

Par. 1. **Material Transmitted and Purpose** – Transmitted with this Manual Letter are changes to Service Chapter 525-05, Home and Community Based Services. New language is in red and underlined and old language is in red and has been struck through.

Par. 2. **Effective Date** – July 1, 2024

Service Payments for the Elderly and Disabled (SPED) 525-05-25-20

(Revised 07/01/~~23~~ 24 ML #~~3742~~-3847)

In order to be determined eligible for the SPED program, the HCBS Case Manager must submit documentation for the applicant to be entered into the SPED Pool maintained by the HCBS Program Administration.

The HCBS case manager must submit a completed [SFN 1820](#), SPED Program Pool Data, and an [SFN 676](#), Add New Record to MMIS Eligibility File. The information contained in the forms must be based on the completion of the comprehensive assessment.

In addition, the Case Managers must complete an [SFN 820](#), which must be signed by the individual. Only those persons who meet ALL of the following criteria are eligible for entry into the SPED Program Pool. Only those persons who are found eligible and have the SFN 1820 and SFN 676 forwarded to HCBS Program Administration will be pulled from the SPED Pool. Any documentation received incomplete or incorrect will not be entered into the SPED Pool.

1. Functional Eligibility for the SPED Program

1. If 18 years of age or older, must be the following:

- The individual is either functionally impaired in at least two (2) Activities of Daily Living (ADLs), OR at least four (4) Instrumental Activities of Daily Living (IADLs), totaling at least four (4) points if living alone, or six (6) points if living with an able-bodied adult.
- The impairments must have lasted or can be expected to last three (3) months or more (must be

noted in the comprehensive assessment narrative of the source of the evidence).

- The applicant/recipient's functional impairments, for which SPED services are being authorized, must be due to a disability which are not the result of a diagnosis of intellectual disability or a related condition or mental illness.
- The individual is living in North Dakota in what is commonly considered a private family dwelling (house, apartment, or camper if the camper is located in a long term campground that rents by the month/year etc.). The renter's living area should consist of a bedroom with or without bath and possibly a sitting area. Congregate/group meals may be available, or meals may be eaten off site. For unique circumstances, contact the HCBS Program Administrator for consideration.
- The individual must be capable of directing their own care or have a legal representative to act in their behalf.
- The individual would receive one or more covered services, in addition to Case Management, in accordance with Department policies and procedures for the specific service.

b. If under age 18, must meet the following:

- The applicant has a functional impairment to indicate eligibility.
- The applicant's functional impairment has lasted, or can be expected to last, three months or longer.
- The applicant's functional impairments for which SPED services are being authorized, are not the result of a mental illness, intellectual disability, or a closely related condition.
- The applicant is living in North Dakota in a housing arrangement commonly considered a private family dwelling and not in an

institution. For unique circumstances, contact the HCBS Program Administrator for consideration.

- The applicant is not eligible for services under the Medicaid waiver program or the Medicaid state plan of personal care services.
- The applicant would receive one or more of the covered services under department policies and procedures for the specific service.
- The applicant's parent or legal guardian agrees to the plan of care developed for the provision of home and community -based services.
- The applicant's parent(s) is not responsible for one hundred percent of the cost of the covered service provided, under the SPED sliding fee scales.
- The applicant's parent(s) have not made a disqualifying transfer of assets.
- The applicant is unable to regularly attend school or is severely limited in the amount of time the applicant is able to attend school.
- The individual must be screened in need of nursing facility level of care. When completing the LOC screening tool, the "HCBS/Other" check box must be completed.
- For an infant under 3 months of age and requiring apnea monitoring, see the [Respite Care](#) section.
- If applying for [Family Home Care](#) or [Respite Care](#), see the sections for additional requirements that must be met.

- SPED Personal Care Service is not available for those under age 18.
- Parents are not eligible to be the paid service provider unless prior approval is granted by the HCBS Program Administrator.

2. Financial Eligibility for the SPED Program

- The applicant's resources cannot exceed a total of \$50,000 in liquid assets and the value of residence(s) other than the primary residence. See [instructions on completion](#) of SFN 820, SPED Income and Asset form.

Real property (e.g. land or farm) is NOT included in the asset resource determination. However, the income produced by the real property is considered when establishing the applicant's/client's share of the cost of services. If the client has real property from which income is NOT being received AT THEIR DISCRETION and the applicant/recipient continues that arrangement, the income that should have been received must be included in determining the client's fee-for-service participation level.

Money and assets in a North Dakota Achieving a Better Life Experience (ABLE) Plan are not considered for the purpose of determining financial eligibility to receive SPED services. See SPED Income and Assets, SFN 820 (525-05-60-20) for specific eligibility guidelines.

- There is an unmet cost for the service(s); that is, the individual is not responsible for 100% of the costs of services delivered.

State law requires that the individual pay for services in accordance with a fee scale based on family size and income. The HCBS Case Manager must use [SFN 820](#), SPED Income and Asset form, to obtain the information needed to establish the individual's share of the costs.

- The individual has not made a disqualifying transfer of assets.

SPED and Medicaid Eligible

It is not necessary that every SPED Program applicant/recipient make an application for Medical Assistance (Medicaid). During

completion of the comprehensive assessment, sufficient information may be obtained to determine whether their assets exceed Medicaid limits. Nor is screening for level-of-care mandatory for all Medicaid recipients.

The Department may not require an individual to apply for services under the state’s medical assistance program as a condition of being eligible to apply for services under SPED if the individual’s estimated monthly HCBS services benefits which could be covered by MSP-PC or Medicaid waiver (excluding the cost of case management) are between the most current medically needy income level for a household of one plus the \$20 disregard established in [NDCC 50-24.1-02.6](#), and the lowest level of the fee schedule for service under this chapter (currently ~~\$1,340-1,383~~), or if the individual is receiving a service that is not available under Medicaid or the Medicaid waiver.

The SPED sliding fee schedule will be adjusted each year on July 1, based on the current Social Security cost of living adjustment. Note that this may cause the lowest level of the fee schedule to either increase or decrease.

SPED Fee Schedule	Less the Medically Needy Amt	Less \$20 Disregard	Max Service Amt
\$1,340.00 <u>1,383</u>	(\$1009.00 <u>1,130)</u>	(\$20.00)	\$311.00 <u>233</u>

The HCBS Case Manager must request this exception from an HCBS Program Administrator when they submit the SPED pool application and note in the case file why the applicant or recipient is not considered eligible for medical assistance or would not meet nursing facility level-of-care or be eligible for Medicaid State Plan (Personal Care). If the service that is being requested is a non-Medicaid Waiver or State Funded service, the applicant/client is not required to apply for Medicaid.

If an individual's services are being paid for at the rural differential rate, determine the cost of the services using the

regular rate. If that amount is \$~~311~~ 233 or less, they are not required to apply for Medicaid. If at any time an individual's service needs increase and the cost exceeds \$~~311~~-233 per month, they will be required to apply for MA.

The HCBS Case Manager's first action is to find out if the applicant/recipient is eligible for Medical Assistance; and, if there is a community spouse, if spousal impoverishment applies. This requires the involvement of an eligibility worker. At the same time the eligibility worker is determining Medicaid eligibility, the HCBS Case Manager should determine service need and provider availability.

If an immediate need for service(s) exists, SPED service(s) can be authorized for eligible clients pending determination of Medical Assistance. If it is found that the person does NOT meet eligibility under the Medicaid State Plan services, but does meet SPED Program eligibility, the effective date of the SPED Program will be established to cover those service costs (within the limits of the SPED Program).

When it appears the applicant/recipient may be eligible for Medical Assistance, choosing not to apply for Medical Assistance is the applicant's decision. However, the applicant/recipient is NOT eligible for the SPED Program as a result of refusal to apply for Medicaid or other federal funded programs. If the applicant/recipient's financial resources are determined by the Case Manager to exceed eligibility requirements for Medicaid, the applicant/recipient is not required to complete the Medicaid application. If the Case Manager is unsure if the individual will meet Medicaid eligibility, the applicant/recipient must request a financial review by the Economic Assistance financial eligibility worker prior to application.

If the applicant/recipient's Medicaid was closed due to not meeting recipient liability, or it is clear that they would not meet recipient liability (after summing the medical expenses, plus the case management, plus Medicaid State Plan Personal Care Services), then the individual may receive SPED Personal Care Services if found eligible through the SPED program.

Institutional Spouse and Community Spouse (Spousal Impoverishment)

Income and Medical Deductions:

If the institutional spouse resides in a nursing home and the community spouse is in need of SPED services:

- All income is counted for the community spouse which would include the deemed income;
- Medical deductions/prescription drugs are counted of community spouse only;
- Household number of one (if no other dependents reside in the home);
- All liquid assets cannot exceed \$50,000 for the applicants/client's SPED services, which includes the deemed assets.

If the institutional spouse resides in the personal home or community based setting and the applicant/client needs SPED services:

- All household income is counted, which would include the deemed income;
- Medical deductions (up to the \$850 maximum)/prescription drugs are counted for all persons in the household;
- Household number of two (if there are no other dependents residing in the home);
- All liquid assets cannot exceed \$50,000, which includes the deemed assets.

Charging for Services

If an individual has a recipient liability or SPED service fee, it is the responsibility of the provider to collect the individual's share of the cost directly from the individual or their identified legal payee or financial decision-maker.

Confidentiality of Financial Records

Financial information regarding a client shall remain confidential except where otherwise provided by law or departmental policy. (See Accounts Receivable Manual, Service Chapter 115-40).

SPED Eligibility & Medicaid Expansion

If a SPED applicant or recipient is eligible for and/or receiving Medicaid Expansion and is requesting personal care services, the individual must be asked to complete an [SFN 1598](#) Medically Frail Questionnaire to determine if they may be eligible to receive their personal care under traditional Medicaid, unless the cost of the personal care services to SPED is \$~~311~~ [233](#) or less per month. The applicant is NOT eligible for the SPED program as a result of refusal to complete this process. If it is determined that the individual is considered to be medically frail and they want to receive personal care services, they must choose traditional Medicaid so they can access Medicaid State Plan personal care.

If the applicant's Medicaid was closed or would be closed due to not meeting recipient liability, (after adding the medical expenses, plus the case management fee, plus the cost of their Medicaid State Plan Personal care) then the individual may receive SPED personal care services if they are otherwise eligible.

Service Fee, SPED Program

With the completion of the SPED Income and Asset form, [SFN 820](#), and by using the sliding fee schedules, the HCBS Case Manager will determine if a participation fee percentage will be assessed to the service costs. The participation fee is applied to not only the direct services but can also apply to HCBS Case Management, unless the SPED client is also on Medicaid. In that case, HCBS Case Management services will be billed to Medicaid, and may be subject to recipient liability.

Refer to Policy 525-05-60-20 SPED Income and Assets regarding the completion of the SFN 820 SPED Financial form and specific Asset, Income, and Deduction information.

Financial eligibility is not complete until the applicant/recipient has signed the [SFN 820](#) indicating the acceptance of the accuracy of the information and service fee. If the service fee is not recorded correctly, the applicant/recipient must be required to sign a corrected page prior to the individual entering the SPED Pool.

Income Verification Method

An income verification method will be used for the individual to indicate family income in all cases. HCBS Case Management staff will review a copy of most recent pay check stubs, bank statements and/or income tax forms to verify the individual's income. If an individual does not supply the documentation, the individual is not eligible to receive or continue SPED services.

All income, assets, and deductions must be verified by the case manager's review of the documents. Case file documentation must contain confirmation they have verified the information for financial eligibility. If the applicant/recipient is receiving Medicaid services, the HCBS case file may cross reference in the file that the verification can be found in the Medicaid eligibility case file.

Financial Status And Family Size Review

The individual's family adjusted gross income and family size shall be reviewed at least every twelve months. In addition, a redetermination shall be made any time a significant change occurs in a family's income or size.

If an applicant/recipient has a spouse who is residing in the nursing home and is receiving Medical assistance under spousal impoverishment rules, consider the spouse requesting SPED services as living in a household of one for both functional and financial eligibility because the institutionalized spouse's income has already been deemed to the community spouse. If a spouse is receiving services under the Medicaid Waiver and lives in a community-based setting or the home with the applicant/ recipient requesting SPED services, consider it a one-person household for functional eligibility and a two person household for financial eligibility because the spouse is still responsible to pay for room, board etc. If an applicant/ recipient has a spouse who is residing in the nursing home and **both** the applicant and spouse are on Medical assistance, consider the individual requesting SPED services as living in a household of one for both functional and financial eligibility.

If the fee schedule changes, the rate charged will be determined at the next visit. The redetermination fee will not be applied to services delivered prior to the date of redetermination. When the service fee changes, the fee will become effective the first day of the following month when the change was identified.

Financial Disclosure

Each applicant/recipient must provide full financial information upon initial assessment or redetermination, every twelve months thereafter, and at such time that the individual/spouse's income or the family size changes significantly. Individuals not providing full financial information will be billed the full service fee and would, therefore, no longer be eligible for SPED.

An applicant/recipient who refuses to complete [SFN 820](#), SPED Income and Asset form, will not be eligible for the SPED Program.

Individual Fees Charged For Services

Each family member who receives a service for which a fee is assessed shall be charged the fee for that service, in accordance with the billing schedule.

Service Fee Changes

Once services have been established and there is a change to the service fee, the HCBS Case Manager must notify the HCBS Program Administration by submitting an [SFN 676](#) to the Aging Services Division within three working days. **The change in fee is effective the first of the month following the month in which the change occurred.** The coinciding care plan must be signed on/prior to the first of the following month of the effective date in order for the rate change to go into effect. **Fee change requests cannot be retroactive.** If extenuating circumstances exist, contact the SPED Program Administrator for consideration.

3. Ineligibility for the SPED Program

1. Other Funding Sources

The individual is NOT eligible for SPED services if their service needs can be met by:

- Medicaid Waiver for Home and Community Based Services;
- Medicaid Waiver for Developmental Disabilities (MR);
- Medicaid State Plan Services;
- Mental Health Services;

An individual is NOT eligible for SPED if they are eligible for the HCBS Waiver or Medicaid State Plan Personal Care and the cost of their HCBS services to SPED (excluding the cost of case management) will exceed \$~~311-233~~.

Overpayment

If an individual or legal representative provides inaccurate or false information about finances, health status, and/or the ability to complete functional tasks, the Department has the authority to recoup funds. The recoupment may be for payments for services that were provided when the individual was not eligible. An overpayment may be collected from any person that benefitted from or was responsible for the overpayment. A statute of limitations or similar statute does not apply.

b. Disqualifying Transfer

Per [NDCC 50-06.2-07](#), a disqualifying transfer has occurred if at any time before or after making application, the individual or the individual's spouse has made any assignment or transfer of any asset for the purpose of making that individual eligible for benefits. A disqualifying transfer is also transferring of any asset which results in making the individual eligible for benefits or decreasing their SPED cost share. If a disqualifying transfer has occurred per [N.D.A.C. 75-03-23-14](#), the individual is not eligible for the SPED program. However, if all of the transferred assets are returned to the applicant, then the situation could be treated as if no transfer ever occurred.

If a disqualifying transfer occurred five years prior to the date that an individual initially applies for SPED services, the

Department will presume that the transfer was not for the purpose of obtaining SPED benefits.

If assets are transferred to a child, grandchild, brother, sister, niece, nephew, parent, grandparent, stepparent, stepchild, son-in-law, daughter-in-law, or grandchild-in-law of the individual or the individuals' spouse as payment made for goods and/or services the amount transferred must be supported by a contractual agreement signed and dated by the SPED applicant/recipient before the goods and/or services were received or provided. Payment for such goods and/or services must be reasonable.

If the applicant/recipient is denied Medicaid based on a disqualifying transfer of assets, the SPED Program applicant/recipient is also ineligible for SPED Program funded services.

An individual is not considered to have made a disqualifying transfer and is not ineligible for SPED if:

- The value of the transferred asset when added to the value of the individual's other assets would not otherwise make them ineligible for SPED or does not decrease the individual's service fee.
- The asset transferred was the title to a home and the home was transferred to the individual's spouse, or to a son or daughter who is under age 21, or who is blind or disabled.
- Assets were transferred to or from the individual's spouse or to another person for the sole benefit of the individual's spouse.
- The individual can show that they intended to dispose of the assets at fair market value as defined in [N.D.A.C. 75-03-23-14](#) and the individual had an objectively reasonable belief that fair market value was received.
- The individual can show that they transferred the assets for a purpose other than to qualify for SPED benefits.
- Where any income or asset is transferred to a relative for services or assistance furnished by the relative, the

services or assistance furnished may not be treated as consideration for the transferred income or asset unless:

1. The transfer is made pursuant to a valid written contract entered into prior to rendering the services, or in the absence of a valid written contract, evidence is provided the services were required and provided.
 2. The contract was executed by the individual or the individual's fiduciary who is not a provider of services or assistance under the contract.
- There is a presumption that a transfer was made for the purpose of making an individual eligible for SPED if:
 - An inquiry about SPED benefits or benefits under this chapter was made by or on behalf of the individual to any other individual before the date of transfer;
 - The individual or the individual's spouse was an applicant for or recipient of SPED benefits before the date of transfer;
 - A transfer is made by or on behalf of the individual's spouse, if the value of the transferred asset, when added to the value of the individual's other assets would exceed SPED limits; or
 - The transfer was made, on behalf of the individual or the individual's spouse, by a guardian, conservator, or attorney-in-fact, to the guardian, conservator, or attorney-in-fact or to any spouse, child, grandchild, brother, sister, niece, nephew, parent, or grandparent, by birth, adoption, or marriage, of the guardian, conservator, or attorney-in-fact.

