is made aware of their appeal rights. The case manager shall document all service monitoring activities and findings in the client's case file.

    1. The HCBS case manager shall monitor the services provided under the Individual Care Plan or under the Person Centered Plan of Care on an as needed basis but not less than direct client contact at least once every three months.

    2. Monitoring for Targeted Case Management (TCM) - The same case management monitoring schedule followed for SPED and Expanded

SPED recipients applies even when TCM covers the cost of case management.

c. Residents of basic care facilities under Basic Care Assistance Program must have two face-to-face visits per year (annual and 6-month review), no other contacts are required.

d. Monitoring for Abuse, Neglect, or Exploitation: When completing monitoring tasks if the case manager suspects a Qualified Service Provider or other individual is abusing, neglecting, or exploiting a recipient of HCBS the following protocol is to be followed by the HCBS Case Manager.

In all situations:

Notify the Program Administrator responsible for complaint resolution in writing of **all actions** taken to follow up on a suspected case of abuse, neglect, or exploitation of an HCBS recipient.

Documentation must include:

- Identify and document in writing the name of the recipient.
- Identify and document in writing the name of the qualified service provider or other individual.
- Document in writing a complete description of the problem or complaint.

Process:

- Immediately report suspected physical abuse or criminal activity to law enforcement.
- If you have reasonable grounds to believe the recipient's health or safety is at immediate risk of harm, make a home visit to further assess the situation and take whatever action is appropriate to protect the recipient.
- If you can document that no immediate risk exists, but a problem requires further action, work with the recipient and other interested parties to resolve the matter as soon as possible.
- If the HCBS Case Manager and Nurse Manager/Trainer determine that an incident is indicative of abuse, neglect, or

exploitation, the HCBS Case Manager must immediately report the incident to the Department.

- Comply with North Dakota State law Chapter 50-25.1, CHILD ABUSE AND NEGLECT.

- When the service is provided on Reservation Lands, the Tribal Laws that govern abuse and neglect on that reservation must be followed.

Process specific to the client's living arrangements, individuals implicated, or the Provider type (all incidents/actions must be reported to the Medical Services Program Administrator):

- Client lives in his or her own home and the qualified service provider is an Individual or Agency enrolled QSP:

  If you can document that no immediate risk exists, but a problem requires further action, work with the recipient and other interested parties to resolve the matter as soon as possible.

- If the provider is a Basic Care Facility or Residential Care Facility that is licensed as a Basic Care Facility:

  Notify the Ombudsman Program Administrator, Aging Services Division

  And

  The North Dakota Department of Health Facilities.

- If the qualified service provider is an Assisted Living Facility:

  Notify the Ombudsman Program Administrator, Aging Services Division

  And

  The DHS Program Administrator responsible for Assisted Living Licensing.

- If the complaint involves the provision of home delivered meals, contact the HCBS Program Administrator.

- Client lives in his or her own home and is being abused, exploited, or neglected by an individual other than the QSP:

File a report with law enforcement and/or Adult Protective Services as indicated by the seriousness of the allegation.

- If the client is living in a AFC Home:

  Contact the CSSB responsible for AFC licensing,

  And

  Contact the Regional Representative at the Human Service Center responsible for AFC licensing.

  And

  Contact the Aging Services Division Adult Foster Care Licensing Program Administrator.

- If the case involves a Licensed Child Foster Care Home, the regional representative responsible for the children's foster care licensing must be contacted.

- If the case involves a client who is receiving DD Services, contact the client's DD Program Manager or the Regional Program Administrator.

The Department of Human Services may remove a Qualified Service Provider from the list of approved providers if the seriousness and nature of the complaint warrants such action. The Department will terminate the provider agreement with a Qualified Service Provider who performs substandard care, fraudulent billing practices, abuse, neglect, or exploitation of a recipient. North Dakota Administrative Code section 75-03-23-08 lists reasons why the Department may terminate a Qualified Service Provider.

5. Reassessing - The case manager reassesses the client, care plan, and services on an ongoing basis, but must do a reassessment at six-month intervals and the comprehensive assessment annually. At the six month and annual visit, the client stated goal must be reviewed and progress or continuation of the goal must be noted in the narrative of the comprehensive assessment.

