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 has been struck through.

Chore Service 525-05-30-20

Purpose

The purpose of Chore Service is to complete tasks which an elderly or disabled individual is not able to complete in order to maintain his/her home or walkway. The chore service tasks authorized must be directly related to the health and safety of the client.

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

Service Eligibility, Criteria for

The individual receiving Chore Service will 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 client may be at risk due to the absence of the other household member(s), contact the HCBS Program Administrator for one-time prior approval to allow a client to receive Emergency Response Service.

3. The individual is not able to complete tasks to maintain his/her residence, 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. No family, friends, or neighbors (informal network) are available/willing/capable of completing the chore tasks to maintain the individual's residence, or walkway.

7. There are no alternative community resources such as local community action agency, housing rehabilitation, church groups, or service groups to complete chore tasks.

8. Pre-approval from the Department of Human Services is required if the cost of the service is expected to exceed $200 per month. See Service Tasks listed below for specific tasks that require additional prior approval.

9. 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 client) Authorized per job, not units
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
Professional ERS installation and monthly rental fees are allowed --	Clean windows (may include seasonal removal of screens or storm windows)

does not include maintenance or repair of ERS	

Community Transition Services 525-05-30-22

Purpose

The purpose of Community Transition Services is to assist eligible individuals transitioning from an institution or another provider-operated living arrangement (to include skilled nursing facility, adult residential, adult foster care, basic care, and assisted living) to a living arrangement in a private residence where the client is directly responsible for his/her own living expenses and needs non-recurring set-up expenses.

Service Eligibility, Criteria for

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

1. Must be on Medicaid;
2. Must be eligible for the Medicaid Waiver for Home and Community Based Services;
3. Must be at least age 18;
4. The care needs of the client must fall within the scope of Community Transition Services as described in this service chapter;
5. The client must be transitioning from an institution or another provider-operated living arrangement to a living arrangement in a private family dwelling where the client is directly responsible for his/her own living expenses; and
6. Prior approval from a HCBS Program Administrator is required before this service may be authorized.

Service Activities

Community Transition Services include one-time set-up expenses and transition coordination.

1. Transition coordination assists an individual to procure one-time moving costs and/or arrange for all non-Medicaid services necessary to assist the individual with the actual coordination and implementation of their individualized plan to move back to the community. The non-Medicaid services may include:
    a. assisting with finding housing to include searching, coordinating deposits, and/or utility set-up;
    b. helping participants set up their households by identifying needs, help with shopping, and/or selection of household goods;
    c. arrange the actual move by getting things out of storage, and/or finding movers;
    d. identifying the community in which the participant wants to live;
    e. identifying and coordinating transportation options for the move; and
    f. assisting with community orientation to locate and learn how to access community resources.

Individual Program Plans

Once an individual begins Community Transition Services, an Individual Program Plan (IPP) must be completed by the interdisciplinary team (to at least include the service provider, the individual and/or their legal representative) and the case manager.

This IPP must be completed within 30 days of the beginning effective date of the services. The IPP must include how the provider will meet the needs of the client and must also identify the goal or goals of the individual and how the goals will be accomplished.

This IPP will be subject to review by the HCBS Case Manager during the initial plan implementation period. At the team meeting, the team will review the goals and progress, and strategies for accomplishing the plan goal or goals.

Preliminary Care Plan

Community Transition Services may be authorized up to 180 consecutive days prior to admission to the waiver of an institutionalized person. A preliminary care plan must be completed by the HCBS Case Manager. The Person Centered Plan of Care (SFN 404) and Authorization to Provide

Medicaid Waiver Services (SFN 410), must be completed and noted "preliminary care plan" at the top. The HCBS Case Manager is responsible to send the completed documents to the HCBS line.

Services Activities, Authorized and Limits

1. Community Transition Services do not include expenses that constitute room and board; monthly rental or mortgage expense; escrow; specials; insurance; food; regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

2. Community Transition Services may be authorized up to 180 consecutive days prior to admission to the waiver of an institutionalized person and 90 days from the date the client became eligible for the waiver.

3. Transition coordination is limited to 300 hours or 1200 units per recipient.

4. One-time set-up expenses are limited to $3000 per recipient.

5. Community Transition Services will require prior approval from the HCBC Program Administrator to prevent any duplication of services.

6. When Community Transition Services are furnished to individuals returning to the community from a Medicaid institutional setting through entrance to the waiver, the costs of such services are considered to be incurred and billable when the person leaves the institutional setting and enters the waiver. The individual must be reasonably expected to be eligible for and to enroll in the waiver. If for any unseen reason, the individual does not enroll in the waiver (e.g., due to death or a significant change in condition), Community Transition Services may be billed to Medicaid as an administrative cost.

Authorization of Services

The service activities within the scope of this service chapter must be identified on the Authorization to Provide Service, SFN 410.

1. One-time set-up expenses
    a. One-time set-up expenses are limited to $3000 per recipient.

b. On the preliminary care plan and preliminary authorization, case managers will authorize the estimated amount of one-time expenses, not to exceed $3000.
c. A copy of all receipts from purchases must be retained in client's file.
d. QSP will bill based on actual expenses.

2. Transition coordination
   a. Transition coordination is limited to 300 hours or 1200 units per recipient.
   b. On the preliminary care plan and preliminary authorization, case managers will authorize the estimated number of units, not to exceed 1200 units.
   c. QSP must document every interaction with recipient. Documentation will include the task and number of units.
   d. QSP will bill based on actual number of units of Transition Coordination provided to recipient.
      1. These services cannot be billed until the recipient has transitioned to a living arrangement in a private family dwelling and
      2. The recipient has been admitted to the waiver and a Person Centered Plan of Care (SFN 404) and Authorization to Provide Medicaid Waiver Services (SFN 410) have been signed.

Standards for Providers

Enrolled agency or individual QSPs, authorized to provide Community Transition Services.

Agency QSP staff: Completion of an associate or bachelor's degree in sociology, social services, social work, nursing, or a field related to programmatic needs from an accredited university. Staff with an associate degree must also have at least one year of progressively responsible experience in programs related to the task.

Individual QSPs: Completion of a bachelor's degree in sociology, social services, social work, nursing, or a field related to programmatic needs from an accredited university.

Environmental Modification 525-05-30-25

Purpose

The purpose of Environmental Modification Service is to modify a recipient's or family member's home (the recipient must reside in the family home) to enhance the recipient's ability to function as independently as possible in the home or family member's home.

Service Eligibility, Criteria for

The individual receiving Environmental Modification Service must meet the following service eligibility criteria:

1. Must be eligible for the programs of SPED, ExSPED, or Medicaid Waiver for Home and Community Based Services.

2. The recipient or family member must own the home prior to application.

3. The individual has a need for a safer and/or adapted environment in which to live, such as the installation of grab bars in the individual's bathroom.

4. The home modification must directly facilitate the applicant's/recipient's ability to complete his/her own cares independently or to receive care. It must be evident that without the home modifications, adequate care or the ability to perform self or environmental care is not possible.

5. The benefit outcome of the home modifications must be proportionate to the cost. Factors to consider are: the age of applicant/recipient, life expectancy, the value of the house, the applicant's/recipient's commitment to remain in the home including the family's commitment to assist.

6. Documentation must be on file that alternative community programs or funding sources available to pay for the home modification costs were explored. Examples are: Office of Vocational Rehabilitation, Community Action (e.g. weatherization, rehab.), Community Development Grant (Housing) Funds, FmHA Loan and Grant Program.

7. The informal network (family members, friends, or neighbors) are not available/willing/capable of completing or paying for the home modifications(s).

8. Physical adaptations to the home required which are necessary and without which, the recipient would require institutionalization.

Limits

SPED and ExSPED tasks are limited to: Labor and materials for installing safety rails.

For the Waiver programs see section Environmental Modification, Scope of which cannot exceed the amount budgeted (per person) for environmental modification in the federally approved Medicaid Waiver for the State of North Dakota.

Modifications are not for routine home maintenance, (such as carpeting and/or floor repair, plumbing repair, roof repair, central air conditioning, appliance repair, electrical repair, etc.) but are to promote independence. Adaptations, which add to the total square footage of the home, are not allowed. All services shall be provided in accordance with applicable state and local building codes.

For environmental modification the dollar limit is the lesser of the highest monthly rate for the highest cost skilled nursing facility or 20% of the tax evaluation of the home. The highest monthly rate for nursing facility is approximately $10,000 per month in some rural areas this amount may be more than the market value of the home thus the 20% limit. This cap may be increased as determined by legislative action. Exceptions to this service cap will not be made. If the client's needs cannot be met within the allowed rate case management would explore other service options with the participant including nursing home placement. The case manager makes participants aware of the service cap.

Funds for this service may only be accessed to meet the excess disability related expenses that are not covered through the Medicaid State Plan to maintain a recipient living in their own home or in the home of their family member. This home must be owned by the recipient or the recipient's family member.

A written recommendation by an appropriate professional is required to ensure that the home modification will meet the needs of the recipient if the estimated cost of the modification is more than $250. The cost of the assessment to provide a written recommendation is an allowable expense if the cost of the assessment is not covered under the State Plan. The cost of the evaluation must be included in the cost estimate submitted to the Department and the total cost of the modification and the assessment cannot exceed the current funding cap.

Pre-Approval Service Eligibility Determination

Environmental Modification Service requires prior approval from HCBS Program Administration. The following procedure is used in determining service eligibility:

1. The individual must make application for services to the HCBS Case Management Agency in their county of physical residence using "Application for Services" (SFN 1047).

2. The HCBS Case Management Agency will determine whether or not the need for home modification is related to the care needs of the applicant. The comprehensive assessment is used to identify functional impairments.

3. A visual inspection of the home is completed by the HCBS Case Manager and, whenever possible, a professional of another discipline with experience in evaluating home care needs of the elderly and disabled. They will determine if the applicant's/recipient's request for Environmental Modification Service will be of direct benefit to the applicant's self- care needs. If it is found the requested/proposed modifications will not be of direct benefit to the applicant/recipient, the County Social Service Board must deny the service request following the service denial policy procedures.

4. If the home is in poor condition and not structurally sound, Environmental Modification will not be approved.

5. A summary of the applicant's/recipient's service request and the recommendation(s) resulting from the home inspection is documented in the case file records. Included in the documentation must be an explanation of the proposed home modifications and how they will enable self-care or enhance care provided by others.

6. Written construction bids must be obtained for any work funded under this service chapter. When the estimated cost exceeds $500.00, bids must be obtained from at least two licensed general contractors if possible. Exceptions may be made to the two bid requirement if it can be demonstrated that there is a lack of available service providers in the area. All bids must include a breakdown of the labor AND material costs of the modifications. See section 525-05-45 for Contractor Standards.

7. Upon receipt of the written bid(s), the following information is sent to the HCBS program administrator: written bids, narrative explanation of the proposed work and how it will assist the applicant/recipient to complete or receive self-care, a photocopy of the most recent Comprehensive Assessment, and the SPED/ExSPED Individual Care Plan, SFN 1467, or Medicaid Waiver Person Centered Plan of Care SNF 404 that lists Environmental Modification Service. If an exception is being requested to the two bid minimum include a written explanation of the facts supporting the request. HCBS Program Administration's decision will be based on this information.

8. If the proposed Environmental Modification Service is not approved, the Case Management Agency will issue a denial notice following the procedures of denying services.

9. After the HCBS Case Management Agency is notified that the environmental modification project is approved, the Case Manager will assist the contractor (awarded the bid) to complete the forms required for enrollment as a Qualified Service Provider. The Authorization to Provide Services for SPED/ExSPED, SFN 1699, or Authorization to provide Medicaid Waiver Services SFN ~~404~~ 410 ~~Section VII~~, is issued to the contractor awarded the bid once the successful bidder has met the requirements of a Qualified Service Provider. The service period dates entered on the Authorization to Provide Services for SPED/ExSPED, SFN 1699, or Authorization to Provide Medicaid Waiver Services SFN ~~404~~ 410 ~~Section VII~~ is the time span in which the contractor agrees to finish the project.

10. Upon completion of the home modification, the HCBS Case Manager and the home care professional that participated in the initial home inspection and service recommendations, will inspect the job to determine if it was completed according to the bid. If not, the HCBS program administrator must be contacted immediately. Any cost overruns are the responsibility of the contractor.

11. Upon completion of Environmental Modification Service, a new care plan must be completed, having deleted the reference to Environment Modification Service.