A transfer is complete when the individual, or the individual's spouse, making the transfer has no lawful means of undoing the transfer or requiring a restoration of ownership.

Contact a HCBS Program Administrator to determine if a disqualifying transfer has occurred.

4. SPED Pool

Upon completion of the comprehensive assessment and the SPED Income and Asset form, AND if it is determined the applicant meets the functional and financial eligibility criteria for the SPED Program, the HCBS Case Manager will forward to the HCBS Program Administration:

- SPED Pool Program Pool Data form ([SFN 1820](#))
- Add New Record to MMIS Eligibility File ([SFN 676](#))

In addition, the Case Managers must transfer the information from the form [SFN 820](#) into the Income and Asset assessment in the web-based data collection system on each person for whom funding is being sought under the SPED Program.

Services must not be authorized until the HCBS Case Manager is notified the applicant was successfully removed from the SPED Pool. HCBS Program Administration will notify the HCBS Case Manager of the decision by forwarding a copy of the SFN 676 with the SPED identification number and start date recorded on the form.

Documents with discrepancies, incompleteness, or apparent ineligibility will not be entered into the SPED Pool and will be returned to the HCBS Case Manager or will be reviewed with the HCBS Case Manager.

When HCBS Program Administration forwards the applicant's identification number and start date to the HCBS Case Manager, the HCBS Case Manager can complete the process for implementing services.

At the time the individual is approved for services funded by the SPED Program, the HCBS Case Manager must re-verify that the person continues to meet the eligibility criteria, develop a care plan and authorize services in accordance with HCBS Case Management.

If a new or current recipient of services has not utilized services within a 30-day period of time, a citation to terminate the case may be requested (if appropriate) from the Program Administrator and an SFN 474 sent too Aging Services if the case is to be closed.

If the individual has not received services because a provider has not been secured, and the individual is still eligible and wants to continue pursuing a provider, the case must remain open. The case manager must make a quarterly contact with the individual. If the individual will incur a case management fee, they must be informed of this. The case manager is required to continue attempts in securing a provider. In doing so, they may need to staff the situation with Aging Services administrators and/or discuss strategies with the individual such as publishing an advertisement for service providers, etc.

If the services are expected to start or resume within 3 months, it is allowable for the case to remain open. This does not require approval from a Program Administrator. The purpose of this exception is to allow eligible individuals to resume services without having to complete the application process again.

- The reason for delay or pause in services must be documented in the individual's file.
- The case manager must document how the need is met while the identified service needs are pending.
- The case manager must follow up monthly with the individual to provide support and assistance mitigating the issue causing the delay in service implementation.
- If the services do not resume or start within 3 months, approval must be received from the Program Administrator to keep the case open OR the case manager must request a termination to close the case and submit an SFN 474 to Aging Services/HCBS.

If a current recipient enters a skilled nursing facility or swing bed, and it is anticipated that the length of stay will be 3 months or less, it is allowable for the case to remain open. This does not require approval from a Program Administrator.

- The case manager must document the admission to the facility.
- The case manager must follow up monthly with the individual and collaborate with the nursing facility/discharge planning team to ensure appropriate services are secured for their return to the community.
- If the services do not resume within 3 months and approval has not been received, the case manager must terminate the case due to institutionalization.

There may be times when a SPED case is closed due to an anticipated long-term admission to a skilled nursing facility, but the circumstances change and the individual is able to discharge back to the community. For those instances:

If a SPED recipient closed due to a skilled nursing facility or swing bed admission, but they re-open SPED within 3 months:

- A new Application for Services (SFN 1047) does not need to be completed.
- A new SPED financial assessment (SFN 820) does not need to be completed unless there has been a substantial financial change, or the individual is due for a required annual assessment.
- An SFN 1820 does not need to be completed.
- An SFN 676 does need to be completed and submitted to HCBS/Aging Services. If all information is the same, it is allowable to use the previously approved SFN 676 and simply indicate the date the individual is to re-open in the field "Date of Application" and select "Re-Open" in the "Application Type" field.

For further instruction and examples, please reference HCBS Policy & Procedure Manual: Closures, Denials, Terminations, Reductions, and Transfer of Services 525-05-40.

SPED Pool Exceptions

As long as the individual still meets all eligibility criteria, the individual does not have to go through the SPED pool to receive SPED services if one of the following applies:

- Individual was discharged from an inpatient hospital stay, skilled nursing facility, swing bed facility, long term care facility, or basic care facility and has been off the SPED program for fewer than 3 months
- Individual has been off the SPED program for 60 days or less for any reason

The HCBS Case Manager must document the date that SPED services re-should start on the [SFN 676](#), Add New Record to MMIS Eligibility File, in the "Date of Application" field and select "Re-open" in the "Application Type" field. For further instruction, please reference

HCBS Policy & Procedure Manual: Closures, Denials, Terminations, Reductions, and Transfer of Services 525-05-40.

The HCBS Case Manager should also include a request for an exception to apply for Medicaid on these forms if the applicant will be receiving personal care but the cost of their services (excluding case management) are less than ~~\$311~~233. If SPED personal cares are to be authorized, the Case Manager must complete the bottom section of the SFN 1820, outlining the estimated amount of SPED Personal Cares, and an Explanation as to why they are to be funded by SPED and not Medicaid State Plan Personal Care Services.

HCBS Case Management 525-05-30-05

(Revised ~~027~~01/2024 ML #~~3797~~3847)

Purpose

Case Management is a service that assists individuals in learning about, applying for, accessing and maintaining home and community-based services in the most integrated setting appropriate to their needs.

The purpose of HCBS Case Management is to assist an 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 leads the person-centered planning process that enables individuals and their natural and formal supports to explore and understand long-term service and support (LTSS) options, identify barriers, set goals, and collaborate with stakeholders to assist the individual in accessing needed community-based services. The HCBS Case Manager also advocates for and promotes individual-focused systems of service delivery, exercises an awareness of the larger target population in need, and exercises prudence in each individual's person-centered plan of care to link individuals 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 Aging Services 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 Aging Services are eligible to receive payment for the service of Case Management under the HCBS Waiver and authorize services if the individual is eligible for services under the 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 Waiver and are eligible to authorize services for an individual if the individual is eligible for services under the Wavier.

Case file documentation must be maintained:

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

Quarterly Visit Requirements for Medicaid Waiver

Case Managers are required to monitor during their quarterly face-to-face contacts to ensure an individual's is being afforded the rights of privacy, dignity and respect, and freedom from coercion and restraint (including the limited use of restraints that are allowable under Adult Residential Services in accordance with NDCC 50-10.2-02 (1)).

- Any violation of an individual's rights must be reported as complaint to the HCBS Program Administrator and/or Vulnerable Adult Protective Services.
- If a restraint or restriction is identified, the case manager must document the restraint or restriction on the Person-Centered Plan of

Care and review the need for the restriction at a minimum of every six (6) months.

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 Developmental Disabilities Professionals (QDDP) 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 Aging Services 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 Developmental Disabilities Professional (QDDP) 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 services and supports 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 Aging Services are eligible to approve services under SPED, EXSPED and Medicaid State Plan - Personal Care (MSP-PC), (see Chapter 535-05).

- DDPMs are eligible to approve MSP-PC services.
 - If the individual 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**:

- HCBS Case Managers, DDPMs, enrolled Individual or Agency Case Managers and enrolled Indian Tribe or Indian Tribal Organizations.
 - If the individual 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 being 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 resides 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 (need anticipated to exceed 30 days). 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.

The applicant or referred individual must agree to a home visit and participate in the assessment and person-centered planning.

Activities of Targeted Case Management

1-Assessment/Reassessment

2-Person Centered 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 individual needs to remain in their home or community and be linked to those services and programs.
- An assessment must be completed, and a person-centered plan developed. The individual's case file must contain documentation of eligibility for TCM. The HCBS Comprehensive Assessment and narrative must be entered into the web-based data collection 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 individual must be informed of that fact by noting Case Management Service and cost on the Person-Centered Plan of Care. Individuals 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 individual receiving SPED services, need not apply for Medical Assistance.
- The case record must include a HCBS Comprehensive Assessment and narrative (entered into the web-based data collection system) 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, personal care, homemaker services, meal preparation, shopping (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 every six months thereafter. At least one home visit is required during the initial assessment of needs process.
- The case manager must schedule an appointment for an initial assessment no later than 5 business days after receiving a request for home and community-based services (HCBS) and must complete an initial comprehensive assessment no later than 10 working days after receiving a request for HCBS. All contacts with an individual must be documented in the case file.

Exception: In cases where the HCBS referral is initiated through ADRL Transition or MFP Transition Services by Money Follows the Person (MFP) and HCBS Case Management, the HCBS Case Manager may follow the established timeline of MFP Transition Coordination.

- MFP Transition Coordination reaches out to the referred individual within 5 working days of the referral and facilitates a Transition Team meeting to initiate the referral within 14 days of the referral. The start date of the referral for HCBS case management is the date that the MFP transition coordinator reaches out to the team to schedule the transition team meeting.

Individuals must sign and be given a "Your Rights and Responsibilities" brochure DN 46 annually and a signed copy of this must be kept in the individual's file.

During the assessment process, when applicable, the information needed for submission to Maximus is obtained. The case management entity must use the existing and established procedures for requesting a level-of-care determination from Maximus.

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

For a child (under 18 years of age): Complete the HCBS Comprehensive assessment AND submit the necessary documents to Maximus for a level-of-care determination.

The following service combinations require approval by the HCBS Program Administrator as indicated in the chart below;

Approval	Description	Frequency
Hospice	<p>Pre-approval is not needed. However, the combination of HCBS services and hospice service requires documentation in the case note that the individual continues to meet eligibility for the service and there is no duplication of services. The hospice service must also be noted on the "other community-based services" section of the person-centered plan. For MSP-PC cases only: The following information must also be sent to provider enrollment:</p> <ul style="list-style-type: none"> • <u>Name of the individual</u> • <u>ND number</u> • <u>Date hospice started</u> • <u>Provider name</u> • <u>Provider number</u> • <u>Document in the email assurance that the hospice plan is on file (the hospice plan must be kept in the individuals HCBS file.)</u> 	One-time
FPC	<p>Approval is needed when the Family Personal Care provider is a legal spouse or legal guardian. Include name, county, name of proposed provider, and why the person acting as the FPC provider is in the best interest of the individual.</p>	One-time
Out-of-state care	<p>If you are seeking to continue to authorize services for an individual while they are out of state: Include name, county of residence, funding source, description of situation for consideration, including whether medical treatment is being sought out of state.</p>	Each instance
FHC/FPC combined w/ any other	<p>Include name, county of residence, funding source, why the additional</p>	One-time

service other than Respite, <u>ERS, N-ED, EPCS, EPCS-N</u>	service is needed and/or cannot be provided by FHC or FPC provider.	
Chore	When the cost of chore labor is over \$500/month, or to approve specific tasks such as professional sanitation, floor care of unusual nature, etc. per policy. Include name, county of residence, funding source, description of need, task, provider, frequency, cost estimate.	Each instance
Residential Habilitation or Community Support	Include name, county of residence, ND number, medical diagnoses, a description and breakdown of all tasks needed, and the number of units needed on average each day or in one month.	One-time, changes
Nurse Education/EPCS	Include name, county of residence, funding source, medical diagnoses, list of medications, list of medical tasks needed.	Each instance
Environmental Modification	Must have prior approval for all. Include name, county of residence, funding source, and description of request. Once approved to proceed, include copy of written recommendation by professional to ensure modification will meet the needs (if cost over \$500), name of who owns/rents home, current value of home if owned, bids, and proposed dates of services.	Each instance
2-person assist	If more than one provider is needed to complete a service or task, include the name, county of residence, funding source, and description of need – why one provider is unable to safely complete the service or task.	Initial, every 6 months
MSP Level C	Include name, county of residence, description of need/functional status, number of personal care units/and assurance that no units are authorized for l/s/h	Initial, every 6 months

Respite when primary caregiver does not reside w/ recipient	Include name, county of residence, funding source, and explain why respite care is appropriate (example: the primary caregiver provides frequent on-site visits throughout the day which is essential to allow the individual to live independently).	Annual
Respite Care provider who resides w/ recipient	Include name, county of residence, funding source, and explain why it is appropriate for the live-in caregiver to be authorized to provide respite care.	Annual
Case remaining open when recipient in NH for over 3 months	Include name, county of residence, funding source, date of nursing home admission, and information related to pending discharge plans back into the community/receipt of HCBS.	Annual
Reasonable Modifications	For reasonable modification requests, include all necessary information that is indicated on the reasonable modification template. For annual re-approval of a reasonable modification, include the information indicated on the reasonable modification template, as well the date of original approval and whether the modification needs to be modified or should continue.	Reasonable modifications need to be re-approved on an annual basis during the annual review or any time there is a change
Exceptions to services/ combinations/ situations not otherwise listed	Include name, county of residence, funding source, services, and detailed description of the request for approval. If a reasonable modification request, include the age of the individual, whether they would reasonably meet LOC, if they are on Medicaid or at risk of being on Medicaid, and why the approval would assist in preventing institutionalization/possible detrimental outcomes of not approving the request.	As needed depending on request

If the individual referred to HCBS appears to potentially meet the criteria for ID/DD waiver, the case manager may contact an HCBS Program

Administrator to request an interdisciplinary team staffing to determine the options available to meet the individuals request for services.

2. Person-Centered Planning

Person-Centered Planning (PCP) is a way of thinking about a person as a whole. PCP is a way to develop a plan using both formal and natural supports to address all areas that are important to the individual. PCP is a process, not a procedure or document. HCBS case management has been utilizing PCP with the current assessment and care planning process. Utilizing the Charting the LifeCourse (CtLC) framework allows HCBS to enhance our PCP practices by really focusing on what matters to the individuals, what the individuals need to live the life they want and how they can be supported to meet their needs. PCP encourages community integration and recognizes the individual's preferred role in the community. The case manager assists the individual to overcome barriers that prevent them from living their best lives in the most integrated setting appropriate.

The purpose of person-centered planning is to identify, arrange, and maintain the supports and services necessary to meet the individual's needs in the most integrated setting, consistent with the member's informed choice as appropriate to the individual's needs.

Person centered plans will be developed with input at a minimum from:

1. The individual to the fullest extent possible, including when the member has a legal guardian, consistent with state law N.D.C.C. 30-1-28-12. The individual will have the primary role in developing the person-centered plan when possible.
2. The individual's family and/or friends with permissions and desire of the individual; and
3. The individual's legal guardian, where applicable, to the extent the guardianship order confers residential and/or medical decision-making upon the guardian per N.D.C.C 30.1-28-04(5).

Any decision(s) made by the guardian about where the member will receive services should reflect the member's preferences, as documented in the person-centered plan, to the fullest extent possible. See N.D.C.C. 30.1-26-01(3).

Case managers should facilitate a process to resolve conflicts that arise during the person-centered planning process if the individual and their family/natural supports or guardians do not agree on where the individual should live and receive services.

Role of Case Manager in Person-Centered Planning

The role of the case manager in the PCP process is to lead and facilitate conversations with the individual requesting or receiving home and community-based services. Person-centered planning is a way of developing a care plan that takes all aspects of what is important to an individual into consideration. The role of the case manager has four components.

1. Request for an assessment/reaching out for services.

The role of the case manager during this phase is to gather information. Identify who is most important to the person and who they would like to be on their team. Discuss with the individual what your role is as a case manager and what you will be discussing at the home visit. Invite them to ask friends, family or other supports to be present at the assessment if they would like. An individual may wish to invite their QSP to the assessment planning process to ensure an understanding of what services are needed and the preferences of the individual. Remind the individual of the sensitive information that you will be discussing at the visit.

2. Assessment

The case manager will engage in facilitated discussion with the individual requesting services. The case manager utilizes the HCBS Comprehensive Assessment, the Vision Tool and the Risk Assessment and Health and Safety Plan with every individual initially, annually, at six-months and when there are significant changes. When a case manager is completing the assessments and vision tool the individual may be asked to provide information about themselves, such as what is important to the

individual, are there community supports or other formal supports that they are involved in? What roles does the individual have in life, such as do they identify as a friend, mother, grandmother, employee, friend, church member, quilter, wood carver, card player, veteran? How can the case manager support the individual to continue in their role? Through these conversations you will be discussing the life domains that are identified in the Charting the LifeCourse Vision tool. Additionally, the financial assessment and caregiver assessment may need to be completed.

The case manager must document in the assessments and vision tool the exchange of information between the individual and the case manager. Additionally, collateral information from the individuals care team may be included. If an individual does not wish to discuss information or questions in the assessment or vision tool, the case manager must document in that area the individuals wish to not answer the questions or discuss the topic.

For each functional impairment identified the functional assessment note must include:

- the reason the individual is unable to complete the task and/or why the individual is impaired,
- who is completing the task, how this need is met.

If the need is met through HCBS, the functional assessment must also include the following information:

- Who assists with the task,
- What service the task falls under
- The overall number of units authorized for this service type
- The anticipated outcome or goal.

3. Developing the plan

Case managers will use the information gathered through the assessment process to coordinate with the individual and team members on an action plan that meets the needs of the individual and reflects their preferences. The plan will be reviewed and updated at least every 6 months, upon individual request, or as situations arise. The PCP of care is based off of the facilitated discussion. Components of the person-centered plan of care includes the Charting the LifeCourse, (CtLC) Vision tool, formal and natural supports, strengths, barriers, unmet needs, services offered and declined, timelines and strategies to meet the individual's goals. Additionally, the Risk Assessment and Health and Safety Plan must be completed.