6. Termination of Service - When documenting that service(s) on the Individual Care Plan or the Person Centered Plan of Care were terminated, and indicating the reason(s) for termination, refer to Section 05-40 Closures, Denials, and Terminations.

Contacts with Clients

For SPED and EXSPED -

- An Initial Assessment is required to establish eligibility for services and following implementation of the service a contact shall be made with a NEW client within the first 30 days of implementation of services. Quarterly contacts with the client are required. Of the four, two must be home visits; one is at the time of the annual assessment and the other at the time of the six month assessment. The other two contacts may be by telephone (if the client can communicate over the phone) or office visit.

Waiver:

- HCBS and TD Wavier Services: An Initial Assessment is required to establish eligibility for services and following implementation of the service a contact shall be made with a NEW client within the first 30 days of implementation of services. Quarterly contacts with the client are required including an annual assessment, 6 month reassessment and two quarter contacts. **All four contacts must be face to face and take place in the client residence.** One of the quarterly visits must include a completion of a Medicaid Waiver Quality review, (this visit should **not** occur during the annual or 6-month contact), and a copy of this review needs to be sent to the Department.

- Services under the HCBS Waiver that are specific to Adult Residential and Transitional Care Services provided to clients as a result of the need for independent living skills training, support and training provided to promote and develop relationships, participate in the social life of the community, or develop workplace task skills including behavioral skill building requires all four contacts to be face to face. The annual and six month contact need to occur in the client's residence. The other contacts must be face to face but can occur at other locations. Case Management coordinates an annual interdisciplinary team conference and invites the legal representative and others as requested by the client.

All required contacts must include responses to the following questions:

- Date

- Reason for contact. (initial, annual, six month, quarterly, collateral, returned call, received call, etc)

- Location of visit (home visit, care conference, hospital visit, office visit, telephone contact, letter sent, etc)

- A description of the exchange between yourself and the client or the collateral contact. If this is a face to face visit- describe the environment, clients appearance, and communication style.

- A listing of identified needs, which includes the services the client is currently receiving.

- Service delivery options which includes, discussion about service caps, and potential service available, needed, or requested.

- Summary of care plan, which includes the outcome of the discussion of the agreed upon services requested, including other agencies or individuals providing care.

- Identify client stated goals, progress, change in goals, etc at the initial, annual and six month contact in this narrative note or in question #1.H.1. Describe the client's stated goals and results or progress

- Review the Individual Service Plan developed by the Adult Residential Provider (who provides services primarily to individual with TBI) or the Transitional Care Provider at the annual and semi-annual interdisciplinary team meeting and document the results of the Individual Program Plan

- Client satisfaction

    - Do the amount, duration and frequency of services meet the client's needs?

    - Does the provider, provide the services outlined on the care plan and authorization in the amount, duration and frequency expected.

- Follow-up plan,

- Case Managers initials

Reimbursement/Payment for Service

The Case Management Entity may bill for case management if the applicant/client meets the eligibility criteria of the programs as identified in HCBS Case Management - Service Activities, Standards of Performance, and Documentation of HCBS Case Management Activities.

Request for reimbursement must be supported by documentation in the client's case file that case management service activities were completed.

When a change in funding source occurs, initial Case Management can be claimed under the new funding source the month of transfer (opening under new funding). The annual case management cycle starts with this action. No claim for case

management can be made to the funding source being closed. Initial case management is allowed to establish the case under the new funding source.

A higher rate may be used for higher-level case management for clients eligible for Medicaid Waiver for Home and Community Based Services. Upon completion of a Person Centered Plan of Care by the case manager and client, the case manager is eligible to bill for Higher Case Management Services. No prior approval is required.

Administrative Tasks (Non-billable)

Any task or activity that is not directly related to the assessment or reassessment of an individual, development, implementation, or monitoring of a care plan; or termination/closure of a case cannot be billed as case management. Administrative tasks such as those listed below are examples of non-billable activities:

1. Assisting a provider with billing issues or enrollment; participating in appeal hearings; attending training or staff meetings; supervising/scheduling of In-home Care Specialists, etc.

Level of Care Determination (LOC)

It is the responsibility of the County to initiate the screening either by telephoning Dual Diagnosis Management (DDM) or by submitting information to DDM (the web based method is the preferred method to submit information to DDM).