Environmental Modification, Scope of

The modifications to the home allowed within the scope of this service must be of direct and substantial benefit to the applicant's/recipient's need to perform self-care or receive care from others that cannot be met by the current physical characteristic of a part of the home.

Examples of allowable home modifications include but may not be limited to the following:

1. Labor and materials to widen doorways to accommodate wheelchair.

2. Labor and materials to install a wheelchair ramp when structural changes to the house are required.

3. Labor and materials to install or relocate plumbing and/or electrical systems to accommodate specialized equipment.

4. Labor and materials to modify a bathroom, including installation or relocation of fixtures to accommodate the individual's personal care needs.

5. Labor and materials to modify a kitchen to enable accessibility for independent meal preparation.

6. Adaptations may include the installation of ramps, and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies and necessary for the welfare of the recipient.

Materials Authorized for Purchase

The materials authorized for purchase must be directly related to the health and safety of the client.

Family Home Care 525-05-30-30

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 client and the qualified family member shall reside in the same residence.
3. The client and the qualified family member shall mutually agree to the arrangement.
4. The qualified family member must be one of the relatives as defined in this chapter and must be the provider performing the care to the client.
5. The need for services must fall within the scope of tasks identified on the SFN 1012, Monthly Rate Worksheet - Live-In Care, and SFN 1699, Authorization to Provider 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 client is responsible for paying the Qualified Service Provider (QSP) directly for room and board IF the client lives in the provider's home.

Service Tasks/Activities - Family Home Care

The service tasks/activities within the scope of this service chapter are identified on the Authorization to Provide Services for SPED/ExSPED, SFN 1699, and only those listed on the SFN 1012, Monthly Rate Worksheet (MRW), can be approved and authorized.

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 client 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.) The child is most likely homebound or bedridden. There must be documentation that application was made for Developmental Disabilities Case Management, and a copy of the denial letter be placed in the client's file. A letter saying the applicant/child is not receiving DD services is not sufficient.

Out of Home Care

Payment can be made for days the client is receiving the SAME care from the SAME caregiver-QSP although not in the home they otherwise mutually share. No payment is allowed for clients out-of-state with the exception of clients seeking medical care out of state.

For care out of state, prior approval must be granted from the HCBS Program Administrator.

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

This provision within the Family Home Care service is appropriate for clients 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 client's welfare and safety. The client 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 client 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 client's continued health and safety.

Service Combinations

Family home care is an inclusive 24-hour service. Therefore, only 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 clients 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 a client cannot be safely left alone.
- If informal respite is in place and of benefit to the client, an exception must be obtained from the HCBS Program Administrator.

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 clients who require supervision for cognitive or heath related reasons. Contact the HCBS Program Administrator in writing to obtain approval for the combination of FHC and ERS service.

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.

Family Personal Care 525-05-30-32

Purpose

The purpose of family personal care (FPC) is to assist individuals to remain with their family members and in their own communities. It provides for the provision of extraordinary care payments to the legal spouse of a recipient for the provision of personal care or similar services.

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 client and qualified provider (who is the legal spouse and is enrolled as a personal care provider) shall reside in the same residence.

3. Before a legally responsible individual who has decision making authority over a client can be enrolled as a qualified service provider for Family Personal Care, the Case manager must ~~pre-~~approve the choice of provider. The case manager is responsible to forward 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 client to the State office. The narrative must be attached to the clients care plan.

4. The client and qualified provider shall mutually agree to the arrangement.

5. The need for services must fall within the scope of tasks identified on the SFN 1012, Monthly Rate Worksheet - Live-In Care (MRW), and Authorization to Provider Waivered Services.

Service Tasks/Activities

The service tasks/activities within the scope of this service chapter are identified on the Authorization to Provide Medicaid Waiver Services form, SFN ~~404~~ 410 and only those listed on the SFN 1012, Monthly Rate Worksheet, can be approved and authorized.

Out-of-Home Care

Payment can be made for days the client is receiving the SAME care from the SAME caregiver-QSP although not in the home they otherwise mutually share. No payment is allowed for clients out-of-state with the exception of clients seeking medical care out of state unless prior approval has been given by an HCBS Program Administrator.

Medical care out of state also requires prior approval from the HCBS Program Administrator.

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

This provision within the Family Personal Care service is appropriate for clients 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 client's welfare and safety. The client 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 client during routine absences from the home.

Limitations

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

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 client meets the eligibility criteria for Respite Care Services or when the spouse provides less than 24-hour per day care on a

routine basis, and the client 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 clients cannot be safely left alone or supervision is an authorized task on the MRW respite care must be authorized so the spouse 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 a client cannot be safely left alone.
- If informal respite is in place and of benefit to the client, an exception must be obtained from the HCBS Program Administrator.

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 clients who require supervision for cognitive or health related reasons. Contact the HCBS Program Administrator in writing to obtain approval for the combination of FPC and ERS service.

Home Delivered Meals 525-05-30-33

Purpose

The purpose of home delivered meals is to provide a well-balanced meal to individuals who live alone and are unable to prepare an adequate meal for them self, or who live with an individual who is unable or not available to prepare an adequate meal for the recipient.

At a minimum each meal must meet the most current meal pattern established by the United States Department of Agriculture's (USDA) Dietary Guidelines for Older Americans.

Service Eligibility, Criteria for

The individual receiving the home delivered meal will meet the following criteria:

1. Must be eligible for one of the following Medicaid Waiver for Home and Community Based Services, Service Payments to the Elderly & Disabled, or Expanded Service Payments to the Elderly & Disabled.

2. Service Payments to the Elderly and Disabled or Expanded Service Payments to the Elderly and Disabled recipients who are eligible for home delivered meals under the Older Americans Act (OAA) can access one additional home delivered meal per day, as long as at least one of their meals is provided and paid for under the OAA. Individuals requesting home delivered meals under the HCBS waiver are not required to use Older American Act meals first.

3. Lives alone and is unable to prepare an adequate meal or lives with someone who is unable or unavailable to prepare an adequate meal.

Limits

Recipients cannot receive more than seven (7) hot or frozen home delivered meals per week under Home and Community Based Services (HCBS).

Standards for Home Delivered Meal Providers

See Standards for Qualified Service Providers 525-05-45

Homemaker Service 525-05-30-35

Purpose

The purpose of Homemaker Service is to complete intermittent or occasional environmental tasks that an elderly or disabled 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. Has no informal network or other agency available/capable/willing to complete environmental task(s)/activities. The client must live-alone or the person(s) living with the client is/are not capable or obligated to complete the task(s). Homemaking services cannot be approved when they are completed for the benefit of both the client and the provider.

   If the live-in provider is a relative as defined in the definition of "family home care"~~,~~ or is a former spouse. the tasks of laundry, shopping, housekeeping, meal preparation, money management or communication CANNOT be authorized; except the department may provide essential homemaking activities such as meal preparation if the adult not receiving care who resides in the home is unavailable due to employment The department may provide shopping assistance only if at least one other activity is performed and no other shopping assistance is available through informal networks or other community providers.

4. For a client who lives with a capable person or a provider, prior approval for Homemaker Service must be obtained from the HCBS Program Administrator.

5. The need for environmental tasks/activities is intermittent or occasional.

6. 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 client (e.g. cooking, cleaning).

7. The department may provide essential homemaking tasks such as meal preparation if the adult not receiving care who resides in the home is unavailable due to employment. Prior approval for these tasks must be obtained from the HCBS Program Administrator.

8. The funding cap applies to a household and may not be exceeded regardless of the number of clients reside in the home.

EXAMPLE: If a husband and wife both qualify for homemaker services and the max funding cap must be shared by both clients. 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

    ~~1. If shopping is the only identified Homemaker Service, Homemaker Service should not be authorized.~~

    2. Transportation or escorting of the client are unallowable.

5. Communication
6. Managing Money

Services Activities, Authorized and Limits

1. The service tasks/activities within the scope of this service chapter are defined on page 2 of the Authorization to Provide Services for SPED/ExSPED, SFN 1699 and page ~~3~~ 2 of the ~~Person-Centered Plan of Care SNF 404~~ Authorization to Provide Medicaid Waiver Services, SFN 410.

2. When a client 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 a client 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.

Non-Medical Transportation 525-05-30-40

Purpose

The purpose of HCBS Non-Medical Transportation service is to enable individuals to access essential community resources/services in order to maintain themselves in their home and community.

Service Eligibility, Criteria for

The individual receiving non-medical transportation service will meet the following criteria:

1. Must be eligible for the Medicaid Waiver for Home and Community Based Services, Technology Dependent Waiver, SPED, or ExSPED.
    1. Clients receiving Transitional ~~Care~~ Living services are limited to eligibility for Non-medical Transportation Driver with Vehicle.
    2. Clients who are receiving Non-Medical Transportation Service under the Technology Dependent Waiver are limited to eligibility for Driver with Vehicle.
3. Is unable to provide his/her own transportation.
4. Needs a means of obtaining basic necessary community resources and/or services (i.e. grocery, pharmacy, laundromat).
5. Transportation alternative is NOT available such as through the informal network.

Service Activities

HCBS Non-Medical Transportation can ONLY be authorized for the client to access basic necessities (which are non-medical related) required in order for the client to remain in their own home. If a provider will be using another individual's vehicle to provide this service, the owner of that vehicle must provide proof of insurance and a written statement that they have given the provider permission to use the vehicle for this purpose.

1. Driver with Vehicle

HCBS Non-Medical Transportation service is to be provided from the client's place of residence to the essential service need/access point(s) and/or return. ~~The client must be transported to and/or from the essential service need/access point UNLESS:~~

~~1. Adverse weather/environmental conditions would expose client to unsafe conditions;~~

~~2. Client's health or impairment(s) restricts or prohibits activity outside his/her home.~~

Local round trip is for transporting the client to and from his/her home for essential services as is limited to flat rate per round trip of one (1) unit per calendar day.

2. Authorization of Escort

An escort may be authorized to accompany a client who uses public transportation IF the client requires assistance in boarding and exiting as well as while being transported AND the escort must be needed by the client in completing the activity. ~~The client must participate in the activity unless:~~

~~1. Adverse weather/environmental conditions would expose client to unsafe conditions;~~

~~2. Client's health or impairment(s) restricts or prohibits activity outside his/her home.~~

3. Authorization of Driver with Vehicle and Escort

An individual providing transportation may also be compensated as an escort IF the escort is needed by the client in completing the activity for which the HCBS Non-Medical Transportation is authorized. Compensation for escort must be separate from the per mile compensation for the transportation (driver AND vehicle). Example: A single provider provides both Driver with Vehicle and Escort. The billing time for the escort starts when the vehicle reaches the destination and stops when the client enters the vehicle to return home. A QSP cannot be reimbursed for escort services while driving.

Unallowable Service Activities

- HCBS Non-Medical Transportation CANNOT be used to transport a client to and from work/or school or to facilitate socialization or to participate in recreational activities, (i.e. wellness programs, church activities, etc.).

- HCBS Non-Medical Transportation CANNOT be used to transport a client to and from a health care provider or medical facility (doctor, dentist, hospital, physical therapy, etc.).

- ~~When escort is approved, shopping should not be approved under any other service including MSP-PC.~~

- If the client is not able to be transported or participate in the activity, this cannot be billed under Non-Medical Transportation. The service may be covered under Homemaker.

Clients receiving Transitional ~~Care~~ Living Services are exempt from this limit, service tasks would include transporting clients to/from work or school or to facilitate socialization, or to participate in recreational activities, escort to accompany the individual while they are being transported is not allowed, as it is a component of transitional ~~care~~ living services.

This service is not available when transportation is provided as a component part of another service.

Nursing Assessment 525-05-30-42

Purpose

The purpose of Nursing Assessment is to identify needs of eligible individuals and ensuring successful transition from an institution or another provider-operated living arrangement (to include skilled nursing facility, adult residential, adult foster care, basic care, and assisted living) to a living arrangement in a private residence where the client is directly responsible for his/her own living expenses.

Service Eligibility, Criteria for

The individual receiving Nursing Assessment will meet the following criteria:

1. Must be on Medicaid;
2. Must be at least age 18;
3. Must be eligible for Community Transition Services through the Home and Community Based Services waiver;
4. The care needs of the client must fall within the scope of Nursing Assessment as described in this service chapter;
5. The client must be transitioning from an institution or another provider-operated living arrangement to a living arrangement in a private family dwelling where the client is directly responsible for his/her own living expenses; and
6. Prior approval from a HCBS Program Administrator is required before this service may be authorized.