- **For Basic Care ONLY, the Personal Care Services Plan of Care and Authorization of Services in a Basic Care Setting, SFN 662, must be completed annually. DO NOT complete the Vision Tool, Person-Centered Plan of Care or the Risk Assessment and Health and Safety Plan for Basic Care. The SFN 662 must be submitted to Aging Services via the HCBS Submission Fax Line.**

For Medicaid Waiver, Service Payments for the Elderly and Disabled, Expanded Services Payments for the Elderly and Disabled and Medicaid State Plan – Personal Care Services the following procedures for the person-centered plan of care applies:

The person-centered plan of care (PCP) includes the Vision Tool, Person-Centered Plan of Care, the preauth in Therap and the Risk Assessment and Health and Safety Plan. Additionally, the plan may include the caregiver assessment, transition plan, and/or the Individual Program Plan.

When completing the person-centered plan of care the case manager will refer to the functional assessment section of the HCBS Comprehensive Assessment to review and discuss with the individual the services and scope of the tasks (limits to the tasks) that can be provided through HCBS. The discussions on services may require gathering additional information as follows:

- In order to authorize the task of vital signs, the case manager must have on file: a written, signed recommendation (provided by a nurse or higher credentialed medical provider) outlining the requirements and frequency of monitoring. For the task/activity of exercise, a written recommendation and an outlined plan by a therapist for exercise must be on file.

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

1. Name, address and telephone number of QSP.
2. Whether QSP is an agency or individual.
3. The unit rate per QSP.
4. If applicable, limitations of the QSP available.
5. If applicable, endorsements for specialized cares:
 6. Global Endorsements (Only a QSP 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 Preauth document the name of the agency or person who is to be contacted to provide the results of the individual'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 individual's file. The provider must obtain documentation that a health care professional has verified the provider's training and competency

specific to the individual's need and provide a copy to the Case Management Entity. The Case Management Entity must forward a copy of the SFN 830 to HCBS Program Administration. Client Specific Endorsements include: Apnea Monitoring, JOBST Stockings, Ostomy Care, Postural/Bronchial Drainage or Nebulizer Treatment, RIK Bed Care (Specialty Beds).

Qualified Service Providers who can provide the required care and whom the individual has selected will be listed on the HCBS Care Plan and PreAuth.

- When a change in service provider occurs between case management contacts – the individual 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 manager's documentation and noted on the person-centered plan of care.
- A copy of the updated care plan must be sent to the individual or legal representative. However, changes in services or the amount of service must be signed by the individual or legal representative and approved.

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 HCBS Care Plan and PreAuth.

- Individuals must be made aware of funding caps and documentation must verify that the individual 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. Or contact the HCBS Program Administration to request an exception or reasonable modification to meet the individual need if the individual is at risk of institutional placement.

Contingency plans

- Contingency planning must occur in all person-centered plans of care. The backup provider or plan must be listed on the HCBS Care Plan.

The case manager must review with all individuals and/or the individual's representative the individual stated goal. The goal must be recorded as part of the Person-Centered Plan of Care. The individual goals must be reviewed and updated annually, every 6 months and as significant changes in the individual's needs occur or if the individual requests an update.

The final step in Care Planning is to review the completed HCBS Care Plan, with the individual/legally responsible party and obtain required agreements/acknowledgments and signatures.

When services are reduced, you must provide the individual or their legal representative.

In situations where the individual has requested the reduction in services, they may sign a statement requesting the services be reduced. This request must be kept in the individual's record, and the reduction in service citation is not required.

Interim Care Plans

Interim care plans are limited to individuals who receive services through 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 an individual who is on Medicaid, has an approved Level of Care (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: An individual 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 individual 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 individual 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. An individual who is receiving service through the HCBS Waiver is required to be receiving Medicaid. If, in the redetermination process, it is determined the individual is not eligible for Medicaid, payment for services stops the day Medicaid terminates. If the individual has an established HCBS Care Plan and PreAuth and the termination is overturned, waiver services could be paid during that period of time.

4. Implementation/Review

The case manager's role during implementation is to educate others in the team about the possibilities of long-term services and supports, facilitating planning now and into the future, problem solving, coordinating integrated services and supports, conflict resolution and advocacy (CtLC, 2020). The case manager is responsible for assessing and authorizing services offered under Aging Services in addition to working collaboratively other formal and natural supports. It is important to understand the role of the case manager in relation to the other team members involved in the individual's care. Open discussion surrounding the roles of the team members should be included in the care planning meeting and implementation planning process. It is helpful to clearly define the roles of each member and write a list of tasks that team members are responsible for in the implementation of the plan. The case manager is responsible for monitoring the plan for progress and any changes in the individual's care needs.

Release of Information (ROI) Guidance for Implementation and Review of Person-Centered Planning

It is best practice is to have a ROI signed by the individual and/or their legal representative whenever releasing information. A ROI provides proof that the individual agrees and understands what

information is being released and the purpose of releasing the information. As a professional, with a professional license or certification, having an ROI on file, also provides guidance and assurance to the professional on the individual wishes to how and what information they have agreed to release to another entity.

Governing Policy; DHHS Confidentiality Manual

01-20. Disclosure of Client-Identifying Information (Revised 03/18 ML #3516)

01-20-01. Use Within the Department (Revised 03/18 ML #3516)

01-20-10. Disclosure Outside the Department (Revised 03/18 ML #3516)

01-25-45.01. Treatment, Payment, Health Care Operations (Revised 03/18 ML #3516)

Treatment: Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

Treatment involves health services provided by a health care provider and tailored to the specific needs of an individual patient (not entire populations).

Activities are considered treatment only if delivered by a health care provider or a health care provider working with another party.

Activities of health plans are not considered to be treatment.

01-25-45-25. Disclosure of PHI to Business Associates (Revised 03/18 ML #3516)

Continuity of Care

In order to coordinate services for an individual, case managers may need to make referrals and gather other collateral information. Not all communication requires a release of information.

Examples, Questions and Answers

Case Managers can share individual information with health care professionals working in these following settings: Home Health Care, Hospitals, Clinics, PACE, and LTC facilities as this communication is part of the continuum of care guidelines under HIPAA. Case Managers can also share information with other case management entities (i.e. DD, VR, Behavioral Health) within the Department of Health and Human Services, as well as Eligibility Workers under the Medical Services Division. Information shared without a release of information must be on a need-to-know basis to coordinate care for the individual, disclosing only the minimum necessary

amount of information pursuant to 45 CFR 164.502(b). Disclosure of information related to Psychological or Substance Abuse Treatment requires that the individual sign a Release of Information.

Question: Are there program federal and state rules and regulations that dictate what information can be disclosed?

Answer: HIPAA permits health care providers to disclose to other health providers any protected health information (PHI) contained in the medical record about an individual for treatment, case management, and coordination of care and, (with few exceptions), treats mental health information the same as other health information. Some examples of the types of mental health information that may be found in the medical record and are subject to the same HIPAA standards as other protected health information include:

- medication prescription and monitoring
- counseling session start and stop times

- the modalities and frequencies of treatment furnished
- results of clinical tests
- summaries of: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

HIPAA generally **does not limit** disclosures of PHI between health care providers for treatment, case management, and care coordination, except that covered entities must obtain individuals' authorization to disclose separately maintained psychotherapy session notes for such purposes. Covered entities should determine whether other rules, such as state law or professional practice standards place additional limitations on disclosures of PHI related to mental health.

Requests for records made by a covered entity to be delivered to another covered entity for care purposes are called "Continuity of Care" requests. **Records necessary for care of the patient fall under the "treatment" provision on the HIPAA Privacy Rule and do not require an**

authorization from the patient.

Question: Are case managers able to release third party records (medical records that the CM may have on file from medical providers) to perspective providers such as AFC, ARS, or skilled nursing facilities?

When an HCBS client asks for assistance with admission into a nursing home or into an agency AFC, ARS, etc., the admitting agency may want medical records to review in order to make a determination for accepting the individual.

Example: An HCBS client is requesting SNF placement. The family isn't much help as they do not understand the paperwork and can't send the records needed. The individual family wants the CM to help with getting this individual admitted ASAP and the individual is in agreement. We are searching for nursing homes across the state, but each NH wants a history and physical, med list, therapy notes, all the medical information they can get to review the case and see if they can meet the individual needs. With an ROI signed, can HCBS

send the requested third-party records to the potential provider?

Answer: Case Managers are able to release (provide) third party records to perspective providers, AFC, ARS or SNF to provide "Continuity of Care" to the individual served. This would include records such as the history and physical, medication list, physical or occupational therapy notes and other medical diagnosis or needs.

Case Manager are **NOT** able to release psychotherapy notes as they are protected information.

Further Guidance referenced from DHS Confidentiality Manual 01-25-35. Information Obtained from Sources Outside the Department (Revised 03/18 ML #3516) Information obtained from sources outside the Department, also known as "third party information" or "collateral information," does not enjoy any special status with regard to its use or transfer within the Department or disclosure outside the Department unless different treatment is specifically required by federal or state law, federal

regulations, or state administrative rules.

Information, which does enjoy special status, includes Social Security records, Vocational Rehabilitation records, substance use disorder treatment information, adoption information, and the identity of a reporter of suspected child abuse or neglect.

The workforce member responsible for responding to requests for information (e.g., counselor, case worker, records custodian) has the duty to be aware of laws and regulations mandating different treatment, and to seek assistance if he or she has questions.

Question: For entities that we have contracts with who are not employed by the DHHS, do we need a release to coordinate services in addition to the contract that permits the disclosure of PHI? (This would include the Alzheimer's Association, CILS, MFP after a case close with MFP, the Senior Centers, etc.)

Answer: This depends.

1. Are there program federal and state rules and regulations that dictate when and how information can be disclosed?
2. Is there a business associate agreement in addition to the contract that permits the disclosure of PHI?
3. Is the disclosure for treatment purposes? Under the "Continuity of Care" law, it talks about info related to "care of the person" so we know we do not releases for HHC or the hospital, but these other entities are more of a gray area.

Due to this being a gray area, a ROI would be needed in most to release information to outside entities such as The Alzheimer's Association, CILS, MFP after a case closes with MFP, the Senior Centers, etc.

Collaboration and PHI Disclosure between LTC Ombudsman and Vulnerable Adult Protective Services (VAPS)

- Case manager disclosing the PHI of a LTC resident for the purpose of filing a complaint about a LTC facility with the LTC Ombudsman. Case managers are health care

providers and are subject to HIPAA. HIPAA permits this disclosure.

- Case Manager disclosing the PHI of a LTC resident for the purpose of reporting abuse/neglect of a vulnerable adult to VAPS. Case managers are health care providers and are subject to HIPAA. HIPAA permits this disclosure and NDCC 50-25.2-03 requires the disclosure.
 - Disclosure by VAPS of information of a LTC resident pursuant to an abuse/neglect report, to the LTC Ombudsman. Neither VAPS nor the LTC Ombudsman are subject to HIPAA. They may receive PHI from a case manager, but once they receive it, it is no longer PHI and is subject to the confidentiality of the VAPS and LTC Ombudsman state confidentiality laws. This disclosure of information from VAPS to the LTC Ombudsman is required under NDCC 50-25.2-04.
3. Implementing the Person-Centered Plan of Care - The Case Manager assures that services are implemented, and existing services continued as identified in the person-centered plan of care. This activity includes contacting the QSP and issuance of a Preauth.
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 individual's progress/condition and the services provided to the individual. 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 individual's health and welfare. If the individual'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 request a team staff meeting through the HCBS Program Administrator to discuss possible terminate termination of services. If the case is closed, the individual is made aware of their appeal rights (see Closures, Denials, Terminations, and Reductions in Services 525-05). The case manager shall document all service monitoring activities and findings in the individual's case file.

- a. The HCBS Case Manager must contact the individual after the first 30 days from the initial care plan implementation. This may be via phone or face-to-face. (If the individual is unable to communicate via telephone, a face-to-face visit is required.) The purpose of this contact is to follow up on the implementation of the person-centered plan of care (PCP), ensure the individual's needs are met and ensure the scope and amount of services authorized are provided.
- b. The HCBS case manager shall monitor the services provided under the PCP on an as needed basis but not less than direct individual contact at least once every three months for Medicaid Waiver, MSP level B and MSP level C.
- c. Residents of basic care facilities under Basic Care Assistance Program must have an initial and annual HCBS Comprehensive Assessment and completion of the SFN 662.
- d. Monitoring contacts and reassessments may be required if there is a change in the individual's condition or critical incident report (CIR) that requires a follow up to ensure health and safety of the individual.
- e. 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:

1. Initiate a formal VAPS (Vulnerable Adult Protective Services) referral according to ND Century Code 50-25.2-03(4).

REPORTING OPTIONS

- Online <https://bit.ly/3vbYbEj>
 - Reporting Form, SFN 1607 sfn01607.pdf (nd.gov) can be emailed to: dhsvaps@nd.gov or faxed to: 701-328-8744
2. Notify the HCBS 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.
 3. The Risk Assessment and Health and Safety Plan may need to be updated and reviewed in the following circumstances.
 - When there is a risk identified during assessment, reassessment or monitoring visits.
 - Critical incident report (CIR) has identified a risk to the individual served by HCBS.
 - The Program Administrator responsible for monitoring and review of all CIR's will contact the case manager in the event there is an event reported that requires an update to the Risk Assessment and Health and Safety Plan.
 - QSP complaint has identified a risk to the individual served by HCBS.
 - The Program Administrator for monitoring and review of all QSP Complaints will contact the case

manager in the event that there is a complaint that requires an update to the Risk Assessment and Health and Safety Plan.

- VAPS report has identified a risk to the individual served by HCBS.
 - VAPS and HCBS case manager will work together to update or revise the Risk Assessment and Health and Safety Plan to address any identified risk or health and safety concerns identified in the VAPS report.

Documentation for an event involving abuse, neglect, exploitation, CIR, QSP complaint or VAPS must be included in the case note and include the following:

- Identify and document in writing the name of the qualified service provider or other individual provider.
- 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 Educator determine that an incident is indicative of abuse, neglect, or exploitation, the HCBS Case Manager must immediately report the critical 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 individual's living arrangements, individuals implicated, or the Provider type (all incidents/actions must be reported to the Aging Services Program Administrator):

- Individual 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.
- Individual 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 individual is living in an AFC Home:

Contact the HCBS Case Manager responsible for AFC licensing,

And

Contact the Aging Services Division 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 an individual who is receiving DD Services, contact the individual'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 individual, 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 individual stated goal must be

reviewed, and progress or continuation of the goal must be noted in the narrative of the vision tool.

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 Closures, Denials, Terminations, and Reductions in Services (525-05-40) unless the individual is requesting services to be reduced. In situations where the individual has requested the reduction in services, they may sign a statement requesting the services be reduced.

Contacts with Individuals

Virtual Supports -

A visit by virtual means can be conducted when individual cannot have an in-person face to face due to extenuating circumstances. The individual may be afforded the option to use the phone or other telehealth technology to engage in the development and/or monitoring of person-centered plans when there are extenuating circumstances impeding the ability to conduct the visit in person.

- Extenuating circumstances may include instances where the in-person visit poses a health or safety risk to the individual or case manager; public emergency as determined by local, state and federal government.
 - Examples of extenuating circumstances may include but are not limited to the following instances:
 - The individual cannot be seen due to having a medical condition, ie., contagious disease, treatments that weaken the immune system,
 - Natural disasters and or threats,
 - Weather related road closures, no- travel advisories.
- The participant's services may not be delivered via virtual support 100% of the time.
- The participant must always have the option to request in-person services.
- Instances of visit by virtual mean must be approved by the HCBS CM Supervisor or HCBS Program Administration as a safeguard to ensure virtual supports can help meet the needs of the participant in a way

that protects the right to privacy, dignity, respect, and freedom from coercion.

- Virtual supports are not a system to provide surveillance or for staff convenience.
- Any issues will be addressed prior to the implementation of remote supports and documented in the individual's case record.
- In virtual supports, the use of cameras in bathrooms or bedrooms impacting the participant's dignity and privacy is not permitted. Provider must use a HIPAA compliant service delivery method.
 - (e.g. Microsoft Teams, Zoom for Healthcare). HIPAA rules apply to all covered entities regarding HIPAA Privacy and Security. Participant will be given education and support on the use of virtual supports by their chosen provider.

Once the extenuating circumstance no longer limits the ability to complete the home visit, the case manager must follow-up with a face-to-face visit for monitoring as outlined in policy.

- The face to face must be scheduled as soon as possible, not waiting until the next required visit.
- The required face to face visits provides assurance that the individual is receiving services within the scope and amount authorized.
- The face to face also assures a view of possible health, welfare and safety concerns that may not be relayed through the phone or virtual contact.

For SPED and EXSPED -

- An Initial HCBS Comprehensive Assessment is required to establish eligibility for services and following implementation of the service a contact shall be made with a NEW individual within the first 30 days of implementation of services. The initial, annual assessment and six-month assessment are required to be face-to-face visits in the individual's home. During the annual and six-month assessments a quality review questionnaire is completed with the individual as part of the assessment process.