A LOC determination/screening must be completed for a client who is requesting services through a waiver program, or a client who under the age of 18 and requesting SPED services. LOC determinations must be updated as significant changes occur that would impact the LOC determination outcome and at minimum on an annual basis. Following are the screen types listed on the LOC Determination Form.

- Tech Dependent Waiver
- HCBS Waiver
- HCBS Waiver/MSP-PC (Check only if eligible for both)
- SPED under age 18
- MSP-PC/SPED under age 18. (Check only if eligible for both)

- MFP-Final and if the client is receiving a HCBS Waiver service, complete a referral to a HCBS Program Administrator to assist with the eligibility determination process.

For the purposes of opening/re-opening or prematurely closing a HCBS screening, see the instruction for the SFN 474.

No screening will be needed if Waiver Services are re-implemented within 90 days of the client's discharge from the nursing home or swing bed and prior to end date of the LOC of the current HCBS screening.

Upon completion of LOC determination, DDM will submit to the Medical Services Division a list of the recipients, with the approval or effective date of eligibility, ID Number, and date of birth. This information will then be entered on the Nursing Home Eligibility file in the payment system. DDM will also send written confirmation of HCBS (NF) determination to the County for filing in the client's record.

When a HCBS client screened for Medicaid Waivered services appears to no longer meet nursing facility (NF) care (Screen Type: HCBS), a re-screening should occur. A significant improvement in the recipient's medical/physical status or a decrease or cessation of services provided are examples that could trigger a re-screening. DDM needs to be informed of the reason for the screening and intended outcome to "other." If DDM concurs the recipient no longer needs NF care, an ending date of services needs to be given to Medical Services by using the SFN 474, to Medical Services/HCBS. The ending date is the responsibility of the case manager and needs to allow sufficient time in which to give the client a ten calendar day notice of service termination under the Medicaid Waiver funding source. DDM will report screening terminations with closing dates to Medical Services. Medical Services will input the ending date of services on the computerized screening.

<u>Nursing Facility (HCBS) Level of Care Determination But The Client Is Not Receiving Waivered Services</u>

The stop date on the screening is important for Medicaid recipients having a spouse in the household. The recipient is treated, for Medicaid budgeting purposes, as if living in the nursing facility only when RECEIVING services paid by the Waiver. At such time as Waiver funded services are NOT provided, the screening must be "closed" so that the correct budgeting method is reflected in TECS. Submit SFN 474, HCBS Case Closure/Transfer

Notice or Request for HCBS NF Determination, so a closing date is entered on the Nursing Home Eligibility File.

Case File Contents

1. For all programs, all case files should have (at a minimum):
    1. Application for Service SFN 1047
    2. Copy of Comprehensive Assessment and narrative notes (updated every six months)
    c. Completed/Signed Individual Care Plan(s) SFN 1467 (updated every six months) or a completed /signed Person Plan of Care SFN 404.
    d. Authorization to Provide Services SFN 1699 (updated every six months) Or an Authorization for Waiver Services SFN 404.
    e. Monthly Rate Worksheet (if daily rate client) (SFN 1012 updated annually)
    f. HCBS Notice of Denial or Termination SFN 1647 (if applicable)
    g. HCBS Case Closure/Transfer Notice SFN 474 (if applicable)
    h. A canceled SFN 1699 (if applicable)
2. The case file for each Medicaid Waiver client must contain:
    1. Verification the person is a Medicaid recipient
    2. Medical information (if applicable)
    c. Record of current level-of-care determination(s) (updated annually)
    d. Completed/Signed Explanation of Client Choice SFN 1597
    e. CSSB HCBS Case Closure/ Transfer Notice or Request for HCBS NF Determination SFN 474 (if applicable)
3. The case file for each Expanded SPED client must contain:
    1. Transmittal Between Units SFN 21 (update annually)
    2. Expanded SPED Program Pool Data SFN 56

c. Add New Record to MMIS Eligibility File, ExSPED, SFN 677

4. The case file for each SPED client must contain the:

    1. SPED Program Pool Data SFN 1820

    2. Add New Record to MMIS Eligibility, SPED, SFN 676

    c. SPED Income and Asset SFN 820, HCBS Income and Asset Assessment (updated annually)