Service Activities

Nursing Assessment includes identifying health care related needs of eligible individuals ensuring successful transition into the community by completing a nurse assessment and related narrative.

Preliminary Care Plan

Nursing Assessment Services may be authorized up to 180 consecutive days prior to admission to the waiver of an institutionalized person. A preliminary care plan must be completed by the HCBS Case Manager. The Person Centered Plan of Care (SFN 404) and Authorization to Provide Medicaid Waiver Services (SFN 410), must be completed and noted "preliminary" at the top. The HCBS Case Manager is responsible to send the completed documents to the HCBS line.

Services Activities, Authorized and Limits

1. Nursing Assessment may not duplicate the assessment completed by the HCBS Case Manager.

2. Nursing Assessment may be authorized up to 180 consecutive days prior to admission to the waiver of an institutionalized person.

3. Nursing Assessment is limited to more than 14 units (unit = 15 min) per recipient to complete the assessment tool. Any exceptions to this limit must be prior approved by an HCBS Administrator.

4. Nursing Assessment will require prior approval from the HCBC Program Administrator to prevent any duplication of services.

5. When Nursing Assessment Services are furnished to individuals returning to the community from a Medicaid institutional setting through entrance to the waiver, the costs of such services are considered to be incurred and billable when the assessment is completed

6. The Nursing Assessment may be shared with the HCBS Case Manager if an appropriate release of information has been completed.

Billing

Nursing Assessment Services may be billed directly to Aging Services using an SFN 78 Request for Reimbursement and cannot be billed through MMIS.

Authorization of Services

The service activities within the scope of this service chapter must be identified on the Authorization to Provide Medicaid Waiver Service, SFN 410.

Standards for Providers

Enrolled agency or individual QSPs, authorized to provide Extended Personal Care Services.

- Individual - N.D.C.C. 43-12.1: N.D.A.C. (54-02, 54-05)
- Agency - N.D.C.C. 43-12.1; N.D.A.C. (54-02, 54-05)

1. An applicant for licensure by examination to practice as a registered nurse or licensed practical nurse shall: Submit a completed application and appropriate fee as established by the board of nursing; submit an official transcript showing completion of an in-state nursing education program or a board-approved out-of-state nursing education program preparing for the level of licensure sought; pass an examination approved by the board of nursing.

2. An applicant for licensure by endorsement to practice as a registered nurse or licensed practical nurse shall: Submit a completed application and appropriate fee as established by the board; submit an official transcript showing completion of a nursing education program preparing for the level of licensure sought; submit proof of initial licensure by examination with the examination meeting North Dakota requirements for licensure examinations in effect at the time the applicant qualified for initial licensure; submit evidence of current unencumbered licensure in another state or meet continued competency requirements as established by the board.

Personal Care Service 525-05-30-45

(Revised ~~7/1/15~~ 1/1/19 ML #~~3460~~)

View Archives

Purpose

The philosophy of the Department is that personal care should be provided so as to assist the eligible client with as many activities of daily living and instrumental activities of daily living as needed and as permitted in order to maintain independence and self-reliance to the greatest degree possible. Care, if appropriate, should be provided when, and as long as, the client needs it, up to 24-hour care if necessary. The client or legally responsible person must direct the care provided~~,~~ and should be involved in training and monitoring the personal care QSP as much as possible and when appropriate.

The informal network, especially family members, should be explored as potential informal providers of care before formal care is provided under the provisions of this chapter. Care provided by the informal network should not be replaced by formal/paid care unless it is necessary for the client to receive such care.

1. Personal care provided up to 24 hours per day, differs from adult foster care in that personal care is provided in the client's home, and adult foster care is provided in the service provider's home. If a non-relative is caring for the client on a 24-hr live in basis in the

provider's home, the service must be Adult Foster Care. It cannot be Personal Care service.

2. Live-in personal cares (daily care) are all inclusive with the exception of Respite Care.

3. Personal care differs from respite care in that respite care is provided to relieve the primary, live-in caregiver, whereas the primary purpose of personal care is to provide the care a client needs and not to relieve the caregiver.

Service Eligibility, Criteria for

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

1. Must be eligible for the SPED program and not eligible to receive Personal Cares under the Medicaid State Plan, or Family Home Care;

2. Be at least age 18;
3. The care needs of the client must fall within the scope of personal care service as described in this service chapter. The care needs may include a combination of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Either the client must have the ADLs and IADLs needs performed for him/her OR a cognitively impaired client may be able to complete the activity ONLY with supervision, guidance, or prompting.
   a. The task of supervision is allowed between other personal care tasks, up to the maximum number of units authorized.

4. Daily Personal Cares live-in must be authorized if the provider and the client live in the same residence.
   a. Daily Personal Care is an all-inclusive service and can only be combined with Respite Care. For unusual or unique circumstances, prior approval from the HCBS Program Administrator must be obtained.

5. Who lives alone or is alone due to the employment of the primary caregiver as the incapacity of other household members.

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

The provision of Daily Personal Cares live-in is appropriate ONLY for clients who can be left alone for routine temporary periods of time (e.g. part-time

employment) without adverse impact to the client's welfare and safety. The client must agree to be left alone.

Cognitively Impaired Clients, Services to

For cognitively impaired clients, the care plan shall identify how the daily care needs are met. During those periods of time when personal care service is not being provided, cooperative and coordinated efforts of meeting the needs of the client by the family, other informal providers, and agency providers are to be identified. The care plan must reflect the ongoing need for supervision, guidance, or prompting and must identify how the informal network entity(s) is involved to meet this primary need with the formal service network filling gaps.

Limits:

1. Clients whose providers do NOT meet the definition of Family Home Care may qualify for Personal Care Service. SPED Personal Care Service is not an option for clients when the live-in care provider is a family member. See N.D.C.C. 50-06.2-02(4) for the definition of family member.

2. Under Personal Care Service, payment can be made for time performing authorized personal care tasks even if performed outside the client's home as long as the cares are provided in the local trade area. The hours remain based on the care necessary in the client's home. The care provided outside the home must be within the defined scope (allowable tasks as authorized) of the service.

    1. Exception: When the client is required to seek essential services outside of the local trade area, contact the HCBS Program Administrator for prior approval.

Assisted Living Facility

A Monthly Rate Worksheet, SFN 1012, is completed for an individual to receive daily (SPED) personal care services in an assisted living facility when the client lives in a licensed assisted living facility and the provider has been approved to use the assisted living billing code.

The following criteria have been established for recipients in an "assisted living facility":

1. Clients meeting one of the following criteria may have a self-employed QSP as a live-in-attendant.

    a. The provider is a family member as defined in State law for Family Home Care.
    b. The intensity of care needs cannot be met under "assisted living" (e.g. need for continuous on-site care).
    c. The assisted living personal care provider is not identified in the tenant's rental agreement.

2. For those clients unable to do their own meal preparation, it will be included in the "assisted living" provider's daily rate. The provider may prepare the meal in the recipient's individual apartment or offer congregate dining. The recipient is responsible for payment of food costs.

The Monthly Rate Worksheet, SFN 1012, for Assisted Living Facilities is used in setting the daily rate for providers of "assisted living." The HCBS Case Manager must determine what services are being provided by the Assisted Living facility as a component of their base rate which includes room and board. For those services included within the base rate, the tasks would not be recorded and calculated in the Monthly Rate Worksheet. The monthly rate worksheet applies to all clients who receive assisted living personal care services.

Service Activities, Authorized and Limits

1. The service tasks/activities within the scope of this service chapter are identified on the Authorization to Provide Services for SPED/ExSPED, SFN 1699.

2. For Personal Care unit rate, housework, laundry, communication, money management, shopping, and meal preparation are considered homemaker tasks and cannot be authorized as a personal care tasks.

3. For Personal Care unit rate, Community Integration, Social Appropriateness, and Transportation are tasks which cannot be authorized under the SPED personal care service.

4. Live-in personal care services are limited to those tasks identified on the SFN 1012, Monthly Rate Worksheet.

Respite Care Service 525-05-30-55

Purpose

Respite care is care to an eligible individual for a specified period of time for the purpose of providing temporary relief to the individual's primary (live-in) caregiver from the stresses and demands associated with constant care or emergencies. This care is provided when there is a need for a specially trained caregiver. Respite care may be provided in the client's home, or outside the client's home in either a Respite Care Providers home or an enrolled Qualified Service Provider of Institutional Respite Care.

Service Eligibility, Criteria for

The individual receiving respite care service will meet the following criteria:

1. Must be eligible for Medicaid Waiver for Home and Community Services, SPED, or ExSPED.

2. The individual has a full time (live-in) primary caregiver OR the individual is a child under 22 years of age who is attending school AND the primary caregiver is responsible for providing full time care when the individual is not in school.

3. The relief is not for the primary caregiver's employment or enrollment/attendance of an educational program.

4. Children three (3) months of age and under would be eligible only for SPED Respite Care for apnea monitoring. See Limits section for infants over three months of age.

5. Clients enrolled in a Hospice program are not eligible for institutional Respite Care but would be eligible for in-home intermittent Respite Care.

6. For a client whose full-time primary caregiver does not live with him/her but provides frequent on-site visits throughout the day which is essential to allow the client to live independently, contact the HCBS Program Administrator for prior approval for Respite Care.

7. The client needs a qualified caregiver or it would be inappropriate to use an unqualified caregiver in the absence of the primary caregiver.

1. If laundry and/or housekeeping are the only service need, Respite Care authorization is unallowable.

8. The primary caregivers need for relief is intermittent or occasional.

9. If the prospective respite care provider lives with the client, contact the HCBS Program Administrator for prior approval.

10. A client who is a resident of an Adult Foster Care home may choose their respite provider and is not required to use a relative of the Adult Foster Care provider for respite.

Information Provided to the Respite Care QSP:

Case Management documentation should verify that the consumer or legally responsible party are responsible to inform the Respite Care provider of the following:

1. The Respite Care QSP shall be informed about the client's daily routine. This may include strengths and weaknesses of the client, what the client enjoys doing, unique instructions for specific activities, or special assistance requirements.

2. The primary caregiver will explain in writing situation(s) which may result in an emergency. The written information should clarify what might happen, the appropriate response, and who the Respite Care QSP should contact for assistance.

3. The primary caregiver shall identify to the Respite Care QSP the location of a first aid kit in the home, the location of the fuse box and spare fuses, the fire exit plan for the home and explain special instructions/restrictions on the operation of household appliances, kitchen equipment, etc.

4. If client specific or global endorsements are required, the Respite Care QSP must meet the competencies for these tasks.

Service Activities, Authorized

The service tasks/activities within the scope of this service chapter are identified on the Authorization to Provide Services for SPED/ExSPED, SFN 1699 or Authorization to Provide Medicaid Waivered Services SFN ~~404~~ 410.

Service Activities, Not Allowed

Shopping, Community Integration, Social Appropriateness, Transportation are tasks that cannot be authorized under the Respite Care service.

Limits

1. Non-institutional Respite Care is capped at the daily swing-bed rate (http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-fee-schedules.html) regardless of whether an overnight stay is included. Respite Care providers must bill using the Procedure Code for a 15-minute unit, not to exceed the daily swing-bed rate. Only providers of Institutional Respite Care can bill using the Procedure Code for a daily rate.

2. Twenty-four hour care shall be allowed in an emergency and cannot exceed the Respite Care cap without prior approval of the HCBS Program Administrator.

3. Respite Care may be provided for up to three (3) months to an infant requiring apnea monitoring if other SPED Program eligibility criteria are met, AND an apnea monitor is recommended by the applicant's physician.

4. An applicant/client requiring apnea monitoring is eligible upon the HCBS Program Administration receiving the SFN 1820, Data for SPED Program Pool Entry/Denial, with the notation the client is on apnea monitoring. The effective date of service will be the date requested by the HCBS Case Manager. Coverage under the SPED program can be extended beyond three (3) months upon written request to the Respite Care Program Administrator documenting the continued need for Respite Care as a result of continued need for apnea monitoring.

5. The total allowable monthly maximum for Respite Care must be prorated for all residents in the Adult Foster Care home (regardless of private or public pay). The number of public and private pay AFC residents in a home should be evaluated quarterly during the quarterly contact. Any changes in the amount of respite should be updated at that time.

6. The total allowable maximum for respite care must be prorated for all clients receiving and living in the same Family Home Care setting.

7. If multiple clients live in the same home and have the same primary caregiver the respite cap must be divided by the number of client's in the home.