Waiver:

- HCBS Waiver Services: An Initial HCBS Comprehensive Assessment is required to establish eligibility for services. Following implementation of the service, a contact (either in person or via telephone) must be

made with a NEW individual within the first 30 days of implementation of services. Quarterly contacts with the individual are required, including an annual assessment, six-month reassessment and two quarter contacts. During the annual and six-month assessments, a quality review questionnaire is completed with the individual. **All four contacts must be face to face and take place in the individual residence.**

- Case Management coordinates an annual interdisciplinary team conference and invites the legal representative and others as requested by the individual.

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 individual or the collateral contact. If this is a face to face visit- describe the environment, individual's appearance, and communication style
- 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
- Individual satisfaction
- Follow-up plan

Reimbursement/Payment for Service

The Case Management Entity may bill for case management if the individual 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 individual's case file and/or web-based case management system 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 is used for higher-level case management for individuals eligible for Medicaid Waiver for Home and Community Based Services.

Administrative Tasks (Non-billable)

Any task or activity that is not directly related to the following cannot be billed as case management; person-centered planning and coordination; assessment or reassessment of an individual; development, implementation, or monitoring of a care plan.

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 HCBS case manager to initiate the screening either by submitting information to Maximus.

A LOC determination/screening must be completed for an individual who is requesting services through a waiver program, or an individual who under the age of 18 and requesting SPED services, and MSP-PC Level B or C. 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.

- HCBS Waiver

- MSP-PC (Level B or C)
- SPED under age 18
- MSP-PC/SPED under age 18 (Check only if eligible for both)

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 individual's discharge from the nursing home or swing bed and prior to end date of the LOC of the current HCBS screening.

- The reopening date of the LOC for HCBS Waiver must be indicated on the SFN 474.

Upon completion of LOC determination, Maximus will submit to the Aging 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 HCBS case manager for filing in the individual's record.

When an HCBS individual screened for Medicaid Waiver 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. Maximus needs to be informed of the reason for the screening and intended outcome to "other". If Maximus concurs the recipient no longer needs NF care, an ending date of services needs to be given to Aging Services by using the SFN 474, to Aging Services/HCBS. The ending date is the responsibility of the case manager and needs to allow sufficient time in which to give the individual a ten-day (calendar days) notice of service termination under the Medicaid Waiver funding source. Maximus will report screening terminations with closing dates to Aging Services. Aging Services will input the ending date of services on the computerized screening.

Nursing Facility (HCBS) Level of Care Determination But The Individual Is Not Receiving Waiver Services

The stop date on the screening is important for Medicaid recipients having a spouse in the household who qualify for spousal impoverishment. The recipient is treated, for Medicaid budgeting purposes, as if living in the nursing facility only when RECEIVING services paid by the Waiver. If an individual is residing in their home, receiving spousal impoverishment under Medicaid, they must receive a Medicaid Waiver service each month to remain eligible under the spousal impoverishment guidelines. If Waiver funded services are NOT provided, the screening must be "closed" so that the correct budgeting method is reflected in the Medicaid data system. Submit SFN 474, HCBS Case Closure/Transfer Notice, so a closing date is entered in the Medicaid data system.

Case File Contents

1. For all programs, all case files, or in the web-based case management system should have (at a minimum):
 - a. Application for Service SFN 1047
 - b. A signed copy of Your Rights and Responsibilities brochure (DN 46)
 - c. Preauth for Medicaid Waiver, SPED/Ex-SPED, and MSP (updated every six months)
 - d. Monthly Rate Worksheet (if applicable)(SFN 1012 updated annually)
 - e. HCBS Notice of Denial or Termination SFN 1647 (if applicable)
 - f. HCBS Case Closure/Transfer Notice SFN 474 (if applicable)
 - g. An end dated or deleted Preauth (if applicable)
2. The case file for each Medicaid Waiver individual must contain:
 - a. Documentation of verification the person is a Medicaid recipient
 - b. Medical information (if applicable)
 - c. Record of current level-of-care determination(s) (updated annually)

3. The case file for each Expanded SPED individual must contain:
 - a. Expanded SPED Program Pool Data SFN 56
 - b. Add New Record to MMIS Eligibility File, SPED and ExSPED, SFN 676
4. The case file for each SPED individual must contain the:
 - a. SPED Program Pool Data SFN 1820
 - b. Add New Record to MMIS Eligibility, SPED and ExSPED, SFN 676
 - c. SPED Income and Asset SFN 820, (updated annually)

Chore Service 525-05-30-20

(Revised ~~05/01/23~~ 07/01/24 ML #~~3730~~3847)

Purpose

The purpose of Chore Service is to complete tasks which an individual is not able to complete in order to maintain their home, lawn, or walkway. The chore service tasks authorized must be directly related to the health and safety of the individual, or maintaining access to safe and appropriate housing.

Chore Service can provide for the completion of one time, intermittent, or occasional home tasks which enable individuals to remain in their homes.

Service Location

Services will be administered in the most integrated setting consistent with the Person Centered Plan of Care, including (**checked if allowable**):

✓ The individual's home

- Workplace
- Other community service settings

Service Eligibility, Criteria for

The individual receiving Chore Service must meet the following criteria:

1. Must be eligible for Medicaid Waiver for Home and Community Based Services, SPED, or ExSPED.
2. For Emergency Response Service, is limited to installation and monthly rental fee. ERS Service is restricted to individuals living alone.
 1. Exception: If an individual resides in a multiple person household and there are occasions when the individual may be at risk due to the absence of the other household member(s), it is allowable to authorize (ERS) as long as the case manager documents the need and benefit to the individual.
3. The individual is not able to complete tasks to maintain his/her residence, lawn, or walkway.
4. The chore activity is a one-time or intermittent task.
5. If the individual is a renter, chore services shall not replace the responsibilities of the landlord to complete tasks to maintain the residence, or walkway.
6. Pre-approval from the department is required if the cost of the service is expected to exceed \$500 per month. See Service Tasks listed below for specific tasks that require additional prior approval.
7. Emergency Response Service is limited to persons cognitively and physically capable of activating the emergency call.

Service Tasks

Professional extermination or sanitation Need prior approval Authorized per job, not units	Snow/Ice removal (when measurable snowfall or drifts present a safety hazard to the individual)
Floor care/cleaning of unusual nature, tacking down loose rugs or tiles Need prior approval	Moving heavy furniture and cleaning on seasonal basis for safety reasons
Cleaning appliances (may include moving to clean around or behind)	Cleaning and garbage removal of unusual nature Need prior approval

<p>Professional ERS installation and monthly rental fees are allowed -- does not include maintenance or repair of ERS</p>	<p>Clean windows (may include seasonal removal of screens or storm windows)</p>
<p>Lawn mowing</p> <p>The purpose of this service is to maintain access and prevent any barriers to safe and appropriate housing. The service is not to be utilized for cosmetic purposes, but instead to comply with city ordinances related to grass control.</p> <p>Limits:</p> <p>Limited to seasonal cutting and trimming grass, bagging/dumping. Does not include landscaping, fertilizing, or weed control. Maximum service amount is set at once per week.</p> <p>If a provider is to use an individual's equipment to complete this task, the individual must sign a statement granting permission. The case manager must maintain this statement in the individual's file.</p>	

Providers

Chore Service may be provided by the following individual QSP's or employees of a QSP agency (**checked if allowable**):

Guardian

✓ Legally Responsible Person - Legal spouse or parent of a minor child.

✓Relative within the definition of Family Home Care under subsection 4 of N.D.C.C. 50-06.2-02.

**Community Support Services 525-05-30-21
(Revised **027/01/2024 ML #37973847**)**

Definition

Community supports is formalized training and supports provided to eligible individuals who require some level of ongoing daily support. This service is designed to assist with and develop self-help, socialization, and

adaptive skills that improve the participant's ability to independently reside and participate in an integrated community. Community Supports may be provided in community residential settings leased, owned, or controlled by the provider agency, or in a private residence owned or leased by a participant.

The participant must be able to benefit from one or more of the following care coordination, community integration/inclusion, adaptive skill development, assistance with activities of daily living, instrumental activities of daily living, social and leisure skill development, medication administration, homemaking, protective oversight supervision, and transportation.

This service may be most beneficial to individuals with physical disability or complex medical needs who require ongoing custodial and/or maintenance care.

Purpose

Community Support Services provides all-inclusive service provided up to 24 hours a day to individuals who otherwise would be in an institutional setting.

Service Eligibility

The individual receiving Community Support Services will meet the following criteria:

1. Must be eligible for Medicaid Waiver for Home and Community Services.
2. Requires some level of on-going daily support.
3. The individual is capable of directing their own care or has a legally responsible party to act on the recipient's behalf.
4. Pre-approval from the Department of Human Services is required before this service can be authorized.

Service Tasks/Activities

Care coordination is the primary responsibility of the QSP Agency Program coordinator. Authorized task includes:

1. Individual program Plan (IPP) Development, Coordination, Implementation and Evaluation.
 - a. Complete tasks such as individual plan development, monitoring the plan and observing to assure that the agency staff are trained, and the program is implemented, assisting with the development of behavior support techniques, assuring appropriate permission and approval is received from the individual and/or the legal decision maker.
 - b. Professional services are included in the "care coordination" hours and are not to be included in determination of direct support service hours.

Care coordination functions provided by the QSP agency include:

1. Management of an individual's property and resources including household budgeting, money management, communicating with creditors and landlords, etc.,
2. Application for generic services, monitoring status of those services, and maintaining communication with families, guardians, and other involved persons and agencies,
3. Coordinating medical needs,
4. Designing and implementing programs to enhance self-direction, independent living skills, community integration, social, recreational, and leisure skills and opportunities, and behavior management,
5. Facilitating the IPP planning process,
6. Assessing effectiveness of personal independence development strategies and other support services through analysis of information, consultation with the individual and/or guardian and family members, and observation of the person's programs and service settings,
7. Asserting and safeguarding the individual's human and civil rights, and
8. Attending to psychosocial needs of the individual.

Hours for direct staff time for personal supports include:

1. General supervision for safety and health monitoring and maintenance,
2. Homemaking which may include home maintenance,
3. Assistance with activities of daily living and instrumental activities of daily living
 - a. bathing
 - b. communication
 - c. dressing/undress

- d. eyecare
- e. feeding/eating
- f. haircare/shaving
- g. housework
- h. incontinence
- i. laundry
- j. meal preparation
- k. mobility (inside/outside)
- l. Money Management
- m. nailcare (fingernails)
- n. shopping
- o. skincare
- p. teeth/mouth care
- q. toileting
- r. transferring/turning/positioning

4. Global Endorsements tasks

- a. exercises
- b. hoier lift/mechanized bath chairs
- c. indwelling catheter
- d. medical gases
- e. prothesis, orthotics
- f. suppository, bowel program
- g. TED socks
- h. vitals

5. Client specific endorsements

- a. apnea monitor
- b. JOBST stockings
- c. ostomy care
- d. postural/bronchial drainage
- e. RIK bed care

6. Medication administration

- a. Under this chapter employees of an enrolled community support services QSP agency who have received Department approved training may administer routine medications to recipients even if they are unable to self-direct their care. The QSP agency must employ or contract with a licensed registered nurse who provides supervision to the employees who are administering routine

medications. The licensed nurse determines competency in medication administration by the employee's successful completion of the Department approved medication practicum. This does not include medications administered through a parenteral route (e.g. intravenous or intramuscular injections). The licensed nurse is responsible for ensuring that medications have been administered correctly according to the six rights of medication administration (individual, dose, time, route, medication, documentation), and that documentation is completed accurately.

- b. The QSP agency must have a training protocol and policy established for the administration of all medications, including PRN medications. The registered nurse is responsible for the training and oversight of all medication administration.
 - c. The licensed registered nurse employed by the QSP agency may perform medication set-up.
7. Transportation to support medical, social, and essential community services.
 8. Accompanying individual to medical appointments.

Hours for direct staff time for personal independence development:

1. Development of natural supports,
2. Activities and strategies to promote community inclusion/integration, leisure skill development, including activities to facilitate socialization and recreation that are tied to a therapeutic goal, and
3. Support and adaptive strategies to enhance the person's control and independence over environment, resources, activities, and self-care.

Authorization for Services

1. The service tasks/activities within the scope of this service chapter must be identified in the assessment and on the Preauth.
2. An Individual Program Plan (IPP) as outlined in the Community Supports provider standards must be developed by the authorized QSP agency and maintained in the individual's file. An IPP is an individualized plan that describes the goals, wants, needs, and

strengths of the person. It describes in detail how the QSP agency is supporting the individual.

- a. Service task and activities must be tied to an individual's goals as determined through the person-centered planning process.
- b. The IPP must correlate with the person-centered plan and services authorization that is completed by the HCBS Case Manager.
- c. The IPP must be developed by the QSP Agency Program Coordinator within the first 30 days of service provision and forwarded to the case manager and every 6 months thereafter.
- d. The IPP must be approved by the state program administrator.
- e. The IPP must include:
 - i. A plan for promotion of the individual's independence in ADLs and IADLs, social, behavioral, and adaptive skills,
 - ii. Tasks being provided which should match the authorization provided by the HCBS case manager,
 - iii. A medication list if medication administration is authorized and description of how medications are being managed;
 - iv. Medical diagnoses;
 - v. A therapeutic goal for community integration activities which would include companionship and socialization activities. The individual should be involved in goal setting and ideas for these activities;
 - vi. Temporary absences and requests for retainer payments. Including any requests for retainer payments and dates of absences submitted to HCBS Program Administration for retainer payment authorization.
 - Note: Retainer payments cannot exceed 30 days per year.
 - vii. Signature of the agency care coordinator and date.

Allowable Service Combinations

Chore, ERS, Environmental Modification, Adult Day Care, Supported Employment, Extended Personal Care includes Nurse Education, Home Delivered Meals, Transition Coordination, and/or Specialized Equipment.

Limits

Community Support Services may not be authorized with Respite Care, Homemaker, Adult Foster Care, Family Home Care, Personal Care, Family Personal Care, Adult Residential, Transitional Living, Attendant Care, Supervision, Companionship, Community Support Services and Non-Medical Transportation. For unusual or unique circumstances, contact the Aging Services Program Administrator for approval consideration.

1. This service shall not be used solely for the purpose of supervision or emergency assistance on a 24-hour basis.
2. Supervision may not be authorized in excess of what is necessary for health and safety.
 - a. For example, the family is requesting that someone stay with their relative 24 hours a day when there is not a safety or health risk other than the possibility that something might happen.
3. Twenty-four hour supervision in a shared living environment- Continuous supervision by paid staff on a one to one basis is not available unless shared staffing arrangements would create a safety threat to the individual or others. This level of service may only be provided as a last resort. All possible strategies for shared or reduced levels of supervision must be ruled out first.
 - a. A 'safety threat' means the individual is so aggressive, self-destructive, or requires such close supervision that any attempt to share one on one staff at any time will place the individual at immediate risk.
 - b. Shared tasks will be considered in a shared living environment, and may affect the daily rate for these services (e.g. housekeeping of common areas, shared meals preparation, and overnight supervision).
4. This service does not include payment for non-medical transportation costs.
5. Payment for Community Support Services does not include room and board, or the cost of facility maintenance and upkeep.
6. Rate for this service and any additional waiver services cannot exceed the current highest daily rate for skilled nursing facility care.

7. Access of services or goods outside of the local area if the same service and goods are available in their local community.
 - a. For example, a grocery store is available in the local community, but the consumer wants to drive to a larger community because they prefer that location, even though the product and cost is the same at both locations.
8. Travel and direct support outside of the individual's community of residence for vacations, family events and socialization unless approval from an HCBS Program Administrator is received.
9. Direct support time is not available for any time which coincides with the recipients using adult day or other authorized services.
10. A personal assistance retainer payment is allowed for reimbursement during a participant's temporary absence from the setting. The personal assistance retainer allows for continued payment while a participant is hospitalized (acute hospital stay) or otherwise away from the setting in order to ensure stability and continuity of staffing up to thirty calendar days per year per participant.
 - o Absences do not include absences due to the individual receiving care in a skilled nursing facility (SNF) or Swingbed facility.

Program Administration enters the Preauth upon request from the provider verifying the dates the individual is temporarily absent from the integrated setting.

The provider must review the retainer payments in the IPP that is completed every 6 months.

This process is handled administratively through the approval of Residential Habilitation and Community Supports.

Providers

Community Support Services may **NOT** be provided by the following employees of a QSP agency:

- Legal spouse

Standards for Providers

Service must be provided by an enrolled Medicaid Agency. Individual QSP are not eligible to provide this service.

Community Support Service providers must be:

Agency QSPs enrolled under NDAC 75-03-23 may include Licensed community support services DD Providers- Licensed according to NDAC 75-04-01 who meet additional enrolment requirements and meet the following:

1. Provider must ensure that staff are adequately trained and qualified as evidenced by:
 - a. Written job descriptions for employees that include plans for participation in training and include requirements for education, experience, and skills,
 - b. Documentation of competency or employed by a Licensed DD provider according to NDAC 75-04-01,
 - c. Department approved training on Traumatic Brain Injury (TBI) and dementia,
 - i. In-service training to direct contact staff by the program coordinator on implementation of individual's programs and observation of implementation in the service setting.
 - ii. To assure staff meet minimum training requirements, TBI and dementia training must be completed within 30 days of providing care to an individual under community supports.
 - iii. Staff must complete TBI and dementia training every 2 years.
 - d. Completion of Minot State University medication modules, testing and practicum. Written test is proctored and completed in person. Practicum is administered by a licensed registered nurse employed or contracted through the Agency Provider.
 - i. Staff must complete department-approved training on the administration of routine medications before administering routine medications. This includes cueing/reminding the individual to take medication.