8. The Department of Human Services may grant approval to exceed the service cap if the client has special or unique circumstances; the need for additional services does not exceed 3 months; and the total need for service does not exceed the individualized budget amount. Under emergency circumstances, the Department may grant a one-time extension not to exceed an additional three months. The case manager must make participants aware of the service cap.

Institutional Respite Care

Institutional respite care is care provided in a residential setting by a provider who is enrolled to provide Institutional Respite Care Services as a Qualified Service Provider of Institutional Respite Care.

1. Placement/Admission: Institutions providing Respite Care are required to follow licensing rules for long term care facilities in North Dakota. Respite care provided in an institutional setting requires the minimum of an overnight stay. Therefore the facility accepting the client for the provision of Respite Care must provide the same sleeping accommodations available to residents or patients of the facility.

   The facility cannot exceed their licensed or approved capacity. The Respite Care client(s) must be included in determining whether the license or approved bed capacity would be exceeded.

2. Staff: Because the facility must meet staffing patterns as defined by their licensing or Medicare-approval authority, the care staff of the facility will not be required to meet the specific standards of this chapter. The facility must make available evidence the care staff meet the requirements of their licensing or Medicare-approval authority upon request of the county social service board and/or representative of the Department.

3. Records: The facility shall maintain such client chart or records as is required for residents/patients of the facility.

Adult Foster Home for Respite Care

Adult Foster Homes that are also enrolled as Respite Care Homes and are providing services for clients who are not current Adult Foster Care

recipients bill their established Respite Care unit rate; the total cost per day cannot exceed the current swing bed rate.

When a client who is a current Adult foster Care client receives overnight care in another licensed foster care home, the rate for that client is the current established foster care rate and the Adult Foster Care procedure code is used.

Respite Care in QSP's Home

The form, Respite Home Evaluation, SFN 659, must be completed to provide evidence that the Respite Care QSP's home meets the standards for home Respite Care in addition to being an enrolled Qualified Service provider for Respite Care Service. The county social service board is responsible for completing the evaluation and forwarding a copy to the HCBS Program Administrator.

1. A minimum of one (1) home visit to the Respite Care QSP's home shall be made by the County Social Service Board to complete the form Respite Home Evaluation.

2. Upon determining the respite care QSP's home meets the standards as outlined in SFN 659, a copy of the completed SFN 659 approving such compliance shall be issued to the respite care QSP to be effective for no more than two (2) years. The Respite Care Home QSP must sign an agreement to maintain the standards and keep a copy of the standards on the premises of the home. The approval shall apply to only the home at the address evaluated. Should the Respite Care QSP move, another evaluation is required.

3. The County Social Service Board shall maintain records of the evaluation, the decision, and the reason for that decision.

Specialized Equipment and Supplies 525-05-30-60

Purpose

Specialized Equipment and Supplies Service includes the purchase of equipment and supplies that will facilitate or promote a recipient's independent functioning within his or her home or family member's home if the recipient resides in the home. The service is not physician driven nor is the allowable equipment and supplies authorized for purchase under this

service chapter to primarily serve medical needs, although, the products may indirectly assist with medical needs.

Specialized equipment is supplies, safety devices, or assistive technology that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Coverage may include the cost of set up, maintenance, and upkeep of equipment, and may also include the cost of training the participant or caregivers in the operation and/or maintenance of the equipment.

Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device.

Assistive technology includes:

1. The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;

2. Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;

3. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;

4. Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and

5. Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

Service Eligibility, Criteria for

The individual receiving Specialized Equipment and Supplies Services must meet the following criteria:

1. Must be eligible for the programs of Medicaid Waiver for Home and Community Services.

2. The basis of need for the equipment is established through the assessment process and must include an adaptive assessment completed by a professional with expertise in the equipment requested, (e.g. PT/OT, Speech and Hearing). Prior approval is required for the purchase of specialized equipment or supplies.

3. The equipment purchased is of significant benefit to the applicant/recipient in the performance of personal cares and/or household tasks in the home.

4. The recipient does not already have access to a product that serves essentially the same purpose.

5. The need for the equipment is expected to extend indefinitely.

6. The individual is motivated to use the equipment.

7. A written bid must be obtained for any specialized equipment and/or supplies funded under this service chapter. If the equipment or supplies are considered durable medical equipment (DME), the bid must include healthcare common procedure coding system (HCPCS) codes.

   ~~7~~8.The equipment is a non-covered item under the Title XIX State Medicaid Plan or unavailable through other funding sources. A list of ND Medicaid DME covered items may be found at http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-fee-schedules.html.

   ~~8~~9. The informal network (family members, friends, or neighbors) is not willing or able to purchase the equipment for the individual.

~~9~~ 10. Pre-approval from the Department of Human Services is required before this service can be authorized.

Limits

The costs are limited to what is budgeted per person for Specialized Equipment and Supplies in the federally approved in the Medicaid Waiver(s).

These goods must not be attainable through other informal or formal resources.

Items reimbursed with waiver funds are only for medical equipment and supplies not covered under the State Plan; and exclude those items that are not of direct medical or remedial benefit to the participant.

All items shall meet applicable standards of manufacture and design.

Specialized Equipment and Supplies, Scope of

The products covered under this Service Chapter are ADL/IADL related products that are not covered under the Title XIX Medicaid State Plan. Examples of such specialized equipment and supplies may include but are not limited to the following:

1. Communication Board
2. Remote control device to safely operate electronic appliances such as microwave, garbage disposal, blender, toaster, television, etc.
3. Special designed wheelchair lap tray
4. Specialized positioning devices(s)
5. Safety devices and equipment

Specialized Equipment and Supplies, Delivery Of

When it has been determined that a specific item(s) (applicable to this service chapter) will be of benefit to the applicant/recipient, the following procedure is followed:

1. The HCBS Case Manager will contact a supplier of the specialized equipment and/or supplies who are enrolled as a Qualified Service Provider or may be willing to enroll as a Qualified Service

Provider. The purpose of the contact is to authorize purchase of the approved item and to verify the cost.

2. The supplier will ship/mail the item only upon receipt of the Authorization to Provide Medicaid Waiver Service, SFN ~~404~~ 410. The Qualified Service Provider will request payment from the Department of Human Services using the QSP payment system.

3. The supplier is responsible to arrange for or provide any instruction the recipient may need to use the specialized equipment.

4. One month following delivery, the HCBS Case Manager is to contact the recipient to monitor the effectiveness of the specialized equipment. The results of this monitoring contact are documented in the case file. It is at this point that Specialized Equipment and Supplies Service should be deleted from the Medicaid Waiver Person Centered Plan of Care, SFN 404 if no further need exists for the reimbursable items of this service chapter.

Transitional Living 525-05-30-70

Purpose

A program which provides training for the client to live with greater independence in the home.

Service Eligibility, Criteria for

The individual receiving Transitional Living Services will meet the following criteria:

1. Must be eligible for the Medicaid Waiver for Home and Community Services;

2. Service/care is delivered in the recipient's private family dwelling (house or apartment);

3. Individual must benefit by receiving Transitional ~~Care~~ Living Services and is cost-effective and necessary to avoid institutionalization;

4. Require supervision, training, or assistance with self-care, communication skills, socialization, sensory/motor development,

reduction/elimination of maladaptive behavior, community living and mobility;

5. Disabled as determined by Social Security Disability criteria; and

6. Recipient is capable of directing own care as determined by the interdisciplinary ICP team~~,~~ or have a (legally) responsible party to act in the recipient's behalf.

7. Pre-approval from the Department of Human Services is required before this service can be authorized.

Service Tasks

Tasks that can be authorized are bathing, communication, community integration, dress/undress, eye care, feeding/eating, hair care/shaving, housework, incontinence, laundry, meal preparation, medication assistance, money management, nail (finger) care, shopping, skin care, social appropriateness, teeth/mouth care, toileting, transferring/turning/positioning. Escort to accompany individuals while they are being transported to/from work or school, to facilitate socialization, or to participate in recreational activities is allowed.

The global endorsements of cognitive/ supervision, exercises, Hoyer lift/mechanized bath chairs, indwelling catheter, medical gases, prosthesis/orthotics, suppository/bowel program, ted socks, temp/BP/pulse/ respiration rate and the client specific endorsements of apnea monitor, Jobst stockings/ostomy care, postural/bronchial drainage and Ric bed care may also be authorized.

Tasks must be identified on the Authorization to Provide Medicaid Waiver Service~~s~~ ~~SFN 404~~ SFN 410.

Service Combinations

1. Non-Medical Transportation Driver w/Vehicle may be combined with Transitional ~~Care~~ Living Service.

2. Non-Medical Transportation Escort Service is Transitional ~~Care~~ Living and therefore would not be authorized.

3. Respite care may be combined with Transitional ~~Care~~ Living Service.

4. Adult Day Care may be combined with Transitional ~~Care~~ Living.

5. Homemaker, adult foster care, adult residential care and family personal care cannot be authorized with Transitional ~~Care~~ Living services.

Individual Program Plans

Once an individual begins Transitional ~~Care~~ Living, an Individual Program Plan must be completed by the interdisciplinary team (to at least include the service provider, the individual and/or their legal representative) and the case manager.

This plan must be completed within 30 days of the beginning effective date of the services. The Plan must include how the provider will meet the needs of the client, AND the plan for the promotion of the client's independence in ADLs and IADLs, social, behavioral, and adaptive skills.

The Plan must also identify the goal or goals of the individual and how the goals will be accomplished. This Plan will be subject to review by the HCBS Case Manager during the initial Plan implementation period and every six months thereafter. At the team meeting, the team will review the goals and progress, and strategies for accomplishing the plan goal or goals.

Service is provided until the interdisciplinary team determines this service is no longer appropriate.

Critical Incident Reporting 525-05-42

Critical Incident

In order to assure the necessary safeguards are in place to protect the health, safety, welfare of all clients receiving HCBS, all critical incidents (as defined in this chapter) must be reported and reviewed (as described in this chapter). The goal of the incident management system is to proactively respond to incidents and implement actions that reduce the risk of likelihood of future incidents.

A critical incident is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of any client receiving HCBS.

Reportable incidents

1. Abuse (physical, emotional, sexual), neglect, or exploitation;
2. Rights violations through omission or commission, the failure to comply with the rights to which an individual is entitled as established by law, rule, regulation, or policy;
3. Serious injury or medical emergency, which would not be routinely provided by a primary care provider;
4. Wandering or elopement;
5. Restraint violations;
6. Death of a client and cause (including death by suicide);
7. Report of all medication errors or omissions; and
8. Any event that has the potential to jeopardize the client's health, safety or security if left uncorrected.

HCBS Case Manager will follow up with all reported critical incidents.

If HCBS Case Manager has first-hand knowledge of a critical incident, follow incident reporting requirements.

If the case involves abuse, neglect or exploitation, a formal VAPS (Vulnerable Adult Protective Services) referral will be initiated according to ND Century Code 50-25.2-03(4). VAPS will be responsible for independent review and follow up.

If the incident involves a provider, the complaint protocol will be followed to determine the next steps, which may include involving law enforcement.

Incident reporting requirements

Any paid provider or family member who is with a client, involved, witnessed, or responded to an event that is defined as a reportable incident, is required to report the critical incident.

As soon as a paid provider or paid family member learns of a critical incident involving a client, the incident must be:

1. Reported to the HCBS Case Manager and

2. Complete an incident report (SFN 53601 – Risk Management Medical Services Incident Report).
    a. SFN 53601 is found here: https://www.nd.gov/eforms/Doc/sfn53601.pdf
    b. The completed SFN 53601 is to be forwarded to the HCBS Case Manager within 24 hours of the incident.
    c. The HCBS Case Manager will forward to Aging Services.

Examples

Example 1: If a client falls while the QSP is in the room but the client didn't sustain injury or require medical attention, a critical incident report is not required.

Example 2: If a family member informs the case manager that a client is in the hospital due to a stroke, a critical incident report is not required because the case manager nor QSP witnessed or responded to the event.

Example 3: If a QSP comes to a client's home and the client is found on the floor and the QSP calls 911 so the client may receive medical attention, a critical incident report is required because the client required medical attention AND the QSP responded to the event (fall).

Application for Service, SFN 1047 525-05-60-05

Purpose: For individuals to formally request Home and Community Based Services (HCBS).

Prior to conducting a comprehensive assessment, an applicant (or legal representative) must complete the application form.

- Applicant's Name – print the name of the applicant (one SFN 1047 per applicant);
- Date – date of application;

- Agency – County Social Service Board of applicant's physical county or HCBS Case Management agency;
- County of Residence – applicant's physical county of residence;

- ~~Name – print the name of the applicant (one SFN 1047 per applicant);~~
- I apply for services to assist me with – the applicant indicates what services or programs for which the applicant is requesting assistance;
- FOR YOUR INFORMATION – applicant or legal representative must read this section prior to signing;
    - ~~The applicant must check to acknowledge the receipt of the "Your Rights and Responsibilities" brochure.~~
- Signature section – the applicant and/or the legal representative must sign and date the application form.

The original is to be filed in the applicant's case file.

An electronic copy is available through the state e-forms (SFN 1047).

Add New Record to MMIS Eligibility File for SPED or Ex-SPED, SFN 676 525-05-60-30

Purpose: In order for an individual to be enrolled in the benefit plans of SPED or Ex-SPED and to receive a client identification number, to change the service fee, to update client statistical information, or to begin applicant client eligibility for payment purposes.

~~For new applicants:~~

~~An "Add New Record to MMIS Eligibility File," SFN 676 must be submitted to the Aging Services Division along with the SPED Program Pool Data, SFN 1820 or Ex-SPED Program Pool Data SFN 56.~~ This form is used to identify active SPED & Ex-SPED program recipients in the payment system. When billings are received from providers, the claim is checked against the SPED or Ex-SPED eligibility Medicaid Management Information System (MMIS) ~~MMIS~~ file.

~~For changes to service fees, statistical information, or re-entry into the SPED or Ex-SPED Pool:~~

~~An "Add New Record to MMIS Eligibility File SPED or Ex-SPED", SFN 676, must be completed~~ This form is also used if there is a change in the

statistical information such as address or corrections to the Social Security Number or birthdate. In addition if there is a change to the SPED service fee (percentage), this form must be completed and forwarded to the Aging Services Division (HCBS) along with the date of the change.

If this form is not submitted when a SPED service fee changes and it results in an over payment or underpayment to the provider the case manager must file an adjustment to correct the payment error.

Steps of Completion:

Client Information: Complete the client's name, identification number, physical address, mailing address (if different from physical address), gender, date of birth and social security number. Record the HCBS case manager's name, the county in which the client resides and county number.

Application Information: Select one of the following boxes: initial, rate change, address change, or re-open.

Funding Type: Select SPED or Ex-SPED.

Date of Application and Approval: The HCBS case manager will complete the date of application, which is the date of the most recent assessment (or level of care screening, if a child) was completed. The approval date will be completed by Aging Services when approved by an HCBS Program Administrator and MMIS has been updated. This field would be completed by the HCBS Case Manager only when there is an exception requested to the SPED or Ex-SPED Pool approval date.

Liability Information: This section is to be completed for SPED clients only. Record the percentage of SPED costs that is the client's responsibility (also referred to as recipient liability, client participation fee, or client share) and the effective date. This percentage will be found by completing the SPED Income and Asset Form (SFN 820). This percentage must match the percentage on the "SPED Program Pool Data" (SFN 1820). If the client does not have a fee, enter zero. After the opening of a new case, a change in liability is effective the first of the month following the month of action.

Note: for changes to the SPED service fee, changes occur the first of the following month of the change. Dates should not include partial months.

New SPED or Ex-SPED Clients Only: This demographic section is to be completed for new SPED clients only.

- Is the client's primary language English? If no, please record the client's primary language.
- What is the client's marital status?
- Is the client a United States citizen? If no, please record the citizenship status.
- Is the client Latino/Hispanic?
- What is the client's race?

~~Below are the instructions for completing those items on SFN 676, "Add New Record to MMIS Eligibility File" (E101) that have not been preprinted.~~

~~ITEM~~	~~-~~
~~COUNTY NUMBER~~	~~Enter the county number where the client resides.~~
~~CASE MANAGERS NAME~~	~~Enter the case managers first and last name.~~
~~SPED/EX-SPED:~~	~~Check the box to indicate if the applicant is applying for SPED or Ex-SPED.~~
~~RECIPIENT ID:~~	~~Enter the clients ND number if known. If not known leave it blank.~~
~~NAME:~~	~~Print the individual's last name, first name and middle initial in spaces provided.~~
~~ADDRESS:~~	~~Enter mailing address of client.~~
~~ZIP CODE:~~	~~Enter the remainder of the zip code. The "58" is preprinted because all zip codes in North Dakota begin with those numbers.~~

~~RACE:~~	~~Check the appropriate box to indicate the applicant's race:~~ ~~White~~ ~~Black or African American~~ ~~American Indian or Alaskan Native~~ ~~Native Hawaiian or Other Pacific Islander~~ ~~Other~~ ~~Asian~~
~~SEX:~~	~~Check the correct box~~ ~~Male~~ ~~Female~~
~~BIRTH DATE:~~	~~The first 2 boxes (mm) are for the month, the second 2 boxes are for the day (dd), the next two boxes are for the century (cc), and the last 2 boxes are for the year (yy). September 7, 1915, is entered as 09071915.~~
~~APPL. DATE:~~	~~Enter the date the most recent assessment (or level of care screening, if a child) was completed. The date is two digits for month, two for day, two for the century, and two for year: September 7, 1915, is entered as 09071915.~~
~~SSN: (NUMERIC ONLY)~~	~~Enter the client's social security number. Do NOT use dummy numbers. If the client does NOT have a social security number of their own, leave blank.~~
~~APPR. DATE:~~	~~SPED & Ex-SPED Program approval date is completed by the Medical Services/HCBS. This field would be completed by the Case Manager only when there is an exception to the SPED or Ex-SPED Pool approval date.~~
~~SPED LIABILITY %:~~	~~Enter the percentage of SPED costs that is the client's responsibility. If the client does not have a fee, enter zero. If there is no~~

	~~entry in this section, it will be returned for completion.~~
~~SPED LIABILITY DATE:~~	~~Effective date of the percentage of "liability." If the client does NOT share in the cost of the services, leave blank. After the opening of a new case, a change in liability is effective the first of the month following the month of action.~~

For new clients, this completed form is to be emailed or faxed to ~~the~~ Aging Services/HCBS at the same time as the SPED or Ex-SPED Program Pool Data form is submitted (SFN 1820 or SFN 56).

For rate change, address change, or to re-open within two calendar months, this completed form is to be emailed or faxed to Aging Services/HCBS.

~~The form is available electronically through the state e-forms system.~~

The original is to be filed in the applicant's case file. A copy must be sent to Aging Services/HCBS.

An electronic copy is available through the state e-forms (SFN 676).

Expanded SPED Program Pool Data, SFN 56 525-05-60-35

Purpose: To provide evidence an applicant is eligible for the Expanded SPED (ExSPED) program. This form, SFN 56, is forwarded to the Aging Services Division, along with the SFN 676, in order to enter the applicant into the ExSPED pool and to assign a recipient identification number.

Steps of Completion:

Name: Complete the name of the applicant

Social Security Number: Enter applicant's SSN

~~Check Here if Person Lives~~ Does the Person Live Alone: If the person lives alone or has minor children or the other family member(s) in the house that are physically or mentally unable to assist the client, check ~~the box~~ "yes".

~~Last/First Name: Print the name of the applicant~~

~~Birth Year/Birth Month/Birth Day: self-explanatory~~

~~Sex: If the applicant is a male, record a **1** in the box; if female – record a **2**~~

ADLs: Based on the functional assessment, transfer the scores from the assessment document to the applicable score box. ~~If the applicant is eligible for the ExSPED program, the applicant cannot be severely impaired in the ADL's of toileting, transferring, or eating impairments (which means the applicant cannot have a score of **3** in these activities).~~ ADLs scored in this section include bathing, eating, mobility inside, transfer bed/chair, dressing, toileting, and continence.

The scoring criteria for ADLs is as follows:

0 = completely able

1 = able with aids/difficulty

2 = able with help

3 = unable

IADLs: Based on the functional assessment, transfer the scores from the assessment document to the applicable score box. ~~If the applicant is eligible for the ExSPED program based on IADLs, the applicants IADL score fields will reflect impairments of Meal Preparation, Housework, Laundry, and/or Taking Medications with a score of one or two in three of these IADLs.~~ IADLs scored in this section include meal preparation, communication, laundry, taking medication, shopping, mobility outside, transportation, housework, and management of money.

The scoring criteria for IADLs is as follows:

0 = without help

1 = with help

2 = unable to do at all

If the applicant is eligible for the Ex-SPED program, the following criteria must be met:

Impaired (score is 1 or 2) in at least three of the following four IADLs meal preparation, laundry, taking medication, or housework.

~~Cost of Service Estimated Monthly Dollars: Record the estimated dollar amount per service that will be anticipated as an authorized service.~~

Case Manager, County, and County Number: Record the HCBS Case Manager's name, county in which the client resides, and ~~C~~county number.

~~The form, SFN 56, is not available from the state office. It is available through the state electronic e-forms.~~

The original is to be filed in the applicant's case file. A copy must be sent to Aging Services/HCBS.

An electronic copy is available through the state e-forms (SFN 56).

Explanation of Client Choice, SFN 1597 525-05-60-50

Purpose: This form is to be completed by the Medicaid eligible applicant/client who is applying for HCBS in lieu of institutional care. The purpose of the form is to document that Medicaid eligible individuals seeking a Medicaid Waiver service are informed of their choice of home and community based services versus nursing home care.

This form is to be completed for all Medical Assistance eligible individuals electing to receive services from the Medicaid Waiver programs.

The SFN 1597 is to be completed prior to the services beginning and not required to be completed on an annual basis. If the individual discontinues

as a Medicaid Waiver recipient and re-applies for services, the form must be completed again prior to services being authorized.

In the first section, record the following applicant's information: ~~Medical Assistance Case Number;~~ Name (Last/First/Middle); Client Identification Number (ND Number); Residential address; City, State, Zip Code, and ~~Telephone Number~~ County of Residence. Also record the Case Manager's name ~~and the applicable County name~~.

After the applicant (or legal representative) reads the applicant's rights section, the applicant (or legal representative) should indicate by checking the acceptance of the HCBS services as identified on the Individual Care Plan or the by checking the box indicating the choice of institutional care.

The applicant or legal representative must sign and date the form at the bottom.

~~The form, SFN 1577, is available from Office Services.~~ The original is to be filed in the applicant's case file ~~at the County office~~, a copy must be given to the applicant or legal representative and a copy must be scanned to Aging Services/HCBS.

An electronic copy is available through the state e-forms (SFN 1597).

SPED/ExSPED Individual Care Plan, SFN 1467
525-05-60-60

Purpose:

The SPED/ExSPED Individual Care Plan (ICP) is a summary of the needs and service options identified in the assessment process and is an outline of the plan developed by the client and Case Manager to meet the client's needs.

This form is only completed for SPED and EXSPED clients.

When Prepared:

The SPED/ExSPED Individual Care Plan is required for all SPED and EXSPED clients receiving Home and Community Based Services (HCBS), including HCBS Case Management and TCM Case Management. It is to be revised or updated as client's needs warrant. It is to be reviewed with the client at the annual~~/~~ and six-month review, and complete a new form if necessary due to changes in service(s) and/or amounts.

The SPED/ExSPED Individual Care Plan must be revised when a change occurs (unless it is a result of legislative action).

By Whom Prepared:

The client's HCBS case manager will complete the SPED/ExSPED Individual Care Plan in conjunction with the applicant/client or his/her legal representative. The signature of the client or legal representative on the ICP completes the care planning assessment of needs process.

If the client or representative refuses to sign the ICP, the reason for the refusal should be noted in the case file, and that the client was made aware of the right to appeal.

Section I Client Identification:

Enter the name, physical address, client identification number, and county of residence, ~~and county code~~. Mark yes or no if this plan overlaps the current plan filed at the department.

Section II Approved Services:

Check the appropriate funding source~~/sources~~. If receiving Rural Differential (RD) Rate (determined under Rural Differential policy 525-05-38) mark the correct tier (RD 1, 2, or 3) for rate.

☐ SPED ☐ ExSPED ☐ RD1 ☐ RD2 ☐ RD3 ☐ RD Removed

Column Headings:

1. SERVICE: Enter the service(s) that has/have been identified for which the client is eligible, a provider is available, and the client has accepted.

2. SERVICE PROVIDER: Identify the qualified service provider (agency or individual) who will provide the service (including the service of Case Management).