- ii. Staff must demonstrate continued competency in medication administration by completing medication practicum with agency RN once yearly and as needed. Staff must complete the practicum checklist specific to the type of medication administration they will be completing (example: if administering an enema, staff must complete the practicum checklist for the administration of an enema prior to administration and yearly).
- e. Agency must name a Program coordinator. Program coordinator requirements:
 1. Must have at least one year of experience working directly with persons with physical disability; and
 2. Is one of the following:
 - a. A doctor of medicine osteopathy,
 - b. a registered nurse, or
 - c. an individual who holds at least a bachelor's degree and who is licensed, certified, or registered as applicable, to provide professional services by the State in which he or she practices (e.g. social worker, occupational therapist, psychologist, physical therapist, etc.).

An individual with a "bachelor's degree in a human service field" means an individual who has received: at least a bachelor's degree from a college or university (master and doctorate degree are also acceptable) and has received academic credit for a major or minor coursework concentration in a human service field (including, but not limited to: sociology, special education, rehabilitation counseling and psychology)

- d. Other:
 - i. An individual who has a bachelor's degree; and
 - ii. completes the department approved TBI and Dementia training; and
 - iii. has one year of experience working with individuals with a physical disability.

3. Ensures quality programs/services for the people supported in the employing agency.
4. Responsible for development of the IPP.

Community Support Service agency providers may employ legally responsible individuals to provide Community Support Service. The following criteria applies when an agency employs a legally responsible person or family member as a staff to provide Community Support Service.

- Community Support Service cannot be provided by spouses,
- Community Support providers or staff cannot live with the care recipient.
- The legal guardian or family member must meet all the required qualifications of a Community Support Service staff member.
- If the legally responsible person wants to provide services as an employee of the provider and has decision making authority over the recipient, the case manager must pre-approve the arrangement with the HCBS Program Administrator for Community Support Service.
- The case manager is responsible to forward a copy of the narrative that explains why the legally responsible person providing the services is in the best interest of the client to the State Medicaid Agency.

The narrative must also be attached to the client's individual care plan when it is submitted to the State.

2. Council on Quality & Leadership (CQL) Accredited

- a. Provider must become CQL accredited. Refer to Council on Quality and Leadership (CQL) Accreditation Policy, see 525-05-47.

Involuntary Discharge of an Individual under Community Support Services:

Involuntary discharge occurs when a Community Support Services provider has decided to discontinue services and terminate supports even though the individual has not requested the termination of services. Any opportunities to prevent an involuntary discharge should be explored prior to the discharge by the provider. Community Support Services providers must have written policies and procedures that define the conditions of termination and transfer of an individual's services. Individuals and/or legal

decision makers should receive a copy of the provider's policy at the time of admission to the provider agency and again when a discharge is being considered.

In the case of an involuntary discharge, the Community Support Services provider is required to give a thirty (30) day written discharge notice to the individual, unless the individual chooses to discontinue the services earlier, schedule a team meeting with the individual and HCBS case manager, and complete a written discharge summary. The timing of the thirty (30) day notice begins the date that the team meeting occurs. The written discharge notice must include the reason for discharge and why the provider cannot continue to serve the individual. A copy of the thirty (30) day notice and the written discharge notice must be forwarded to the HCBS Case Manager. The Community Support Services provider must also file a Critical Incident Report. Any opportunities to prevent discharge should be explored prior to discharge by the provider.

Settings where service can be provided

This service may be provided in a private family dwelling or in a licensed adult foster care home N.D.A.C. 75-03-21.1 that is approved to provide this service. The HCBS settings rule applies to all agency foster homes and the setting must be fully compliant before services can begin.

Services will be administered in the most integrated setting consistent with the Person-Centered Plan of Care, including (**checked if allowable**):

- ✓ **The individual's home**
- ✓ **Workplace**
- ✓ **Other community service settings**

Maximum Room and Board Rate effective 7-1-20~~23~~24

The current maximum monthly room and board rate that providers may charge community support services recipients is ~~\$884.00~~ **1,005**. The maximum room and board rate is equal to the current Medicaid medically needy income level for a one person household less a \$125 personal needs allowance. The rate is reviewed annually.

Providers are not required to charge a room and board rate and may choose to charge less than the maximum rate.

Extended Personal Care Service 525-05-30-27 **(Revised 037/01/2024 ML #~~3829~~3847)**

Legal Authority

[N.D. Admin. Code 54-05-01](#)

[N.D. Admin. Code 54-05-02](#)

Purpose

The purpose of Extended Personal Care Services (EPCS) is to complete tasks that are medical in nature and specific to the needs of an eligible individual. Approval to complete these tasks is provided by the Nurse Educator who has provided training to the EPCS Provider and is enrolled with the Department to provide Nurse Education. Or, if a necessary medical task is too complex to be taught to an unlicensed provider the nurse may provide the service directly to the individual. Services that must be provided by a licensed nurse include but are not limited to nurse assessments, care planning, care coordination, training, periodic review of individual's care needs, medication set up, foot care, feeding tubes, changing, and flushing catheters, bowel programs that include manual removal of waste and bowel stimulation, or the provision of direct care that is too complicated to delegate to an extended personal care provider.

Per [NDAC 54-05-01](#) and [54-05-02](#): The initial or comprehensive nursing assessment shall be completed and implemented by an RN. The RN will develop a nursing plan of care based on the assessment and medical diagnoses and can provide education on nursing interventions for which the QSP has the necessary skills and competence to accomplish safely.

Approval of the Nursing Plan of Care is required by the R.N. Program Administrator, **before** implementing the service.

This service may include nursing care to the extent permitted by state law under [NDCC 43-12.1](#) and [NDAC 54-05](#), which will maintain the health and well-being of the individual and allow the individual to remain in the community. EPCS are services that an individual without a functional

disability would customarily and personally perform without the assistance of a licensed health care provider, such as administration of medications, or wound care.

Service Eligibility, Criteria for:

The individual receiving EPCS must be:

1. Eligible for the Medicaid Waiver for Home and Community Based Services or Service Payments to the Elderly & Disabled.
2. Competent to participate in the education of the Extended Personal Care Service Provider by the Nurse Educator or have a legally responsible representative directly participate in the process.
3. The need for EPCS is limited to individuals who have a cognitive or physical impairment that prevents them from performing extended personal care service activities.
4. Requires skilled or nursing care that requires training by a nurse licensed under NDCC 43-12.1.
5. Have an informal caregiver support system to provide contingency (backup) care in case of the absence of EPCS providers.
6. Be competent to actively participate in the development and monitoring of their individual care plan or have a legally responsible party available to participate.

Service Location

Services will be administered in the most integrated setting consistent with the Person-Centered Plan of Care, including (**checked if allowable**):

- ✓ **The individual's home**
- ✓ **Workplace**
- ✓ **Other community service settings**

Authorization for Service

1. The initial Request for Extended Personal Care Services (written request by the HCBS Case Manager), Individual Care Plan, Authorization to Provide Services, and Nursing Plan of Care (NPOC) (including documentation of education provided for tasks, monitoring plan, and instructions for incident reporting) must be pre-approved by the Extended Personal Care Service (EPCS) RN Program Administrator, Adult & Aging Services Section. The HCBS case

manager is responsible to submit/upload the completed documents to the electronic record.

2. The Authorization and NPOC must be updated and reviewed at the six-month level by the Extended Personal Care Service (EPCS) RN Program Administrator, Adult & Aging Services Section. The HCBS case manager is responsible for uploading the completed documents to the electronic record for review and approval by Adult & Aging Services/HCBS. The NPOC must be approved by the Extended Personal Care Service (EPCS) RN Program Administrator before pre-authorizations are entered to provide Extended Personal Care Nurse (S5115-TD) or Extended Personal Care (S5115) into the electronic record.
3. The Individual Care Plan, Authorization, and NPOC must be completed and reviewed every six months by the Extended Personal Care Service (EPCS) Program Administrator, Adult & Aging Services Section. The HCBS case manager is responsible to submit/upload the completed documents to the electronic record.

Service Delivery

EPCS and Nurse Education are provided in accordance with the nursing plan of care (NPOC), developed by the individual and the RN Nurse Educator, to meet the identified needs of the individual. The Case Manager is responsible to complete the Individual Care Plan and Authorization taking into consideration the needs identified in the NPOC.

The EPCS individual or their legally responsible person is required to identify and oversee their EPCS providers. The individual, with the assistance of the HCBS Case Manager, must develop a contingency plan to assure health, welfare, and safety in the event the individual's care needs change or providers are not available.

The RN Nurse Educator must complete and send the following forms to the HCBS Case Manager

1. Nursing Plan of Care (SFN 807)
 - o Completed by RN, initially, and every 6-months while services are in place.
 - o Comprehensive assessment must be completed face-to-face with the individual by the RN.
 - o Billing service code

- POC and Nurse Educator training: S5108.
 - Nurse completing the medical task: S5115-TD.
 - Non-nurse QSP completing medical task: S5115
2. Extended Personal Care Services (EPCS) Provider Training Procedure Agreement (SFN 576) completed by all trained staff and RN Nurse Educator.
 3. If the Nurse Educator is training staff, use NE code S5108 for the training time only.
 4. Update NPOC if there are changes in the individual's instructions before the 6-month assessment is due. RN Nurse Educator must send updated NPOC to HCBS Case Manager for EPCS RN Program Administrator approval.

The HCBS Case Manager will upload all forms into the electronic record for the EPCS RN Program Administrator's review.

NPOCs will not be approved until all forms are received accurate and signed by the RN Nurse Educator, if applicable.

Incidents

The Nurse Educator provides written documentation to the Department that shows he or she has provided instructions to the EPCS Provider that outlines the types of situations that are considered reportable incidents, and instructions on who should be contacted, and this may include contacting the individual's primary health care provider for instruction and then contacting the HCBS Case Manager. If the HCBS Case Manager and Nurse Educator determine that the incident is indicative of abuse, neglect, or exploitation, the HCBS Case Manager must immediately report the incident to the Department. The Case Manager must also follow the policy found in HCBS Case Management [525-05-30-05](#), Monitoring for Abuse, Neglect, or Exploitation. The incident plan needs to be updated on an annual basis and a copy provided to the Extended Personal Care Service (EPCS) Program Administrator.

Limits

1. Units for routine assessments for the health and welfare of the individual, incident reporting, assistance with activities of daily living (ADLs) and instrumental activities of daily living are not part of this service.

2. Due to the complexity of the care provided to individuals receiving Extended Personal Care Services, contingency plans are required as a prerequisite to receive this service to assure that health welfare and safety are maintained if a provider is unavailable to provide the service.
3. The Nursing Plan of Care (NPOC) assessments must be done face to face to assure the health, welfare, and safety needs of the individual are met.
4. Vital signs may only be authorized under EPCS if a written order from an outside agency medical practitioner is obtained with the frequency and parameters listed. The HCBS Case Manager must keep a current order for vital signs in the electronic record.
5. Authorized EPCS approvals are nontransferable between QSP Agencies or individual QSPs.
6. Virtual Supports Option may only be utilized after approval from a EPCS RN Program Administrator. The EPCS RN Program Administrator will document approval.

Providers

Extended Personal Care Services may be provided by the following individual QSP or employees of a QSP agency (**checked if allowable**):

Guardian

✓Legally Responsible Person - Legal spouse or parent of a minor child.

✓Relative within the definition of Family Home Care under subsection 4 of N.D.C.C. 50-06.2-02.

Per [NDAC 54-05-01](#) and [54-05-02](#): The initial or comprehensive nursing assessment shall be completed and implemented by an RN.

1. The RN will develop a nursing plan of care based on the assessment and diagnoses.
2. The RN provides education on nursing interventions that the QSP Provider has the necessary skills and competence to accomplish safely.

The LPN can:

1. Participate in the development, evaluation, and modification of the nursing plan of care.

2. Conduct a focused nursing assessment and contribute that information to the nursing plan of care.
3. Provide education on nursing interventions for which that QSP provider has the necessary skills and competence to accomplish safely. **The NPOC must be signed by an RN.**

Service Activities, Authorized and Limits

1. Documentation outlining the tasks the nurse has trained the Extended Personal Care Service Provider on are maintained by the Nurse and a copy is sent to the HCBS Case Manager. A copy of the training documentation form is also given to the trained Extended Personal Care Provider listing the tasks to be completed. The Case Manager notes the units authorized by the EPCS Program Administrator.
2. If a necessary medical task is too complex to be taught to an unlicensed provider, the nurse may be paid to provide the service directly to the individual. Services provided by a licensed nurse include but are not limited to nurse assessments, care planning, training, periodic review of individual care needs, care coordination, medication set up, foot care, feeding tubes, changing, and flushing catheters, bowel programs that include manual removal of waste and bowel stimulation, or the provision of direct care that is too complicated to delegate to an extended personal care provider.
3. The nurse educator will provide at a minimum, a review of the individual's needs every six months to determine if additional training and or tasks are required.
4. If the nurse educator fails to provide six-month NPOC service documents the HCBS Case Manager and EPCS Nurse Program Administrator will re-educate the EPCS nurse educator. If the documents are not provided to the Department after re-education has been provided to the Nurse Educator, a Qualified Service Provider (QSP) complaint will be filed with the QSP Complaints Program Administrator.
5. Nurse education service may be provided remotely through virtual supports as determined necessary to ensure services are delivered while considering participant choice, compliance with CMS requirements and identified in the participant's person-centered plan.

If the participant requires hands on assistance for a specific task, then virtual supports service delivery cannot be an option for that task but may be utilized for other tasks that do not need hands on support.

Examples of when Nurse Education, virtual supports **MAY** be used:

- Toenail Care
- Vitals when ordered by a physician
- Bowel program
- Compression Wraps
- Nebulizers
- Topical prescriptions

Examples of when Nurse Education, virtual supports may **NOT** be used:

- Medication Set-up – Required by the Nurse
- Tubes, wounds and suctioning tasks
- Lab work
- Colostomy Care
- Injections

Requirements for utilizations of Nurse Education – Virtual Supports

- Virtual Supports require the initial NPOC has been completed in person with the provider, individual and other team members during the person-centered planning process.
 1. The NPOC will ensure that the planning process has considered service needs and if these needs can be met by using a virtual supports method of service delivery.
 2. The NPOC includes a Virtual Support Checklist will be required to be completed by the Nurse Educator and the team during the person-centered planning process.
 3. This checklist will act as a safeguard to ensure virtual supports can help meet the needs of the participant in a way that protects the right to privacy, dignity, respect, and freedom from coercion.
 4. Any issues will be addressed prior to the implementation of remote supports. The checklist will ensure that the planning process has considered service needs and if these needs can be met by using a virtual supports method of service delivery.

5. The Virtual Support Checklist will include consideration of the estimated hours/visits that virtual supports delivery will be utilized.
- The risk assessment and service plan require the team to develop a plan to address health, safety, and behavioral needs while remote supports are utilized so appropriate assistance can be provided.
 - In virtual supports, the use of cameras in bathrooms or bedrooms impacting the participant's dignity and privacy is not permitted.
 - Virtual supports reinforce community integration by encouraging the participant to engage in community life as independently as possible and to be able to safely engage in activities in his or her home or in the community without relying on the physical presence of staff to accomplish those activities.
 - The participant's services may not be delivered via virtual support 100% of the time.
 - The participant must always have the option to request in-person services. The amount of time chosen shall be determined during the person-centered planning process and outlined in the Individual Program Plan (IPP).
 - Provider must use a HIPAA compliant service delivery method (e.g. Microsoft Teams, Zoom for Healthcare). HIPAA rules apply to all covered entities regarding HIPAA Privacy and Security.
 - Participant will be given education and support on the use of virtual supports by their chosen provider. Virtual supports are not a system to provide surveillance or for staff convenience.

Family Home Care 525-05-30-30

(Revised ~~03~~ 7/01/2024 ML #~~3829~~3847)

Purpose

The purpose of family home care is to assist individuals to remain with their family members and in their own communities. It provides an option for an individual who is experiencing functional impairments which contribute to his/her inability to accomplish activities of daily living.

Service Eligibility, Criteria for

The individual receiving Family Home Care will meet the following criteria:

1. Must be eligible for the SPED or ExSPED program.
2. The individual and the family member must reside in the same residence.
3. The individual and the family member must mutually agree to the arrangement.
4. QUALIFIED SERVICE PROVIDER (QSP) SERVICE AGREEMENT -LIVE IN PAID CAREGIVERS, SFN 1654, is required for all Family Home Care providers.
5. The [family member](#) must be one of the relatives as defined in Family Home Care N.D.C.C [50-06.2-02\(4\)](#), and must be the provider performing the care to the individual. Family Home Care can be provided by the "spouse or by one of the following relatives, or the current or former spouse of one of the following relatives, of the elderly or disabled person: parent, grandparent, adult child, adult sibling, adult grandchild, adult niece, or adult nephew."
6. The need for services must fall within the scope of tasks that includes bathing, communication, dressing/undressing, eye care, feeding/eating, hair care/shaving, housework, incontinence, laundry, meal preparation, medication assistance, mobility, money management, fingernail care, shopping, skin care, teeth/mouth care, toileting, transferring/turning/positioning, supervision, exercises, hoyer lift/mechanized bath chairs, indwelling catheter, medical gases, prosthesis/orthotics, suppository/bowel program, TED socks, temp/bp/pulse/respiration rate, apnea monitor, jobst stockings, ostomy care, postural/bronchial drainage, and RIK bed care. The identified tasks for the individual are listed on the service authorization.
 - a. The FHC provider is not required to have global endorsements or client specific endorsements.
 - b. The FHC provider may be authorized for medication administration even if the individual is not able to self-direct their medications.
7. The individual must have a daily personal care and/or supervision need that is provided by the FHC provider.
8. The provider for FHC must provide a minimum total of one (1) hour of care to the eligible individual per day. The one hour per day includes the daily personal care or supervision need and any other allowable task under FHC.