3. PROVIDER NUMBER: Enter the qualified service provider's number (including the service of Case Management).

4. UNIT RATE: Refer to the Qualified Service Provider (QSP) listing for rate. Enter the QSP unit rate (including the service of Case Management).

    a. If RD box was marked – rate should match rates determined within Rural Differential policy. (Total rate cost may be over cap however units should match cap~~:~~. For example: Homemaker service cap is 70 units~~'~~ for individual QSPs or ~~50~~ 51 units~~'~~ for agency QSPs ~~cap out Homemaker services.~~)
    b. If removal of Rural Differential is required: make mark the box "RD removed" and write the end date by QSP name being removed from RD, cross off RD rate and write correct rate. Complete the SFN 212.

5. UNITS PER MONTH: Enter the total number of units of service to be provided per month.

6. COST/MONTH: The cost per month is calculated based on the amounts in the columns headed "Unit Rate," and "Units per Month" (based on a 31-day month).

Case Management has been pre-entered on the form. The Service Provider, Provider Number, and Unit Rate must be entered by the Case Manager. The Units Per/Month has been pre-entered, Cost/Month section has a pre-entered notation.

Complete the "Estimated Monthly Cost to Client for Services" by adding the SPED fee percentage and the estimated monthly amount and complete the "Plus the Amount for HCBS Case Management."

The Contingency Plan must be completed. A Contingency Plan is required if the provider is not an agency. If a contingency plan is not required, N/A~~s~~ needs to be entered in this section.

Total Cost: The total per month costs of services is the total to be reimbursed SPED/Expanded SPED Programs. The Grand Total does NOT include the cost of HCBS Case Management. When authorizing services by unit and or daily rate, the maximum amount must not exceed on the program and/or service cap.

Section III: Other Agencies/individuals Providing Services.

The HCBS Case Manager records the services not authorized by the county social service board but being received by the applicant/client or being arranged. This would include home and community-based services provided by a home health agency or senior service provider (home delivered meals, congregate meals, transportation, etc.) for example.

Column Headings:

1. SERVICE: Name of the service being arranged or received.

2. PROVIDER: Name of the agency, or if an independent contractor, name of the person.

Section IV: Goals: For all recipients, the case manager will discuss with the recipient the goal(s) they may be striving to achieve; and this section must be completed on all care plans.

Column Headings:

1. ~~CLIENT STATED~~ GOAL: Enter the client's stated goal.

2. START DATE ~~GOAL ESTABLISHED~~: Enter the date the goal was established.

c. END DATE ~~Date GOAL COMPLETED~~: Enter the date the goal was completed, do not complete when the goal is determined to no longer be applicable.

~~d. CONTINUED: Check if the goal was continued from the last care plan and enter the date the goal was established.~~

~~e. COMPLETED: Check when the goal is completed.~~

~~f. NO LONGER APPLICABLE: Check if the goal is no longer applicable.~~

A goal should not be removed from the care plan until it has been ~~checked~~ completed or no longer applicable. After it has been completed or is no longer applicable, it does not need to be listed on the ICP.

Section V: ~~ADLS~~ ADLs and ~~IADLS~~ IADLs Scores (scores from functional assessment): ADL~~'~~s & IADL~~'~~s Scores must be added from the Functional Assessment scoring.

Section VI: Signatures:

The client/legally responsible party must check all applicable boxes acknowledging agreement and or awareness of the specific information.

The effective date of plan and the ~~The~~ signature of the client/legal representative and HCBS Case Manager is required ~~in the left hand portion of~~ on all ICPs.

"Six-Month Review": If there is NO change to be made ~~in Section I~~ to the ICP as a result of the six-month review, the client/legal representative can sign the original SPED/ExSPED Individual Care Plan ~~ICP~~, SFN 1467, in the area provided. The signature of the HCBS Case Manager completes the six-month review requirements for the ICP.

Number of Copies and Distribution:

The original is filed in the applicant's/client's case ~~record~~ file. One copy is provided to the applicant/client/legal representative when completed. One copy is ~~mailed~~ emailed or faxed within three working days to Aging Services Division - HCBS/DHS. This includes ICPs completed annually, continued, updated at the six-month contact and a care plan that identifies a change.

~~This form is available from Office Services and an electronic copy is available through the state e-forms.~~

An electronic copy is available through the state e-forms (SFN 1467).

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

Purpose: The Monthly Rate Worksheet, SFN 1012, is used by the Case Manager to determine the daily rate of payment for live in, 24 hour care. This is to be completed and forwarded to ~~Medical~~ Aging Services/HCBS on an annual basis regardless of a change.

SECTION I: IDENTIFYING INFORMATION

Complete the ~~individual's~~ client's name, client's identification number (ND number), ~~the Case Manager's name,~~ date the assessment is completed, ~~individual's~~ county of residence, HCBS Case Manager's name, ~~the individual's recipient identification number,~~ the effective date of the rate as determined on the rate worksheet, and the ~~individual's~~ client's date of birth. Check the appropriate funding source and if the client is served under developmental disabilities (DD) services.

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.

Exception (only applies to SPED personal care): If a provider is caring for more than one client in the home, some of the point tasks could be shared by the clients. For example, if there are two SPED personal care clients in the provider's home, the housekeeping point value of

10 would be shared by the two clients (or each client would receive only 5 points each).

Effective January 1, 2010 full point values for laundry, shopping and housekeeping can be used to calculate Adult Foster Care (AFC) ~~AFFC~~ rates for each ~~AFFC~~ AFC private pay residents. The points for these tasks no longer need to be split between residents.

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 Unit 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 unit rate.

SECTION IV: PROVIDER INFORMATION

Enter the provider's name, number, and mailing address in the spaces provided. In most instances, the provider will already have been assigned a Qualified Service Provider Number. ~~Enter the provider's number in the space provided.~~

DISTRIBUTION

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

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

Authorization to Provide Services for SPED/ExSPED, SFN 1699 525-05-60-70

Purpose: The Authorization to Provide Services is used to grant authority to a qualified service provider for the provision of agreed upon service tasks to an eligible SPED and EXSPED client.

When Prepared:

The Authorization to Provide Services for SPED/ExSPED is completed when arrangements are being made for the delivery of service as agreed to in the individual's care plan. The client must have an identified need for the services in order to be authorized to receive the services. For example, if a client is not scored as being impaired in bathing, no authorization can be given for a provider to assist the client with bathing.

By Whom Prepared:

The HCBS Case Manager (CM) completes the "Authorization to Provide Services for SPED/ExSPED" form. The HCBS ~~Case Manager~~ CM will determine the Qualified Service Provider (QSP) the client has selected is available and qualified to provide the service. CM must ensure the chosen QSP has the ability to provide the requested service by checking the web-searchable database.

SPECIFIC INSTRUCTIONS:

Section I is identifying information.

Enter the QSP's name, physical address, telephone number, and Medicaid provider number ~~of the provider~~.

> If services are to be provided by multiple providers and all providers are authorized/endorsed to complete the same tasks, multiple provider names can be listed on the SFN 1699 but each provider must receive a copy.

If a QSP will be receiving the Rural Differential (RD) rate for traveling to clients within rural areas, mark the correct RD tier.

Do not combine services on the same authorizations, e.g. If you have a client that is receiving SPED homemaker services and SPED personal care services from the same provider you still need to send two SFN 1699~~'~~s, one with homemaker and one with personal care. In addition, do not combine Medicaid Waiver services and SPED or Ex-SPED services on the same authorization, e.g. If you have a client who is receiving a service under SPED and ~~the~~ Medicaid waiver from the same provider you must send one SFN 1699 listing the SPED services ~~and the recipient ID number~~ and one SFN ~~404~~ 410 ~~authorization~~ listing the Medicaid Waiver service ~~and the recipient ID number~~.

Enter the client's name, identification number (ND number), phone number, and ~~SPED/EXSPED/~~ physical address~~, and telephone number~~.

"Authorization Period" - Identify the period of time the authorization is in effect. The authorization period MAY NOT exceed six (6) months except the initial. Renewal of the authorization would coincide with the 6-month Review or Annual Reassessment.

"Six Month Review -- Service Period" (this section is completed at the six month review only if there is no change in the authorization). Identify the additional period of time the authorization is in effect. The additional authorization period MAY NOT exceed six (6) months.

Section II is the authorizing of the service(s).

Column Headings

a. Service: Write in the name of the Service being authorized.
b. Procedure Code: Enter the correct billing procedure code for the service authorized.
c. Unit/Daily Rate: Enter the correct unit/daily rate for the service authorized.
d. Units ~~Authorized~~: Enter the total number of units authorized.
e. ~~Dollar~~ Amount: Enter the total dollar amount for the service.

If Rural Differential was marked in Section I put in determined RD rate for service.

Section III is the authorizing of the service(s) Tasks Authorized.

Check tasks authorized to be completed by this Qualified Service Provider. The explanation of tasks found on the back of the HCBS Authorization to Provide Services for SPED/ExSPED should be referenced in defining the parameters of the service tasks.

After the marked task write in the approved number of units for this service.

Example:

SERVICE: HMK Procedure Code: 00010 Unit/Daily Rate: $5.09 UNITS: 41 ~~Dollar~~ Amount: $208.69

Task: X Meal Prep:__31 units

X Housekeeping: 10 units

A written, signed recommendation for the task of vital signs provided by a nurse or higher credentialed medical provider must be on file which outlines the requirements for monitoring, the reason vital signs should be monitored, and the frequency. When the tasks of Temp/Pulse/Respiration/Blood Pressure are authorized, the individual to be contacted for readings must be listed on the SFN 1699.

For the task/activity of exercise a written recommendation and outlined plan by a therapist for exercise must be on file and is limited to maintaining or improving physical functioning that was lost or decreased due to an injury or a chronic disabling condition (i.e., multiple sclerosis, Parkinson's, stroke etc.). Exercise does not include physical activity that generally should be an aspect of a wellness program for any individual (i.e., walking for weight control, general wellness, etc.).

"Global Endorsements" These activities and tasks may be provided only by a service provider who has demonstrated competency and carries a global endorsement. Review the QSP list to determine which global endorsements the provider is approved to provide. If "Temp/Pulse/Respiration/Blood Pressure" are checked, enter who is to be contacted for the readings.

"Client Specific Endorsements" These activities and tasks may be provided by a service provider who has demonstrated competency and carries a

client specific endorsement to provide the required care within the identified limitations. The case manager must maintain documentation that a health care professional has verified the provider's training and competency specific to the individual's need in the client's file.

The case manager must sign and date the form to officially authorize, reauthorize, or cancel the services authorized. The SFN 1699 must be cancelled when a QSP is no longer providing services or when a client is no longer eligible.

If client is no longer eligible for RD, enter the date removed in the box beside the Tier selection and ~~mark RD removed box at end of Tier selection, enter end date,~~ adjust rates by crossing off RD rate and enter new eligible date. Send copy to QSP and to Aging Services/HCBS State office. If QSP is no longer providing services to identified client, then cancel entire SFN 1699.

Complete ~~SNF~~ SFN 212 and send to ~~the~~ Aging Services/HCBS State Office.

The six-month review may be completed and signed if there are no changes in the plan.

Number of Copies and Distribution

When a service is provided by multiple providers only one SFN 1699 is completed listing all providers, noting the units are shared. If one of the providers does not have a required /needed endorsement, a separate SFN 1699 must be provided and reflect limits in the units authorized to assure that all providers do not provide units over the total authorized amount.

Complete separate authorizations for each service authorized (even if the services are provided by the same provider).

File a copy in the client's case ~~record~~ file and give a copy to the client/legal representative. Forward the original to the ~~service provider~~ QSP(s) and ~~scan~~ email or fax a copy to Aging Services/HCBS.

~~This form is available through the state e-forms.~~ An electronic copy is available through the state e-forms (SFN 1699).

HCBS Notice of Reduction, Denial or Termination, SFN 1647 525-05-60-75

Purpose: The applicant must be informed in writing of the reason(s) for a denial or termination of service or program.

Before the SFN 1647 is sent to a client, the HCBS Case Manager must contact the HCBS Program Administrator responsible for SPED, Ex-SPED and Medicaid Waiver closings via email to obtain the appropriate citation to use in the "As set Forth" section of the form. The legal reference must be from state or federal law and/or Administrative Code, citing policy and procedure manual references is not sufficient.

The email from the HCBS case manager must include the ~~clients~~ client's name, funding source (i.e. SPED, Ex-SPED, Medicaid Waivers) and the reason ~~you are~~ services are reducing, closing, or terminating ~~services~~. ~~You do not need to send a~~ A copy of the completed SFN 1647 does not need to be sent to the State office.