- a. The one hour of care per day may include homemaker tasks within the limits allowable under SPED.
9. The number of reimbursable hours of care for this service cannot exceed 10 hours per day.
10. The individual does not qualify for Family Personal Care (FPC). If an individual receives or would be eligible for Medicaid and meets level of care screening, FPC must be sought as opposed to Family Home Care (FHC).

Exception: If authorizing FPC would be detrimental to the household and FHC is preferred, contact Program Administrator for consideration.

Note: A provider who is on Medicaid is not allowed to request a lower rate than what is calculated based on the service recipient's needs. Per Medicaid guidelines: if a provider is on Medicaid, all income available to that provider must be considered and counted.

- If a provider on Medicaid has questions about how payment will affect their eligibility, they should refer to their eligibility worker.
- If a provider receiving other financial assistance such as TANF, SNAP, housing assistance, SSI, etc. has questions about how payment will affect their eligibility, they should refer to the authorizing entity.

Note: If FHC is preferred, FPC does not need to be sought if:

The cost of FHC services is less than ~~\$311~~ 233 a month.

Note: If FHC is preferred, FPC does not need to be sought if:

The individual's Medicaid was closed due to not meeting recipient liability, or it is clear they would not meet recipient liability (after summing the medical expenses, plus the case management, plus Medicaid waiver services).

A flat rate of no more than the current maximum room and board rate per month has been established for room and board. The individual is responsible for paying the Qualified Service Provider (QSP) directly for room and board IF the individual lives in the provider's home.

Service Tasks/Activities - Family Home Care

Tasks of laundry, shopping, housekeeping, meal preparation, money management, and communication are allowed only when the service

activity benefits the individual. The service of family home care is not intended to be used primarily for environmental tasks. The individual must have a daily personal care and/or supervision need to qualify for this service.

The department may pay a provider for homemaker tasks that would otherwise be considered the individual's share of the responsibility to complete the task. An example of this would be authorizing housekeeping for the individual's personal private space OR their shared responsibility of cleaning the common living space.

Family Home Care Limitation, Under 18 Years of Age

In addition to the eligibility criteria set forth above, the following conditions must be met by the under 18 year old potential recipient of family home care AND caregiver/qualified service provider. If the conditions cannot be met, the individual under 18 years of age is NOT eligible for Family Home Care:

1. The provider must be either the parent or spouse of the individual who is under the age of 18.
2. The caregiver/qualified service provider provides continuous care to the child. That is, the individual's/child's disability prohibits his/her participation in programs and/or activities outside the home; the child is unable to regularly attend school OR is severely limited in the amount of time at school. (The relationship to school attendance applies even when school is not in session; would the child be able to attend school and to what extent if it were in session.) If it appears that the child may be eligible for DD services, an application must be made to the DD Division to make this determination prior to consideration of SPED. There must be documentation that application was made for DD services, and a copy of the denial letter be placed in the individual's file. A letter saying the applicant/child is not receiving DD services is not sufficient.

Service Location

Services will be administered in the most integrated setting consistent with the Person Centered Plan of Care, including (**checked if allowable**):

- ✓ **The individual's home**
- ✓ **Workplace**
- ✓ **Other community service settings**

Out of Home Care

Payment can be made for days the individual is receiving the SAME care from the SAME caregiver-QSP although not in the home they otherwise mutually share. For care out of state, prior approval must be granted by the HCBS Program Administrator. No payment is allowed for care provided outside of the country.

Provider Need Not be Present in the Home on a 24-Hour Basis

This provision within the Family Home Care service is appropriate for individuals who can be left alone for routine temporary periods of time (e.g. part-time employment of the qualified family member) without adverse impact to the individual's welfare and safety. The individual must agree to be left alone.

- This provision does NOT allow for the qualified family member to hire a provider to provide care for the individual during routine absences from the home.
- This provision does not allow a provider to work full time unless the arrangement has been approved by an HCBS Program Administrator and assures the individual's continued health and safety.

Service Combinations

Family home care is an inclusive 24-hour service. Therefore, respite care service along with family home care is acceptable as described under the following circumstances:

1. There is full-time family home care service provided by a qualified family member. When the family member provides less than 24-hour per day care on a routine basis, respite care is only appropriate when the qualified family member's absence occurs outside the routine scheduled absences, for example, to attend a wedding.
2. If individuals cannot be safely left alone so that the provider can take necessary breaks away from their caregiving responsibilities respite must be authorized.

If supervision is an authorized task on the MRW, respite care must be an authorized service, as it is not reasonable to allow one provider to be responsible for 24 hours of care per day.

- Respite care must be authorized because FHC providers cannot delegate their care to another individual if the individual cannot be safely left alone.
 - If informal respite is in place and of benefit to the individual and the family home care provider, the case manager must document that formal respite care was offered and declined.
3. Emergency response is acceptable if a safety risk (i.e. potential fall risk or sudden illness) has been identified during the FHC provider's short term absence. ERS is not acceptable for individuals who require supervision for cognitive or health related reasons. ~~Contact the HCBS Program Administrator in writing to obtain approval for the combination of FHC and ERS service.~~
 4. For some situations, it may be appropriate for two Family Home Care providers to be authorized to provide care to one individual if both providers meet the Family Home Care definition. However, both Family Home Care Providers cannot bill for the service on the same day.
 5. Under unusual or unique circumstances other HCBS service combinations may be appropriate. In such cases, contact the HCBS Program Administrator in writing to obtain approval.

Providers

Family Home Care may be provided by the following individuals (**checked if allowable**):

✓ **Guardian**

✓ **Legally Responsible Person - Legal spouse or parent of a minor child.**

✓ **Relative within the definition of Family Home Care under subsection 4 of N.D.C.C. 50-06.2-02. (Required)**

Limits

If the provider is a live-in provider and meets the criteria for FHC, the individual is not eligible for SPED PC Daily Rate.

The number of reimbursable hours of care for FHC cannot exceed 10 hours per day.

1. The provider may provide more care than 10 hours, but the State is not obligated to pay because that care is being provided because of their close personal relationship and that they share a household with the eligible individual.

Family Personal Care 525-05-30-32

(Revised 037/01/2024 ML #~~38293847~~)

Purpose

The purpose of family personal care (FPC) is to assist individuals to remain with their family members and in their own communities by allowing individuals who want to choose their spouse or one of the following family members as defined under N.D.C.C. 50.06.2-02; parent, grandparent, adult child, adult sibling, adult grandchild, adult niece, or adult nephew, as their family personal care service provider.

Service Eligibility, Criteria for

The individual receiving Family Personal Care will meet the following criteria:

1. Must be eligible for the HCBS Medicaid Waiver program.
2. The individual and qualified provider (who is a qualified family member and is enrolled as a personal care provider) must reside in the same residence.
 - a. The qualified family member must be one of the relatives as defined in Family Home Care N.D.C.C 50-06.2-02(4), and must be the provider performing the care to the individual. Family Personal Care can be provided by the "spouse or by one of the following relatives, or the current or former spouse of one of the following relatives, of the elderly or disabled person: parent, grandparent, adult child, adult sibling, adult grandchild, adult niece, or adult nephew."
3. Before a legally responsible individual who has decision making authority over an individual can be enrolled as a qualified service provider for Family Personal Care, the Case manager must approve the choice of provider. The case manager is responsible to forward to the HCBS Program Administrator a copy of the narrative that explains why the legally responsible person acting as the family personal care provider is in the best interest of the individual. A legally responsible individual would include a Legal Spouse or Guardian.
4. The individual and qualified provider must mutually agree to the arrangement. The provider indicates their agreement with the care plan by signing the Person-Centered Plan of Care.

- a. In addition to the FPC providers signature on the care plan the Qualified Service Provider (QSP) Service Agreement - Live In Paid Caregiver, SFN 1654, is required for all Family Personal Care Providers.
5. The individual must have a daily personal care and/or supervision need that is provided by the family personal care provider.
 - a. When determining whether the individual has a daily personal care or supervision need, **do not include** homemaker tasks such as assistance with meal prep, laundry, shopping, housework, money management, or communication as part of the daily need.
6. The provider for FPC must provide a minimum total of three (3) hours of care to the eligible individual per day. The three (3) hours per day includes the daily personal care or supervision need and any other allowable task under FPC.
 - a. The three hour of care per day may include homemaker tasks within the limits allowable under Medicaid Waiver.
 - b. If family member is providing less than 3 hours of care per day, (including homemaker tasks allowable under the service cap) live-in care is to be provided under MSP-PC, T1020 with a provider agreement as long as the provider is eligible for MSP-PC.
 1. Three (3) hours per day may be calculated by taking the total number of units required per month x 12, divided by 365.
7. The number of reimbursable hours of care for this service cannot exceed 10 hours per day.
8. The need for services must fall within the scope of tasks identified on the Authorization to Provide Services, otherwise known as the Preauth.
9. Individuals with Live in Providers (except for Spouses or legal Guardians) may choose to have their services Under Medicaid State Plan Personal Care – Daily Rate (T1020). MSP-PC Note that T1020 does not include reimbursement for the task of supervision, but does reimburse for personal cares.

Service Tasks/Activities

The service tasks/activities within the scope of this service chapter are all inclusive, including personal care, cog/supervision, and homemaker.

1. Family personal care tasks include bathing, communication, dressing/undressing, eye care, feeding/eating, hair care/shaving, housework, incontinence, laundry, meal preparation, medication assistance, mobility, money management, fingernail care, shopping, skin care, teeth/mouth care, toileting, transferring/turning/positioning, supervision, exercises, hoist lift/mechanized bath chairs, indwelling catheter, medical gases, prosthesis/orthotics, suppository/bowel program, TED socks, temp/bp/pulse/respiration rate, apnea monitor, jobst stockings, ostomy care, postural/bronchial drainage, and RIK bed care. The identified tasks for the individual are listed on the service authorization.
 - a. The FPC provider must have global endorsements in order to be authorized for supervision, exercises, hoist lift/mechanized bath chairs, indwelling catheter, medical gases, prosthesis/orthotics, suppository/bowel program, TED socks, and temp/bp/pulse/respiration rate.
 - b. The FPC provider must have client specific endorsements in order to be authorized for apnea monitor, jobst stockings, ostomy care, postural/bronchial drainage, and RIK bed care.
 - c. The FPC provider may be authorized for medication administration even if the individual is not able to self-direct their medications.
2. Homemaker tasks of laundry, shopping, housekeeping, meal preparation, money management, and communication are allowed only when the service activity benefits the individual.
 - a. The service of family personal care is not intended to be used primarily for environmental tasks. The individual must have a daily personal care and/or supervision need to qualify for this service.
 - b. The Department may pay a provider for homemaker tasks that would otherwise be considered the individual's share of the responsibility to complete the task. An example of this would be authorizing housekeeping for the individual's personal private space OR their shared responsibility of cleaning the common living space.

Service Location

Services will be administered in the most integrated setting consistent with the Person Centered Plan of Care, including (**checked if allowable**):

- ✓ **The individual's home**

□ Workplace

✓ **Other community service settings**

Out-of-Home Care

Payment can be made for days the individual is receiving the SAME care from the SAME caregiver-QSP although not in the home they otherwise mutually share.

1. For care out of state, prior approval must be granted by the HCBS Program Administrator for each instance of out of state care.
2. No payment is allowed for care provided outside of the United States.

Provider need not be Present in the Home on a 24-Hour Basis

This provision within the Family Personal Care service is appropriate for individuals who can be left alone for routine temporary periods of time (e.g. part-time employment of the qualified family member) without adverse impact to the individual's welfare and safety. The individual must agree to be left alone.

- This provision does NOT allow for the qualified family member to hire a provider to provide care for the individual during routine absences from the home.

Limitations

Family Personal Care cannot be combined with adult residential care, adult foster care, and transitional living.

1. The number of reimbursable hours of care cannot exceed 10 hours per day.
 - The provider may provide more care than 10 hours, but the State is not obligated to pay because that care is being provided because of their close personal relationship and that they share a household with the eligible individual.
2. Under FPC, the tasks of housework, laundry, meal prep, shopping, money management, and community are considered homemaker tasks and are limited to the maximum monthly amount set by the Department.

Providers

Family Personal Care may be provided by the following individuals is provided by the live-in-qualified family member. The family member may also have the following relationship to the eligible individual (checked if allowable):

✓ **Guardian**

✓ **Legally Responsible Person - Legal spouse or parent of a minor child**

✓ **Relative within the definition of Family Home Care under subsection 4 of N.D.C.C. 50-06.2-02. (Required)**

Note: A provider who is on Medicaid is not allowed to request a lower rate than what is calculated based on the service recipient's needs. Per Medicaid guidelines: if a provider is on Medicaid, all income available to that provider must be considered and counted.

- If a provider on Medicaid has questions about how payment will affect their eligibility, they should refer to their eligibility worker.
- If a provider receiving other financial assistance such as TANF, SNAP, housing assistance, SSI, etc. has questions about how payment will affect their eligibility, they should refer to the authorizing entity.

Service Combinations

Family Personal Care is an all-inclusive 24-hour service. Therefore, respite care service and Emergency Response System (ERS) along with Family Personal Care is acceptable only as described under the following circumstances:

1. The individual meets the eligibility criteria for Respite Care Services or when the qualified family member provides less than 24-hour per day care on a routine basis, and the individual can be left alone safely for brief periods of time, respite care is appropriate only when the qualified family member will be gone for an extended period of time, for example, to attend a wedding.

If individual cannot be safely left alone or supervision is an authorized task on the MRW respite care must be authorized so the qualified family member can take necessary breaks away from their caregiving responsibilities.

- Respite care must be authorized because FPC providers cannot delegate their care to another individual if an individual cannot be safely left alone.

- If informal respite is in place and of benefit to the individual, the case manager must document that formal respite care was offered and declined.
2. Emergency response is acceptable if a safety risk (i.e. potential fall risk or sudden illness) has been identified during the FPC provider's short term absence. ERS is not acceptable for individuals who require supervision for cognitive or health related reasons.
 3. For some situations, it may be appropriate for two Family Personal Care providers to be authorized to provide care to one individual if both providers meet the Family Personal Care definition. However, both Family Personal providers cannot bill for the service on the same day.
 4. Under unusual or unique circumstances other HCBS service combinations may be appropriate. In such cases, contact the HCBS Program Administrator in writing to obtain approval.

Homemaker Service 525-05-30-35

(Revised ~~02 7/01/2024~~ ML #~~37973847~~)

Purpose

The purpose of Homemaker Service is to complete intermittent or occasional environmental tasks that an eligible individual is not able to complete him or herself in order to maintain that individual's home.

Service Eligibility Criteria for

The individual receiving homemaker service will meet the following criteria:

1. Must be eligible for the Medicaid Waiver for Home and Community Based Services, SPED, or ExSPED.
2. Needs assistance with environmental tasks that are within the scope of this service.
3. For live-in providers: the tasks of laundry, shopping, housekeeping, meal preparation, money management, and communication are allowed only when the service activity benefits the individual.

The department may pay a provider for homemaker tasks that would otherwise be considered the individual's share of the responsibility to complete the task. An example of this would be authorizing

housekeeping for the individual's personal private space OR their shared responsibility of cleaning the common living space.

4. For an individual who lives with an able-bodied adult, the department may pay a provider for homemaker activities involving the individual's personal private space and if the individual is living with an adult, the individual's share of the common living space.
- e. The need for environmental tasks/activities is intermittent or occasional.
- f. Occasionally the provision of Homemaker Service tasks/activities may impact other family members. When this occurs, it must be considered insignificant or must be inseparable from tasks/activities provided to the individual (e.g. cooking, cleaning).
- g. The funding cap applies to a household and may not be exceeded regardless of the number of eligible individuals residing in the home.

EXAMPLE: If a husband and wife both qualify for homemaker services, the max funding cap must be shared by both individuals. The total number of units should be divided between the individuals in the home and included on each individual care plan, but the cap cannot be exceeded.

Service Tasks/Activities

1. Housework
2. Meal Preparation
3. Laundry
4. Shopping
 - a. Transportation or escorting of the individual are unallowable
5. Communication
6. Managing Money

Service Location

Services will be administered in the most integrated setting consistent with the Person Centered Plan of Care, including (**checked if allowable**):

- ✓ **The individual's home**
- Workplace
- Other community service settings

Services Activities, Authorized and Limits

1. The service tasks/activities within the scope of this service chapter are defined on the Authorization to Provide Services.
2. When an individual receives assistance with laundry, shopping, housekeeping, under Medicaid State Plan Personal Care (MSP-PC) in excess of the funding cap allowed for homemaker services under SPED, EXSPED, or HCBS Wavier, additional tasks of Meal Prep, Communication or Managing Money may not be authorized under Homemaker Services.
3. If an individual is receiving MSP-Personal Care assistance for meal prep, communication, and money management, these tasks are not allowable homemaker tasks unless approval is obtained from a HCBS Program Administrator.
4. If an individual is receiving MSP-Personal Care, the tasks of laundry, shopping, and housekeeping cannot exceed 30% of the entire care plan. When MSP-PC units are authorized, homemaker tasks must be authorized under this funding source (MSP-PC) unless:
 - a. MSP-PC Level C is authorized; or
 - b. The total cost of the maximum number of units that are able to be moved from SPED/Ex-SPED and authorized under MSP-PC is less than \$150. (When calculating whether this cost is under \$150, first determine how many homemaker units you are able to move to MSP-PC. Then, take that number of units and multiply it by the current homemaker rate. If that total is less than \$150, you do not need to move the units from SPED/Ex-SPED over to MSP-PC.)
 - i. If a rural differential (RD) rate is authorized, the RD rate must be used to calculate the laundry, shopping, housekeeping total cost.
 - c. Homemaker is authorized under Medicaid Waiver. In that case, all HMK tasks may be authorized under MSP-PC Levels A and B or Medicaid Waiver since both (MSP-PC and Medicaid Waiver) are Medicaid-funded programs.

Providers

Homemaker Service may be provided by the following individual QSP's or employees of a QSP agency (**checked if allowable**):

Guardian

✓ Legally Responsible Person - Legal spouse or parent of a minor child.

✓**Relative within the definition of Family Home Care under subsection 4 of N.D.C.C. 50-06.2.02.**

Residential Habilitation 525-05-30-50

(Revised ~~027~~/01/2024 ML# ~~37973847~~)

Definition

Residential Habilitation is formalized training and supports provided to eligible individuals who require some level of ongoing daily support. This service is designed to assist with and develop self-help, socialization, and adaptive skills that improve the participant's ability to independently reside and participate in an integrated community. Residential Habilitation may be provided in community residential settings leased, owned, or controlled by the provider agency, or in a private residence owned or leased by a participant.

The participant must be able to benefit from skills training in order to assist individuals to independently complete tasks, restoration or maintenance and could also benefit from one or more of the following care coordination, community integration/inclusion, adaptive skill development, assistance with activities of daily living, instrumental activities of daily living, social and leisure skill development, medication administration, homemaking, protective oversight supervision, and transportation.

This service may be most beneficial to individuals with cognitive impairments, brain injury, stroke etc.

Purpose

Residential Habilitation provides all-inclusive service, provided up to 24 hours per day, to individuals who otherwise would be in an institutional setting.

Service Eligibility

The individual receiving Residential Habilitation will meet the following criteria:

1. Must be eligible for Medicaid Waiver for Home and Community Services.
2. Requires some level of on-going daily support.

3. Requires skills training, restoration or maintenance.
4. The individual is capable of directing his/her own care or has a legally responsible party to act on the recipient's behalf.
5. Pre-approval from the Department of Human Services is required before this service can be authorized.

Service Tasks/Activities

Care coordination is the primary responsibility of the Quality Service Provider (QSP) Agency Program coordinator. Authorized task includes:

1. Individual program Plan (IPP) Development, Coordination, Implementation and Evaluation.
 - a. Complete tasks such as individual plan development, monitoring the plan and observing to assure that the agency staff are trained, and the program is implemented, assisting with the development of behavior support techniques, assuring appropriate permission and approval is received from the individual and/or the legal decision maker.
 - b. Professional services are included in the "care coordination" hours and are not to be included in determination of direct support service hours.

Care coordination functions provided by the QSP agency include:

1. Management of an individual's property and resources including household budgeting, money management, communicating with creditors and landlords, etc.,
2. Application for generic services, monitoring status of those services, and maintaining communication with families, guardians, and other involved persons and agencies,
3. Coordinating medical needs,
4. Designing and implementing programs to enhance self-direction, independent living skills, community integration, social, recreational, and leisure skills and opportunities, and behavior management,
5. Facilitating the IPP planning process,
6. Assessing effectiveness of personal independence development strategies and other support services through analysis of information, consultation with the individual and/or guardian and family members, and observation of the person's programs and service settings,
7. Asserting and safeguarding the individual's human and civil rights, and
8. Attending to psychosocial needs of the individual.

Hours for direct staff time for personal supports include:

1. General supervision for safety and health monitoring and maintenance,
2. Homemaking which may include home maintenance,
3. Assistance with activities of daily living and instrumental activities of daily living
 - a. bathing
 - b. communication
 - c. dressing/undress
 - d. eyecare
 - e. feeding/eating
 - f. haircare/shaving
 - g. housework
 - h. incontinence
 - i. laundry
 - j. meal preparation
 - k. mobility (inside/outside)
 - l. Money Management
 - m. nailcare (fingernails)
 - n. shopping
 - o. skincare
 - p. teeth/mouth care
 - q. toileting
 - r. transferring/turning/positioning
4. Global Endorsements tasks
 - a. exercises
 - b. hoier lift/mechanized bath chairs
 - c. indwelling catheter
 - d. medical gases
 - e. prothesis, orthotics
 - f. suppository, bowel program
 - g. TED socks
 - h. vitals
5. Client specific endorsements
 - a. apnea monitor
 - b. JOBST stockings
 - c. ostomy care
 - d. postural/bronchial drainage
 - e. RIK bed care

6. Medication administration

- a. Under this chapter employees of an enrolled residential habilitation QSP agency who have received Department approved training may administer routine medications to recipients even if they are unable to self-direct their care. The QSP agency must employ or contract with a licensed registered nurse who provides supervision to the employees who are administering routine medications. The licensed nurse determines competency in medication administration by the employee's successful completion of the Department approved medication practicum. This does not include medications administered through a parenteral route (e.g. intravenous or intramuscular injections). The licensed nurse is responsible for ensuring that medications have been administered correctly according to the six rights of medication administration (individual, dose, time, route, medication, documentation), and that documentation is completed accurately.
- b. The QSP agency must have a training protocol and policy established for the administration of all medications, including PRN medications. The registered nurse is responsible for the training and oversight of all medication administration.
- c. The licensed registered nurse employed by the QSP agency may perform medication set-up.

7. Transportation to support medical, social, and essential community services.

8. Accompanying individual to medical appointments.

Hours for direct staff time for personal independence development:

1. Development of natural supports,
2. Activities and strategies to promote community inclusion/integration, leisure skill development, including activities to facilitate socialization and recreation that are tied to a therapeutic goal,
3. Support and adaptive strategies to enhance the person's control and independence over environment, resources, activities, and self-care, and
4. Training of skills development and/or maintenance.

Authorization for Services

1. The service tasks/activities within the scope of this service chapter must be identified in the assessment and on the Authorization to Provide Service.
2. An IPP as outlined in the Residential Habilitations provider standards, must be developed by the authorized QSP agency and maintained in the individual's file. An IPP is an individualized plan that describes the goals, wants, needs, and strengths of the person. It describes in detail how the QSP agency is supporting the individual.
 - a. Service task and activities must be tied to an individual's goals as determined through the person-centered planning process.
 - b. The IPP must correlate with the person-centered plan and service authorization that is completed by the HCBS Case Manager.
 - c. The IPP must be developed by the QSP Agency Program Coordinator within the first 30 days of service provision and forwarded to the case manager and every 6 months thereafter.
 - d. The IPP must also be reviewed and approved by the state program administrator.
 - e. The IPP must include:
 - i. A plan for promotion of the individual's independence in ADLs and IADLs, social, behavioral, and adaptive skills,
 - ii. Tasks being provided which should match the authorization provided by the HCBS case manager,
 - iii. A medication list if medication administration is authorized and description of how medications are being managed;
 - iv. Medical diagnoses;
 - v. A therapeutic goal for community integration activities which would include companionship and socialization activities. The individual should be involved in goal setting and ideas for these activities;
 - vi. Temporary absences and requests for retainer payments. Including any requests for retainer payments and dates of absences submitted to HCBS Program Administration for retainer payment authorization.

Note: Retainer payments cannot exceed 30 days per year.
 - vii. Signature of the agency care coordinator and date.

Allowable Service Combinations

Chore, ERS, Environmental Modification, Adult Day Care, Supported Employment, Extended Personal Care includes Nurse Education, Home Delivered Meals, Transition Coordination, Specialized Equipment,

Limits

Residential Habilitation may not be authorized with Respite Care, Homemaker, Adult Foster Care, Family Home Care, Personal Care, Family Personal Care, Adult Residential, Transitional Living, Attendant Care, Supervision, Companionship, Community Support Services and Non-Medical Transportation. For unusual or unique circumstances, contact the Aging Services Program Administrator for approval consideration.

1. This service shall not be used solely for the purpose of supervision or emergency assistance on a 24-hour basis.
2. Supervision may not be authorized in excess of what is necessary for health and safety.
 - a. For example, the family is requesting that someone stay with their relative 24 hours per day when there is not a safety or health risk other than the possibility that something might happen.
3. Twenty-four hour supervision in a shared living environment- Continuous supervision by paid staff on a one to one basis is not available unless shared staffing arrangements would create a safety threat to the individual or others. This level of service may only be provided as a last resort. All possible strategies for shared or reduced levels of supervision must be ruled out first.
 - a. A safety threat means the individual is so aggressive, self-destructive, or requires such close supervision that any attempt to share one-on-one staff at any time will place the individual at immediate risk.
 - b. Shared tasks will be considered in the shared living environment, and may affect the daily rate for these services (e.g. housekeeping of common areas, shared meals preparation, and overnight supervision).
4. This service does not include payment for non-medical transportation costs.
5. Payment for Residential Habilitation does not include room and board, or the cost of facility maintenance and upkeep.

6. Rate for this service and any additional waiver services cannot exceed the current highest daily rate for skilled nursing facility care.
7. Access of services or goods outside of the local area if the same service and goods are available in their local community.
 - a. For example, a grocery store is available in the local community, but the consumer wants to drive to a larger community because they prefer that location, even though the product and cost is the same at both locations.
9. Travel and direct support outside of the individual's community of residence for vacations, family events and socialization unless approval from an HCBS Program Administrator is received.
10. Direct support time is not available for any time which coincides with the recipients using adult day or other authorized services.
11. A personal assistance retainer payment is allowed for reimbursement during a participant's temporary absence from the setting. The personal assistance retainer allows for continued payment while a participant is hospitalized (acute hospital stay) or otherwise away from the setting in order to ensure stability and continuity of staffing up to thirty calendar days per year per participant.
 - o Absences do not include absences due to the individual receiving care in a skilled nursing facility (SNF) or Swingbed facility.

Program Administration enters the preauth upon request from the provider verifying the dates the individual is temporarily absent from the integrated setting.

The provider must review the retainer payments in the IPP that is completed every 6 months.

This process is handled administratively through the approval of Residential Habilitation and Community Supports.

Providers

Residential Habilitation may **NOT** be provided by the following employees of a QSP agency:

- Legal spouse or parent of a minor child.

Standards for Providers

Service must be provided by an enrolled Medicaid Agency. Individual QSPs are not eligible to provide this service.

Residential Habilitation providers must be:

Agency QSPs enrolled under NDAC 75-03-23 may include Licensed residential habilitation DD Providers- Licensed according to NDAC 75-04-01 who meet additional enrolment requirements and meet the following:

1. Provider must ensure that staff are adequately trained and qualified as evidenced by:
 - a. Written job descriptions for employees that include plans for participation in training and include requirements for education, experience, and skills,
 - b. Documentation of competency or employed by a Licensed DD provider according to NDAC 75-04-01,
 - c. Department approved training on Traumatic Brain Injury (TBI) and dementia,
 - i. In-service training to direct contact staff by the program coordinator on implementation of individual's programs and observation of implementation in the service setting.
 - ii. To assure staff meet minimum training requirements, TBI and dementia training must be completed within 30 days of providing care to an individual under residential habilitation.
 - iii. Staff must complete TBI and dementia training every 2 years.
 - d. Completion of Minot State University medication modules, testing and practicum. Written test is proctored and completed in person. Practicum is administered by a licensed registered nurse employed or contracted through the Agency Provider.
 - i. Staff must complete department-approved training on the administration of routine medications before administering routine medications. This includes cueing/reminding the individual to take medication.
 - ii. Staff must demonstrate continued competency in medication administration by completing medication practicum with agency RN once yearly and as needed. Staff must complete the practicum checklist specific to the type of medication administration they will be completing (example: if administering an enema, staff must complete the practicum

checklist for the administration of an enema prior to administration and yearly).

e. Agency must name a Program coordinator. Program coordinator requirements:

1. Must have at least one year of experience working directly with persons with physical disability; and
2. Is one of the following:

- a. A doctor of medicine osteopathy,
- b. a registered nurse, or
- c. an individual who holds at least a bachelor's degree and who is licensed, certified, or registered as applicable, to provide professional services by the State in which he or she practices (e.g. social worker, occupational therapist, psychologist, physical therapist, etc.). An individual with a "bachelor's degree in a human service field" means an individual who has received: at least a bachelor's degree from a college or university (master and doctorate degree are also acceptable) and has received academic credit for a major or minor coursework concentration in a human service field (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology).
- d. Other:
 - i. Individuals who have a bachelor's degree; and
 - ii. Completes the department approved TBI and Dementia training; and
 - iii. Has one year experience working with individuals with a physical disability.

3. Ensures quality programs/services for the people supported in the employing agency.
4. Responsible for development of the IPP.

2. Council on Quality & Leadership (CQL) Accreditation

- a. Provider must become CQL accredited. Refer to Council on Quality and Leadership (CQL) Accreditation Policy, see 525-05-47.

Residential Habilitation agency providers may employ legally responsible individuals to provide Residential Habilitation Service. The following criteria applies when an agency employs a legally responsible person or family member as a staff to provide Residential Habilitation.

- Residential Habilitation Service cannot be provided by spouses,
- Residential Habilitation providers or staff cannot live with the care recipient.
- Payment may be made to a legal guardian or family member by the provider agency if the recipient chooses the legal guardian or family member as their provider.
- The legal guardian or family member must meet all the required qualifications of a Residential Habilitation Service staff member.
- If the legally responsible person wants to provide services as an employee of the provider and has decision making authority over the recipient, the case manager must pre-approve the arrangement with the HCBS Program Administrator for Residential Habilitation.
- The case manager is responsible to forward a copy of the narrative that explains why the legally responsible person providing the services is in the best interest of the client to the State Medicaid Agency.
- The narrative must also be attached to the client's individual care plan when it is submitted to the State.

Involuntary Discharge of an Individual under Residential Habilitation:

Involuntary discharge occurs when a Residential Habilitation provider has decided to discontinue services and terminate supports even though the individual has not requested the termination of services. Any opportunities to prevent an involuntary discharge should be explored prior to the discharge by the provider. Residential Habilitation providers must have written policies and procedures that define the conditions of termination and transfer of an individual's services. Individuals and/or legal decision makers should receive a copy of the provider's policy at the time of admission to the provider agency and again when a discharge is being considered.

In the case of an involuntary discharge, the Residential Habilitation provider is required to give a thirty (30) day written discharge notice to the individual, unless the individual chooses to discontinue the services earlier, schedule a team meeting with the individual and HCBS case manager, and

complete a written discharge summary. The timing of the thirty (30) day notice begins the date that the team meeting occurs. The written discharge notice must include the reason for discharge and why the provider cannot continue to serve the individual. A copy of the thirty (30) day notice and the written discharge notice must be forwarded to the HCBS Case Manager. The Residential Habilitation provider must also file a Critical Incident Report. Any opportunities to prevent discharge should be explored prior to discharge by the provider.

Settings where service can be provided:

This service may be provided in a private family dwelling or in a licensed adult foster care home N.D.A.C. 75-03-21.1 that is approved to provide this service. The HCBS settings rule applies to all agency foster homes and the setting must be fully compliant before services can begin.

Services will be administered in the most integrated setting consistent with the Person-Centered Plan of Care, including (**checked if allowable**):

- ✓ **The individual's home**
- ✓ **Workplace**
- ✓ **Other community service settings**

Maximum Room and Board Rate effective 7-1-20~~23~~ 24

The current maximum monthly room and board rate that providers may charge residential habilitation recipients is \$~~884.00~~ **1,005**. The maximum room and board rate is equal to the current Medicaid medically needy income level for a one person household less a \$125 personal needs allowance. The rate is reviewed annually.

Providers are not required to charge a room and board rate and may choose to charge less than the maximum rate.

**Maximum Monthly Amount - Aggregate and Per Service
525-05-35**

(Revised ~~037~~/01/2024 ML #~~3829~~3847**)**

The maximum amount allowable under the Medicaid Waiver for Home and Community Based Services per Medicaid waiver recipient and per month is an aggregate of the cost and is limited to the highest monthly rate allowed

to a nursing facility within the rate setting structure of the Department of Human Services.

See link below:

[2024 Nursing Facility rates.xlsx \(nd.gov\)](#)

The maximum amount allowable under the SPED and ExSPED Programs per individual and per month is an aggregate of ~~\$3914~~ 4,029 for all services excluding Case Management and Adult Foster Care. If an individual is receiving Adult Foster Care under SPED or ExSPED, the maximum amount allowable, excluding Case Management, is ~~\$6,753~~ 6,796.