The ~~county~~ HCBS case manager may send a cover letter with the Notice identifying other public and/or private service providers or agencies that may be able to meet the applicant's needs.

When the client is no longer eligible for a specific HCBS Program or service, the ~~county~~ HCBS case manager must terminate services under the funding source and cancel any current ~~"HCBS Authorization to Provide Services,"~~ authorizations (SFN 1699, or SFN 410) issued to the client's ~~providers~~ provider(s). Even if services continue under another funding source, the client must be informed in writing of the reasons he/she is no longer eligible for the program using the SFN 1647 form.

Steps of Completion:

~~Date: Record the date of completion;~~

Denial, Termination, or Reduction, Checkbox: Check the appropriate box whether it is a denial of a requested service or program; or termination of an existing service or program; or reduction of an existing service.

Date: Record the date of completion;

Client Name, Client ID: Record the individual's first and last name and the identification number (if applicable);

County Employee Name, County Name, Title of Employee: ~~Self Explanatory~~ Record the HCBS case manager's name, county and title;

"It has been determined...program or service": Indicate the service(s) or program(s) being denied, terminated, or reduced.

"Reason": Record the reason why the individual is being terminated for service or program or the reason for denial or the reason for a reduction in existing services.

"As Set Forth in": Record the state or federal legal reference supporting the reason for denial, termination, or reduction in service that you received from the HCBS Program Administrator.

Date This Reduction, Denial….is Effective: The client must be notified in writing at least 10 days prior to the date of termination, denial, or reduction of a service or program. The date entered on the line is 10-calendar days from the date of mailing the Notice or the next working day if it is a Saturday, Sunday, or legal holiday.

If a Medicaid appeal is received before the date of termination above is effective, services can continue until a hearing decision has been made. If the department's decision is upheld the individual will be required to reimburse for services provided after the termination date.

If a SPED or Ex-SPED appeal is received before the date of termination above is effective, services and payment for the services can continue only until the date of termination above is effective.

~~This form is not available through the State Office. It is available through the State e-form system. Click here to view and/or print this form.~~

An electronic copy is available through the state e-forms (SFN 1647).

HCBS Case Closure/Transfer Notice, SFN 474 525-05-60-80

Purpose: To notify Aging Services/HCBS an HCBS case has closed or was transferred to another county OR To take action on a level of care screening for a Medicaid Wavier case that would temporarily or permanently end a screening or to reopen a current screen.

When Prepared:

This form is to be completed ~~for closures related to SPED, ExSPED, Medicaid Waiver for Aged & Disabled.~~

- Closures related to clients receiving HCBS under SPED, Ex-SPED, and Medicaid Waiver;
- Transfers to another county or agency for clients receiving HCBS under SPED, Ex-SPED, Medicaid Waiver and Medicaid State Plan;
- Termination of a QSP if a QSP is closing his/her status when the client's case is closed (i.e. Family Home Care or Family Personal Care providers).

Steps of Completion:

In the first section, complete the client's name and identification number and **always** complete the County name and Case Manager section even if submitting the form to transfer a case. ~~Also complete the Client Name: Record the first and last name.~~

~~ID Number: Record the Medicaid recipient identification number.~~

Waiver reopen/close section:

Reopen Current Screening effective date: Record the date the Medicaid Waiver services are to begin. This line is used when a previous Medicaid Waiver client was screened for skilled nursing facility level of care, the individual was admitted to a facility or received services from a non-Waiver services, and now the individual will be transitioning back to the Waiver services. If the initial screening had expired during the individual's stay in the facility or while seeking other services, a new HCBS screening would be required and this form would not be completed/submitted;

Termination/Closure effective date: Use this line for closures/terminations that may occur due to ineligibility, death, or other that is not related to entering a nursing home or swing bed or Basic Care facility. This will designate when the Medicaid Waiver services are to end.

Closure/Denial Section:

Mark the correct funding source being closed, SPED~~/~~, EXSPED or Waiver.

~~Closure/Denial Section:~~ Enter date of closure, and the closure code. The closure codes are identified in the "Closure Codes" section of the form.

If a client is closed due to death, a critical incident report must be completed (see Critical Incident Reporting 525-05-42).

~~If Waiver Client is Closed Due to Death Section: Enter the location of waiver client's death (home, hospital, etc.), cause of death, age of client at death or date of birth, and any additional information.~~

Transfer Case to Another County Section:

~~Transfer Case to Another County Section:~~ Print the client's ~~last, first, and middle (initial)~~ name; ~~record the applicable ND identification number,~~ the receiving county name, receiving case manager's name, and the client's new address (if known). Enter the date client is leaving current county and date client is entering new county.

Aging Services/HCBS will process a stop date in the outgoing county's eligibility line in the payment system. A start date for the incoming county will not be processed until the new case manager indicates when the client can begin services by forwarding a complete SFN 676 ~~or 677~~. Once Aging Services receives the transfer notice, they will contact the incoming county to alert them the notice has been received.

Provider Termination Section:

~~Provider Termination:~~ If the client's case is closing/transferring and the provider of that client is **no longer continuing as a Qualified Service Provider (QSP)**, complete this section and Aging Services/HCBS will process the documentation in order to close the QSP provider file. If,

however, the **QSP is continuing and providing care** to others or moves with the client, do not complete this section.

The ~~new~~ HCBS Case Closure/Transfer Notice is due to Aging Services/HCBS within 3 working days of the date of closure. If the case is to be transferred, the form is due to Aging Services/HCBS within 3 working days from the date the County is made aware that the case is transferring to another County.

~~This form is not available from the state office. It is electronically available through the state's e-forms.~~

The original is to be filed in the applicant's case file.

An electronic copy is available through the state e-forms (SFN 474).

Medicaid Waiver Quality Review, SFN 1154 525-05-60-100

~~Effective 12/31/16~~ Purpose: Case Managers are required to continuously monitor to ensure an individual 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). The Medicaid Waiver Quality Review process is used to obtain information from clients/responsible parties that is related to quality and quantity of services. The information is aggregated and reviewed by the Department to develop quality measures and services.

When Prepared:

Complete on an annual basis during ~~one of~~ the first quarterly contact~~s~~ (this visit should **not** occur during the annual or 6-month assessment) ~~for current clients, and at the first quarterly contact for new clients~~.

The review is required to be completed with clients who are receiving services under the HCBS Wavier (does not include SPED/EXSPED/TD Waiver or MSP-PC).

By Whom Prepared:

The HCBS Case Manager completes the "Medicaid Waiver Quality Review.

SPECIFIC INSTRUCTIONS:

Enter the client's name, identification number (ND number) and date. If the client is not the individual providing the response to the questions, enter the respondent's name and their relationship to the client. Enter the client ID and list the wavier services the client is currently receiving.

Ask each question and score by circling or marking an X by the boxes scored: Yes-No-N/A-Other. If the response is: No, N/A, or other please explain.

a. If the response is: no, n/a or other, please explain.
b. If the response is: no, n/a or other, please explain.
c. If the response is: no, n/a or other, please explain.
d. If the response is: no, n/a or other, please explain.
e. If the response is: no, n/a or other, please explain.
f. If the response is: yes, please explain.
g. If the response is: no, n/a or other, please explain.
h. If the response is: yes, please explain.
i. If the response is: yes, please explain.

If the response results in an answer that requires an immediate response and is related to abuse, neglect or exploitation, follow monitoring policy outlined in the service of Case Management.

Complete the Narrative as appropriate and Sign sign your name and enter the name of the County the client lives in.

File the original a copy in the client's case record. Forward a copy the original to Aging Services/HCBS the Department.

An electronic copy is available through the state e-forms (SFN 1154).

Medicaid Waiver Person Centered Plan of Care, SFN 404 525-05-60-105

Purpose:

The Medicaid Waiver Person Centered Plan of Care (SFN 404) is a summary of the needs and service options identified in the assessment process and is an outline of the plan developed by the client, Case Manager and others to meet the client's needs.

This form is only completed for clients receiving Medicaid Waiver service(s).

When Prepared:

The Medicaid Waiver Person Centered Plan of Care is required for all clients receiving HCBS Case Management/Services under the Medicaid Waiver(s). It is to be revised or updated as client's needs warrant. It is to be reviewed with the client at the annual and ~~/~~six-month review~~,~~ and complete a new form if necessary due to changes in service(s) and/or amounts. Quarterly visits to the client are required with a follow-up note within the narrative in the web-based data collection system ~~SAM's~~.

~~Six month reviews: during client visit CM must complete a new front page listing services and new section VII to include new signatures. Cm may copy section X – Risk Assessment and Section VI – Restrictions from annual plan. CM adds date of 6 month visit to these sections and completed bottom portion of the Section VI. All pages are then sent to the department within 3 days of completed plan.~~

The Medicaid Waiver Person Centered Plan of Care must be revised when a change occurs (unless it is a result of legislative action).

Section I Client Identification:

Enter the name, client identification number (ND number), physical address, ~~client identification number,~~ county of residence, ~~county code,~~ and level of care (LOC) screening effective date ~~of screening of level of care~~.

Section II ~~Approved~~ Services:

If receiving Rural Differential (RD) Rate (determined under Rural Differential policy 525-05-38) mark the correct tier (RD 1, 2, or 3) for rate.

HCBS/TD Waiver Removed ☐ RD1 ☐ RD2 ☐ RD3 ☐ RD

When ~~marking~~ adding or removing RD, ~~RD Removal~~ a SFN 212 is required to be sent to ~~the department~~ Aging Services/HCBS.

Mark "yes" or "no" if this plan overlaps the current plan filed at Aging Services/HCBS.

Column Headings:

1. SERVICE: Enter the service that has been identified for which the client is eligible~~,~~ and the client has accepted.

2. ~~SERVICE~~ PROVIDER: Identify the qualified service provider (agency or individual) who will provide the service.

3. PROVIDER NUMBER: Enter the provider's number.
4. UNIT RATE: Refer to the Qualified Service Provider (QSP) listing for rate. Enter the QSP unit rate.
   a. If RD box was marked – rate should match rates determined within Rural Differential policy. (Total rate cost may be over cap however units should match cap~~:~~. For example: Homemaker service cap is 70 units~~'~~ for individual QSPs or ~~50~~ 51 units~~'~~ for agency QSPs ~~cap out Homemaker services.~~)

   b. If removal of Rural Differential is required: ~~make~~ mark the box "RD removed" and write the end date by QSP name being removed from RD, cross off RD rate and write correct rate. Complete SFN 212.

5. UNITS PER MONTH: Enter the total number of units of service to be provided per month.

6. COST/MONTH: The cost per month is calculated based on the amounts in the columns headed "Unit Rate," and "Units per Month" (based on a 31-day month).

Case Management has been pre-entered on the form. The ~~Service~~ Provider~~,~~ and Provider Number~~, and Unit Rate~~ must be entered by the Case Manager.

Total Cost: The total per month costs of services is the total to be reimbursed under the Medicaid Waiver~~s~~. The Grand Total does NOT include the cost of HCBS Case Management. When authorizing services by unit and or daily rate the maximum amount must not exceed on the program and/or service cap.

The Contingency Plan must be completed. Name of person assisting with meeting contingency plan must be listed along with phone number to be reached at. A Contingency Plan is required if the provider is not an agency. If a contingency plan is not required, N/As need to be entered in this section.

Section III: ADL~'~s & IADL~'~s

ADL~'~s & IADL~'~s Scores: must be added from the Functional Assessment scoring.

~~Section IV: Contingency Plan~~

~~The Contingency Plan must be completed. Name of person assisting with meeting contingency plan must be listed along with phone number to be reached at.~~

Section IV: Signatures

The client/legally responsible party must check all applicable boxes acknowledging agreement and or awareness of the specific information.

The signature of the client/legal representative and HCBS Case Manager is required. ~~Any other person attending the Person Centered planning must sign here as an other.~~

If legal representative is not present in-person, the plan is not complete and will not be able to have effective dates entered until signature has been received. Effective date of plan could either start on date of legal representative's signature or a future date.

Six-Month Review: If there is NO change to be made ~~in Section I~~ to the Medicaid Waiver Person Centered Plan of Care as a result of the six-month review, the client/legal representative can sign the original Medicaid Waiver Person Centered Plan of Care, SFN 404, in the area provided. The signature of the HCBS Case Manager completes the six-month review requirements for the care plan.