Homemaker Service	70 units
Respite Care	<p>\$1214-1247</p> <p>(Daily amount not to exceed daily swing bed rate).</p> <p>Refer to link:</p> <p>https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/swing-bed-fee-schedule.pdf</p>
Respite Care in Homes with Multiple Residents	<p>\$1214-1247 split by the total number of public and private pay residents in the home.</p> <p>Plus \$202.29 <u>224.94</u> per month for each additional (2nd 3rd or 4th) public pay residents in the home, the total amount will need to be divided between the public pay residents.</p> <p>For Example: An AFC provider has a total of 3 residents, 2 are public pay & 1 is private pay. To calculate respite for the public pay residents you should divide the current respite cap (\$1214-1247) by the total number of public & private pay residents living in the home (3) that equals \$404.67 <u>415.67</u> for each resident or \$809.34 <u>831.34</u> for the 2 public pay residents combined. Now add \$202.29 <u>224.94</u> for the 2nd public pay resident that equals \$1011.63 <u>1,056.28</u>. Now divide that amount between the</p>

	<p>2 public pay residents $\frac{1,056.28}{2} / \\$1,011.63 = \\505.82 528.14.</p> <p>The final step is to allocate \$505.82 <u>\$528.14</u> on each of the public pay resident's care plan.</p>
Adult Foster Care	\$150.00 <u>154.50</u> flat rate per day
Family Home Care	\$72.50 <u>74.68</u> flat rate per day
Family Personal Care	\$154.89 <u>159.54</u> flat rate per day
Daily Rate for SPED Personal Care	\$85.20 <u>87.76</u> flat rate per day
SPED Personal Care Assisted Living	\$85.20 <u>87.76</u> per day

When authorizing services that will be paid at the rural differential rate service maximums may be exceeded but the number of units cannot exceed the number of units that are available when using the original service maximum. It is allowable for costs to exceed the service maximum if RD is the **only** factor causing it to exceed the cap and costs are within the service maximum when calculating the base rate. This also applies to the respite care cap.

- Example 1 (monthly respite care cap): An individual resides 70 miles from the agency respite care provider and RD applies. The individual is requiring the maximum amount of respite care per month, which is 157 units. It is allowable for respite care to exceed the monthly maximum of ~~\$1214~~ 1247 because the only factor that causes it to exceed is the additional cost of the RD rate. When calculating the base rate of respite, 157 units falls within the cap.

- Example 2 (daily respite care cap): An individual resides 70 miles from the agency respite care provider and RD applies. The individual requires overnight respite care & the daily respite care cap is limited to the swing bed daily cap. Under these guidelines, the agency would be allowed to bill a maximum of ~~45~~ 46 units of respite care per day. Even though the RD rate will add on an additional cost to this service, it is allowable as that is the only factor causing it to exceed the swing bed cap.

Service Maximums Per Individual Per Month for Dates of Service.

Extraordinary Costs/Exceed Monthly Aggregate or Service Maximum

This policy provides for additional dollars that may be needed because of an individual's special or unique circumstances that warrant a temporary exception of department policy. IT IS TIME LIMITED.

The HCBS case manager must submit in WRITING a request to exceed the monthly service or funding source maximum prior to authorizing the service(s) in excess of the monthly maximum. The request is to be sent to the HCBS Program Administrator to include:

- Name, county of residence, and ID number of the individual.
- Reason for the request: the individual's circumstances that necessitate the short duration extraordinary costs AND what options were explored as alternatives to meeting individual's need.
- The additional dollar amount request, for what funding source, service(s), and for what period of time.

The program administrator will notify the case manager in writing of the department's decision. It will include the conditions under which the approval is granted AND the procedure for the Qualified Service Provider to bill for the additional funds.

Maximum Room and Board Rate effective 7/1/202~~3~~4

The current maximum monthly room and board rate that providers may charge Adult Foster Care, Adult Residential and Family Home Care recipients is ~~\$884.00~~ 1,005.00. The maximum room and board rate is equal to the current Medicaid medically needy income level for a one person household less a \$125 personal needs allowance. The rate is reviewed annually.

Providers are not required to charge a room and board rate and may choose to charge less than the maximum rate.

Rural Differential Rates 525-05-38

(Revised 7/1/2024 ML #36633847)

[IM-5417](#)

[IM-5413](#)

Purpose

The purpose of the rural differential rate (RD) is to create greater access to home and community-based services for individuals who reside in rural areas of North Dakota by offering a higher rate to Qualified Service Providers (QSPs) who are willing to travel to provide services. QSPs that are willing to travel at least 21 miles round trip to provide care to authorized individuals in rural areas will be reimbursed at a higher rate for those cares. QSPs are not paid for the time they drive to or from the individual's home; the rural differential rate may only be used for the time spent actually providing services.

Standards for Providers

Enrolled agency or individual QSPs, authorized to provide Respite Care, Homemaker, Personal Care, Nurse Education, Extended Personal Care, Chore Labor, Supervision, Companionship, Transitional Living services, [Waiver Personal Care](#), or Community Transition Services.

All individual QSPs and agency employees that are authorized to bill using the RD rate will be required to submit proof of address upon request to Aging Services/Home and Community Based Services. The only proof of address that will be accepted for North Dakota residents will be a valid North Dakota driver's license. Once the driver's license is received the Department will verify that the address is current with the Department of Transportation.

If the QSP or agency employee resides in another State, the Department will accept another form of address verification i.e. current utility bill etc. If

out of state residents submit other forms of identification the decision to accept it for purposes of being eligible to receive the RD rate will be made on a case by case basis.

Service Activities, Authorized

A Rural Differential Unit Rate Authorization/Closure (~~SFN-212~~) must be completed by the case manager in the web-based case management system for each provider eligible to bill a rural differential rate. The Rural Differential Unit Rate Authorization/Closure SFN-212 must be submitted with a mapped verification of distance to Aging Services/HCBS.

The RD rate must be identified on the Individual Care Plan (SFN-351) Person-Centered Plan (PCP) and the rate must be entered on the preauthorization in Therap.

Service Eligibility, Criteria for

An individual receiving services paid at the RD rates will meet the following criteria:

1. Individual must be eligible for one of the following services: Medicaid Waiver, Service Payments to the Elderly & Physically Disable (SPED), Expanded Service Payments to the Elderly & Disabled (EX-SPED), Medicaid State Plan personal Care (MSP-PC). For MSP-PC please see Personal Care Services 535-05-40.
2. Individual must reside outside the city limits of Fargo, Bismarck, Grand Forks, Minot, West Fargo, Mandan, Dickinson, Jamestown, and Williston.
 - Situations where there is a discrepancy in what is considered city limits must be prior approved by the Rural Differential Coordinator. The HCBS Case Manager must send a written request for verification to the HCBS Program Administer responsible for program oversight.
 - Exception may be requested to allow a QSP in a rural area to receive a rural differential rate when providing services in the city limits of Minot, West Fargo, Mandan, Dickinson, Jamestown, and Williston if the following criteria are met.
 - The individual has at least two ADL impairments and will need at least 100 units of service or supervision needs met to assure health and safety.

- The HCBS case manager has reached out to a minimum of three QSPs in the local area who are unable or unwilling to serve the individual. The HCBS CM must outline the efforts made to find a local QSP. Include the name of the three providers and the date the providers were contacted in the case narrative with a brief description of the reason for the denial.
- QSP cannot be a family member.
- Case Managers must request prior approval from RD Program Administrator.

A request for this exception can be made by sending an email to the program administrator outlining the efforts made to find a local QSP. Include the name of the three providers, the date the providers were contacted, and a brief description of the reason for the denial. The exception email must be kept in the consumer's individual's file and documented in the case narrative.

3. Individual needs any of the following services: respite care, homemaker, personal care, nurse education, extended personal care, chore labor, transitional living, supervision, companionship, waiver personal care, or community transition services and does not have access to a QSP of their choice, within 21 miles of their residence, that is willing to provide care.

Service Delivery

The RD rate is based on the number of miles (round trip) a QSP travels from their home base to provide services at the home of an authorized HCBS recipient.

- Home base is either the individual QSPs physical address, or the Agencies home office, satellite office, or employees physical address (if they are not required to report to the home office each day) whichever is closer.
- If an agency employee is not required to report to the home office each day and they live 21 or more miles (round trip) from the individual's home, the RD rate may be used. If the employee lives less

than 21 miles (round trip) from the individual's home, the RD may not be used.

- Rural differential rates are based on the distance it takes to travel to each individual's home even if the QSPs serve more than one recipient in the community or in the same home.
- If the QSP travels to the individual's home and remains in that community overnight or for a period of days, they are not eligible to claim the RD rate for those dates of service. The RD rate may only be claimed on the day the QSP travels to and from the individual's home.
 - For example, if a QSP travels more than 21 miles round trip to provide care to their Mother, and then stays with their Mother for a few days, the RD rate would only be claimed on the first and last days they provide the care. The QSP must use the standard QSP rate for the days they do not travel to and from their home base.

Addresses:

Case Managers must use the physical address (PO BOX is not acceptable) listed on the QSP list when determining which RD rate to use for individual QSPs and Agency providers. A QSP list including the provider's physical addresses will be provided to the HCBS Case Managers monthly.

Agency employees who are not required to report to their agency each day must make their address available to the HCBS office for verification. This address must be entered on the [Rural Differential Unit Rate Authorization/Closure SFN-212](#) under QSP physical address. If a QSP states the physical address on the QSP list is incorrect, they must contact the HCBS office to change it before an authorization can be provided that includes a rural differential rate. It is not sufficient to notify the individual manager.

If the QSP's address changes, the provider must notify HCBS and their Case Manager within 14 days. Once the Case Manager receives a notification of address change, they must recalculate a Map Quest to determine if there are any the case manager must submit the [Rural Differential Unit Rate Authorization/Closure SFN-212](#) noting the change of address and an updated Map Quest with the current address.

If the QSP's new address changes the tier the provider is eligible to bill, the case manager must update the tier and rate on the [Rural Differential Unit](#)

[Rate Authorization/Closure SFN-212](#) and develop a new authorization with the correct rate and provide it to the client and QSP.

If the QSP no longer qualifies for an RD rate, the Case Manager must complete and submit a [Rural Differential Unit Rate Authorization/Closure in the web-based case management system. for SFN-212 to Aging Services/HCBS.](#)

Determining Distance:

Case managers are required to verify distance between the HCBS individual's home and the QSP's home base by using a reputable internet-based mapping service. The Case Manager is responsible to choose the most reasonable route and print a copy of the mapped verification of distance, a copy must be kept in the individual's file and submit to Aging Services/HCBS along with the [Rural Differential Unit Rate Authorization/Closure form SBN-212.](#)

- If there is a discrepancy when calculating distance, the final decision will be made by the Rural Differential Coordinator charged with program oversight. The HCBS Case Manager must send a written request explaining the issue to the Rural Differential Coordinator responsible for program oversight.

SPED Sliding Fee Schedules 525-05-60-25

(Revised 07/01/234 ML #3742-3847)

The SPED sliding fee schedule will be adjusted each year on July 1, based on the current Social Security cost of living adjustment. Note that this may cause either an increase or decrease in the sliding fee scale caps.

Click to view and/or print these schedules.

[Schedule 1](#)

[Schedule 2](#)

Nursing Plan of Care, SFN 807 525-05-60-52
(New 07/01/2024 ML #3847)

Registered Nurse approved to provide Nurse Education will complete the entirety of the Nursing Plan of Care.

Nurse Educator will fill in member name, member ID number, nurse educator, back-up nurse educators name with nurse educator phone numbers, case manager, and case manager phone number.

Section 1:

1. Nurse Educator will fill in all medical diagnoses and pertinent medical history
2. Nurse Educator will complete physical assessment
 - a. Ailments are fillable or drop-down box
 - b. Provide comments related to ailments
 - c. Nurse may add or delete rows to accommodate the needs of the consumer
3. Nurse Educator will assess and fill out blood pressure, pulse, pulse type, respirations, temperature, pain assessment, height, weight, diet, supplements, and any additional comments related to physical assessment
4. Nurse Educator will fill out allergies and sensitivities
5. Nurse Educator will fill out medication list with name, dose, and times per day
 - a. Nurse Educator may add or delete rows to accommodate medication list needs
 - b. May provide separate document of medication list
6. Nurse Educator will fill out the requested nursing tasks, frequency and units needed for each task and if a nurse or non-nurse will be completing the task
 - a. Nurse Educator may add or delete rows to accommodate medical task list
 - b. Nurse Educator to provide any additional comments related to medical tasks requested
7. Nurse Educator will fill out number of units estimated per month and six months
 - a. Fill out nursing tasks per nurse as the QSP
 - b. Fill out nursing tasks per non-nurse as the QSP
8. Nurse Educator will fill out any additional nurse educator units that are requested for training non-nurse QSPs

9. Nurse Educator will fill check the box for what type of QSP will be completing the medical task(s): nurse or non-nurse who is trained and verified competent to complete the medical task
 - a. Nurse Educator will fill out instructions and steps for approving nursing tasks including:
 - i. Contraindications
 - ii. Risks
 - iii. Precautions
 - iv. Reportable Incidents
 - v. Contingency Plan in case of emergency
10. Nurse Educator will fill review Nurse Educator agreement and critical incident reporting requirements
11. Nurse Educator prints or types name, date, and time of completion of the SFN 807
12. Nurse Educator signs SFN 807
13. Print RNs name and license number
 - a. **If licensed outside of North Dakota in a Nurse Compact state, provide State where the nurse is licensed**
14. If nurse education has not been approved for Virtual Supports Option, the QSP Nurse Educator will stop here and submit document to HCBS Case Manager for State RN Program Administrator review

Section 2:

If the Nurse Educator has received approval from the State RN Program Administrator to provide EPCS via Virtual Supports Option, the RN Nurse Educator will continue to fill out Section 2 of the SFN 807.

1. Nurse Educator will review Virtual Support Option requirements
2. Nurse Educator will acknowledge completion by checking each box listed below the requirements to confirm understanding
3. Nurse Educator will fill out which HIPPA compliant service delivery provider was utilized
4. Nurse Educator will fill out where the Nurse Educator was located during the time the Virtual Supports Option was utilized
5. Nurse Educator will fill out where the client was located during the time the Virtual Supports Option was utilized
6. Nurse Educator will complete the number of Nurse Education units requested per month if additional units are needed and the frequency needed
7. Nurse Educator will total the units for a six-month period
8. Nurse Educator will write detailed plan on how the Nurse Educator will address any health, safety, or behavioral needs while the Virtual Supports Option is being provided

9. Nurse Educator will review HIPPA laws and print Nurse Educator name, sign, and date the form
10. Nurse Educator will submit document to HCBS Case Manager for State RN Program Administrator review

Extended Personal Care Service (EPCS) Provider Training Procedure Agreement, SFN 576 525-05-60-57

(New 07/01/2024 ML #3847)

Nurse Educator will complete the SFN 576 if medical tasks will be provided by a non-nurse QSP who has been trained and verified to be competent at time of training.

1. Nurse Educator will fill out member name, member Medicaid ID number, nurse educator name and phone number, back up nurse educator name and phone number, and case manager name and phone number
2. Nurse Educator will fill review critical incident reporting requirements with non-nurse QSPs completing the medical tasks
3. Procedure and Training
 - a. Nurse Educator will fill check boxes after completing training tasks including: reason for task and risk of task, observation of client response, possible side effects to client and response, proper procedure, nurse demonstration, return demonstration and procedural guidance provided
 - b. Nurse Educator will fill include detailed instructions and steps for nursing tasks including:
 - i. Contraindications
 - ii. Risks
 - iii. Precautions
 - iv. Reportable incidents
 - v. Contingency Plan in case of emergency
 - c. Each trained non-nurse QSP verifies agreement and compliance with the information listed on the SFN 576.
 - i. Non-nurse QSP prints name, signs, and dates
 - ii. Nurse educator signs name and date
4. Nurse Educator will submit document to HCBS Case Manager for State Program Administrator review.

Monthly Rate Worksheet - Live-in Care, SFN 1012 525-05-60-65

(Revised ~~037/01/2024~~ ML #~~38293847~~)

Purpose: The Monthly Rate Worksheet, [SFN 1012](#), is used by the Case Manager to determine the daily rate of payment for SPED Personal Care Assistive Living. This is to be completed and forwarded to Aging Services/HCBS initially when the case is opened, on an annual basis, as well as any time there is a change to the tasks and/or rate.

SECTION I: IDENTIFYING INFORMATION

Complete the client's name, client's identification number (ND number), date the assessment is completed, county of residence, HCBS Case Manager's name, the effective date of the rate as determined on the rate worksheet, and the client's date of birth.

Note: Any change in the rate becomes effective the first day of the following month. For example, if the Monthly Rate Worksheet (MRW) is completed based on an assessment dated April 12, 2006, the rate change becomes effective with services delivered beginning May 1, 2006.

SECTION II: ASSIGNMENT OF POINT VALUE(S)

For each task that needs to be performed for the individual (as identified in the functional assessment) assign the associated point value in the appropriate service column.

Note: The point values of the tasks cannot be less or more than the pre-recorded point value. For example, in Bathing, individuals will receive 20 points if they need this assistance. No one would receive a point value greater than 20 if they need greater help or less than 20 if they need less help.

When point values have been assigned, the form will automatically sum up the points in the column and record the sum in Total Points row (applicable to the authorized service).

~~**Note:** The description for the task of supervision on the MRW.~~

SECTION III: RATE CALCULATION

When using the electronic MRW, a portion of the first area of Section III will automatically fill in the figures through the SFY~~23~~24 Rate. The rate that calculates in this column is the daily rate.

If the calculated rate exceeds the funding source maximum (see maximum amounts at the bottom of the MRW), record the maximum rate in the column marked SFY~~23~~24 Rate.

SECTION IV: PROVIDER INFORMATION

Enter the provider's name, number, and mailing address in the spaces provided.

DISTRIBUTION

File the original copy in the ~~applicant's~~/individual's case file. Email or fax a copy to Aging Services/HCBS within 3 days of completion.

An electronic copy is available through the state e-forms ([SFN 1012](#)).