Section V~~I~~: Restrictions

Purpose:

Any restriction on the client's living experience needs to be documented in the Medicaid Waiver Person Centered Plan of Care. A restriction is any control over a client that has been identified specifically towards one client and not required for all clients within that environment. ~~Service where restrictions may occur are AFC/ ADC/ ARS.~~

Example: client living in ~~AFFC~~ AFC not being allowed to have to food in bedroom for fear of choking, yet other individuals living there have this option.

SPECIFIC INSTRUCTIONS for Section V~~I~~:

If no restrictions are required for the client, mark the box "Reviewed – No restrictions required".

Behavior: enter the behavior/ diagnosis that is requiring the restriction.

Identified Restriction: What is the restriction needed due to behavior?

Example: if client does not know when to stop eating. The restriction would be to not have food available at all times.

Current Restrictive Plan: What is the facility going to do to prevent the behavior?

Example: client would not be allowed to have a refrigerator in their personal space.

Plans Tried in the Past: what plan(s) has/have been ~~Plan~~ tried in the past? What has been tried to before getting to this restriction?

Client/Legal Representative Signature: Of client or legally responsible person and of the case manager is required.

The Team feels this plan will NOT cause harm to the client.

Mark this box if team is in agreement.

Six- ~~6~~ month review:

If the plan is working and there are no negative impacts to the client for the restrictions mark the box ~~for~~ "yes" and client/legal representative and ~~CM~~ case manager sign.

If the plan is not working mark the box ~~for~~ "no", note what is not working in the plan and develop new restriction plan, date ~~this~~ and sign.

Restriction plan may be revised any time a restriction is not working – CM does not have to wait until annual or ~~6~~ six month~~s~~ review to make changes.

~~Section VII: Authorization of Waiver Services~~

~~The HCBS Case Manager completes the "Authorization of Waiver Services" (Section VII) the HCBS Case Manager will determine the Qualified Service Provider (QSP) the client has selected is available and qualified to provide the service.~~

~~CM must ensure the chosen QSP has the ability to provide the requested service by checking the web-searchable database.~~

~~SPECIFIC INSTRUCTIONS for Section VII:~~

~~Section I: identifying information.~~

~~Enter the name, physical address, telephone number, and Medicaid provider number of the provider.~~

~~If QSP will be receiving the Rural Differential rate for traveling to clients within rural areas, mark the correct tier.~~

~~Do not combine services on the same authorizations, e.g. If you have a client that is receiving waiver homemaker services and waiver respite services from the same provider you will need to send two Section VII - one with homemaker and one with respite.~~

~~Enter the client's name, Medicaid number, physical address, and telephone number.~~

"Authorization Period" - Identify the period of time the authorization is in effect. The authorization period MAY NOT exceed six (6) months except the initial. Renewal of the authorization would coincide with the 6-month Review or Annual Reassessment.

"Authorized Not to Exceed" - (Intermittent Unit Rate) is completed by recording the total dollar amount for all services based on a 31-day month.

"Authorized Not to Exceed" - (Daily Rate) is completed by recording the total dollar amount for services based on the daily rate times the number of days up to the maximum allowed for the funding source.

Section VIII is the authorizing of the service(s).

Column Headings

1. Service: Check ( ) the service(s) being authorized. If the service provider qualifies to deliver more than one service and will be doing so, more than one service may be checked.

2. Billing Code: Enter the correct billing procedure code for the service authorized.

3. Units Authorized: Enter the number of units authorized

4. Dollar Amount: Enter the dollar amount for the service.

   If Rural Differential was marked in Section I put in determined RD rate for service.

Section IX is the authorizing of the service(s) Tasks Authorized:

Check tasks authorized to be completed by this Qualified Service Provider. The explanation of tasks found on the back of the HCBS Authorization to Provide Services should be referenced in defining the parameters of the service tasks.

A written, signed recommendation for the task of vital signs provided by a nurse or higher credentialed medical provider must be on file which outlines the requirements for monitoring, the reason vital signs should be monitored, and the frequency. When the tasks of

~~Temp/Pulse/Respiration/Blood Pressure are authorized, the individual to be contacted for readings must be listed on the SFN 404.~~

~~For the task/activity of exercise a written recommendation and outlined plan by a therapist for exercise must be on file and is limited to maintaining or improving physical functioning that was lost or decreased due to an injury or a chronic disabling condition (i.e., multiple sclerosis, Parkinson's, stroke etc.). Exercise does not include physical activity that generally should be an aspect of a wellness program for any individual (i.e., walking for weight control, general wellness, etc.).~~

~~"Global Endorsements" These activities and tasks may be provided only by a service provider who has demonstrated competency and carries a global endorsement. Review the QSP list to determine which global endorsements the provider is approved to provide. If Temp /Pulse Respiration/Blood Pressure are checked, enter who is to be contacted for the readings.~~

~~"Client Specific Endorsements" These activities and tasks may be provided by a service provider who has demonstrated competency and carries a client specific endorsement to provide the required care within the identified limitations. The case manager must maintain documentation that a health care professional has verified the provider's training and competency specific to the individual's need in the client's file.~~

~~Section VII: must be sent to the identified provider for a returned signature – agreeing to provide the waiver service. Plan is not completed unless this signature is obtained.~~

~~**Note:** No signature from provider is required for ERS service– the signature on their provider agreement will be utilized.~~

~~IF a HDM provider is delivering the meals to the client – they need a signature on the Section VII. IF there is no contact (Mom's Meals) there is no need for a signature – the signature on their provider agreement will be utilized.~~

~~The case manager must sign and date the form to officially authorize, or cancel the services authorized.~~

~~Section VII must be canceled when a QSP is no longer providing services or when a client is no longer eligible.~~

~~If client is no longer eligible for RD, mark RD removed box at end of Tier selection, enter end date. Send copy to QSP and to HCBS State office. Send completed SFN 212. If QSP is no longer providing services to identified client, then cancel entire Section VII.~~

Section ~~VI~~ VI: Waiver Risk Assessment

Indicate the date of the annual assessment.

List client's ~~person~~ strengths~~/,~~ needs~~/,~~/ goals and ~~responsible person~~ tasks within each identified category. Plan must have minimum of two goals.

Every category under the risk assessment must include at least one strength. If there is not a need, indicate "n/a". If there is a need identified, the risk assessment must list a goal and tasks to meet the stated goal.

Services listed on page one should be reflective in reaching client's goals on the risk assessment.

> **Example**: if goal is "I will have assistance within my home to meet my personal needs." Then ~~you~~ the service may be Personal Cares.

~~If there are no needs within a category then enter "N/A".~~

Six-month review:

Indicate the date of the six-month assessment.

Note any changes/additions to each category under the risk assessment. If there are not any changes, note "n/a".

Three- and Nine-month contacts:

A new Medicaid Waiver Person Centered Plan is not required unless changes are indicated. ~~must be completed at annual and six month, a~~ A note in the narrative section of the web-based data collection system ~~SAM's~~ may be completed at 3 month and 6 month contacts.

Number of Copies and Distribution:

The original is filed in the ~~applicant's~~/client's case ~~record~~ file. One copy is provided to the ~~applicant/~~client/legal representative when completed. One copy is ~~mailed~~ emailed or faxed within three working days to Aging Services/HCBS ~~Division - HCBS/DHS~~. This includes plans completed

annually continued, updated at the six-month contact and a care plan that identifies a change.

~~This form is available through the state e-forms.~~

An electronic copy is available through the state e-forms (SFN 404).

This is a NEW section:

Authorization to Provide Medicaid Waiver Services, SFN 410 525-05-60-107

Purpose:

The Authorization to Provide Medicaid Waiver Services for is used to grant authority to a qualified service provider (QSP for the provision of agreed upon service tasks to an eligible Medicaid Waiver client.

This form is only completed for clients receiving Medicaid Waiver service(s).

When Prepared:

The Authorization to Provide Medicaid Waiver Services is completed when arrangements are being made for the delivery of service as agreed to in the individual's care plan. The client must have an identified need for the services in order to be authorized to receive the services.

By Whom Prepared:

The HCBS Case Manager (CM) completes the "Authorization to Provide Medicaid Waiver Services" form. The HCBS CM will determine the Qualified Service Provider (QSP) the client has selected is available and qualified to provide the service. CM must ensure the chosen QSP has the ability to provide the requested service by checking the web-searchable database.

Specific Instructions:

Identifying information

Enter the QSP's name, QSP provider number, and physical address.

Enter the client's name, identification number (ND number), physical address, and phone number.

If a QSP will be receiving the Rural Differential (RD) rate for traveling to clients within rural areas, mark the correct RD tier.

"Authorization Period" - Identify the period of time the authorization is in effect. The authorization period MAY NOT exceed six (6) months except the initial. Renewal of the authorization would coincide with the 6-month Review or Annual Reassessment.

"Six Month Review Authorization Period" (this section is completed at the six-month review only if there is no change in the authorization). Identify the additional period of time the authorization is in effect. The additional authorization period MAY NOT exceed six (6) months.

Services Authorized

Select all authorized services and complete the unit or daily rate, number of units and record dollar amount for the service(s).

Column Headings

a. Service: Select the name of the service(s) being authorized.
b. Code: Most procedure codes have been pre-populated, if not, enter the correct billing procedure code for the service(s) authorized.
c. Unit/Daily Rate: Enter the correct unit/daily rate for the service authorized.
d. Units: Enter the total number of units authorized.
e. Not to Exceed Total: Enter the total dollar amount for the service.

If RD is authorized, put in determined RD rate for service.

Tasks Authorized

Select all authorized tasks to be completed by the QSP. The explanation of the tasks on page two of the Authorization to Provide Medicaid Waiver Services (SFN 410) should be referenced in defining the parameters of the service tasks.

A written, signed recommendation for the task of vital signs provided by a nurse or higher credentialed medical provider must be on file which outlines the requirements for monitoring, the reason vital signs should be monitored, and the frequency. When the tasks of Temp/Pulse/Respiration/Blood Pressure are authorized, the individual to be contacted for readings must be listed on the SFN 410.

For the task/activity of exercise, a written recommendation and outlined plan by a therapist for exercise must be on file and is limited to maintaining or improving physical functioning that was lost or decreased due to an injury or a chronic disabling condition (i.e., multiple sclerosis, Parkinson's, stroke etc.). Exercise does not include physical activity that generally should be an aspect of a wellness program for any individual (i.e., walking for weight control, general wellness, etc.).

"Global Endorsements" – These activities and tasks may be provided only by a QSP who has demonstrated competency and carries a global endorsement. Review the QSP list to determine which global endorsements the provider is approved to provide. If Temp/Pulse Respiration/Blood Pressure are checked, enter who is to be contacted for the readings.

"Client Specific Endorsements" – These activities and tasks may be provided by a QSP who has demonstrated competency and carries a client specific endorsement to provide the required care within the identified limitations. The case manager must maintain documentation that a health care professional has verified the provider's training and competency specific to the individual's need in the client's file.

The case manager must sign and date the form to officially authorize, reauthorize, or cancel the services authorized. The SFN 410 must be cancelled when a QSP is no longer providing services or when a client is no longer eligible. The cancelled authorization is to be filed in client's case file but does not need to be submitted to Aging Services/HCBS State Office.

Authorization to Provide Medicaid Waiver Services must be sent to the identified provider for a returned signature – agreeing to provide the waiver service. Plan is not completed unless this signature is obtained. **Note:** No signature from provider is required for ERS service– the signature on their provider agreement will be utilized.

If a Home Delivered Meals provider is delivering the meals to the client – they need a signature on the SFN 410. If there is no contact (Mom's Meals) there is no need for a signature – the signature on their provider agreement will be utilized.

If client is no longer eligible for RD, enter the date removed in the box beside the Tier selection and adjust rates by crossing off RD rate and enter new eligible date. Send copy to QSP and to Aging Services/HCBS State office. If QSP is no longer providing services to identified client, then cancel entire SFN 410. Complete the Rural Differential Unit Rate Authorization/Closure (SFN 212) form and send to Aging Services/HCBS.

The six-month review may be completed and signed if there are no changes in the plan.

Number of Copies and Distribution

File a copy in the client's case record and give a copy to the client. Forward the original to the service provider(s) and scan a copy to Aging Services/HCBS with the Medicaid Waiver Person Centered Plan of Care (SFN 404).

Number of Copies and Distribution:

File a copy in the client's case file and give a copy to the client/legal representative when completed. Forward the original to the QSP(s) and email or fax a copy to Aging Services/HCBS.

An electronic copy is available through the state e-forms (SFN 404).