

**Home & Community Based Services
Policies and Procedures**

Service Chapter 525-05

**North Dakota Department of Human Services
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Abuse

The willful act or omission of a caregiver or any other person which results in physical injury, mental anguish, unreasonable confinement, sexual abuse or exploitation, or financial exploitation to or of a vulnerable adult.

Activities of Daily Living (ADLs)

Tasks of a personal nature that are performed daily which involves such activities as bathing, dressing, toileting, transferring from bed or chair, continence, eating/feeding, and mobility inside the home.

Adaptive Assessment

An evaluation to identify adaptive devices, equipment, or modifications that enhance the independence and functional capabilities of an individual who may otherwise be unable to remain in the individual's home.

Adaptive Equipment

Equipment and supplies, which enable recipients to increase their abilities to perform ADLs. See also "Specialized Equipment and Supplies".

Adult

All persons eighteen years of age and over are adults. Children who are adults should not be considered the responsibility of their parents, even if living in the same household.

Adult Day Care (ADC) Service

A program of non-residential activities provided at least three (3) hours per day on a regularly scheduled basis one or more days per week and

encompasses both health and social services needed to insure the optimal functioning of the individual.

Adult Day Care (ADC) Center

An adult day care program operated in a public accessible building. The program shall operate a minimum of three hours per day up to a maximum of ten hours per day.

Adult Day Care (ADC) Home

An adult day care program operated in a private residence. The program shall operate a minimum of three hours per day up to a maximum of ten hours per day. The maximum number of participants in the home at any one time shall be no more than four.

Adult Foster Care (AFC)

The provision of food, shelter, security and safety, guidance, and comfort on a twenty-four-hour per day basis, in the home of the caregiver, to a person age eighteen or older, who is unable, neglects, or refuses to provide for the person's own care.

Adult Foster Home/Facility

An occupied private residence in which Adult Foster Care is regularly provided by the owner or lessee thereof, to four or fewer adults who are not related by blood or marriage to the owner or lessee, for hire or compensation. (For additional Adult Foster Care definitions – see the Adult Foster Care Licensing.)

Adult Residential Care (ARC)

A facility in which at least five (5) unrelated adults reside, and in which personal care, therapeutic, social and recreational programming is provided in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled and unpredictable needs and to provide supervision, safety, and security.

Aged

Means sixty-five years of age or older.

Agency - Qualified Service Provider (QSP)

An agency that enrolls with the department as a Qualified Service Provider, which allows that agency to bill the department for services rendered. Agency providers can include Department of Health and Human Services, Human Service Centers, and County Social Service Boards.

Aging Services Division

A Division within the Department of Health and Human Services (DHHS) within the Program and Policy's organizational structure with administrative and programmatic responsibility for Home and Community Based Services (HCBS).

Aid and Attendance

A financial benefit given to a veteran from the Veterans Administration for assistance with personal care tasks. The amount of the "aid and attendance" must be considered as income in the Service Payments for the Elderly and Disabled (SPED) Program.

Applicant

An individual making application for services. An applicant may have a legal representative seeking services on behalf of the individual.

Assisted Living Facility

For purposes of this Chapter, it means the setting in which daily personal care is provided. It includes the definition at North Dakota Century Code (N.D.C.C.) [50-32-01\(1\)](#): "Assisted living facility" means any building or structure containing a series of living units operated as one business entity to provide services for five or more individuals who are aged or disabled adults and who are not related by blood or marriage to the owner or manager of the entity and which is kept, used, maintained, advertised, or held out to the public as a place that makes available individualized support services to accommodate an individual's needs and abilities to maintain as much independence as possible.

Assistive Technology

A term that refers to devices, products, or equipment that enhance the ability of an individual with functional impairment(s) to engage in major life activities, actions, and tasks.

Attendant Care Service

Attendant Care Services (ACS) is hands on care, of both a supportive and medical nature, specific to a client who is ventilator dependent for a minimum of 20 hours per day and includes nursing activities that have been delegated by the nurse manager to the ACS provider. ACS is an all-inclusive service that provides direct care to ventilator-dependent individuals to meet their care needs.

- An Attendant Care Service Provider is a QSP or a nurse aide enrolled and in good standing with the North Dakota Department of Health and Human Services. The service is provided under the direction of a licensed nurse who is enrolled with the department as a QSP to provide Nurse Management.
- Nurse Management is an aspect of Attendant Care Services. Nurse Management is the provision of nursing assessment, care planning, delegation of skilled nursing tasks to an Attendant Care Services (ACS) provider, and monitoring of delegated tasks, for clients who are ventilator dependent and receiving ACS.

Balance Due

The amount of fees for which a responsible party is billed and required to pay.

Case Manager (CM)

An agency staff member, who is a Licensed Social Worker and who is responsible for completing a comprehensive assessment, developing and implementing of client's plan of care for services.

Case Management Service

HCBS Case Management is the process within the framework of generic social work practice of providing specialized assistance to aged and

disabled individuals desiring and needing help in selecting and/or obtaining resources and services. This includes coordinating the delivery of the services in order to assist functionally impaired persons remain in the community in the most cost effective manner. The specialized assistance is based on the results of a comprehensive assessment.

Chore Service

The provision of one time, intermittent or occasional home tasks including heavy duty housecleaning, minor home maintenance, and walk maintenance. The service is provided to clients who reside in their own home or rental housing where the rental arrangement does not include these tasks. [Emergency Response Systems](#) (ERS) services are considered as a Chore Service.

Client

An individual who has met the eligibility criteria for services under the provision of this chapter.

Client Share

Monthly amount a SPED client is required to pay towards the cost of the client's services. It works like a monthly deductible. This amount is determined after deducting allowable medical expenses from their countable income. See also "Cost Share" and/or "Service Fee".

Community Support Services

Community supports is formalized training and supports provided to eligible individuals who require some level of ongoing daily support. This service is designed to assist with and develop self-help, socialization, and adaptive skills that improve the participant's ability to independently reside and participate in an integrated community.

Community Transition Services (CTS)

Assists 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.

Companionship Services

Reduces social isolation in older adults and individuals with physical disabilities. Companionship services are non-medical care, supervision and socialization, provided to a waiver recipient who lives alone or with an individual who is not capable or obligated to provide the service.

Competency Level

The skills and abilities required to complete a task or activity to an established standard.

Comprehensive Assessment

Instrument used to record basic demographic and medical information about an individual, including age, date of birth, spoken language, marital status, household members, emergency contacts, medical resources, health care coverage, and source and reason for referral, and to secure measurable information regarding: physical health, cognitive and emotional functioning, activities of daily living, instrumental activities of daily living, informal supports, need for twenty-four hour supervision, social participation, physical environment, financial resources, and other information not recorded elsewhere.

Congenital Disability

A congenital disability is one that exists at birth or shortly thereafter and for this chapter is not attributable to a diagnosis of either intellectual disability or a closely related condition.

Congregate Housing

Congregate housing means housing shared by two or more individuals not related to each other which is not provided in an institution. N.D.C.C. [50-24.5-01\(3\)](#).

Cost Share

Monthly amount a SPED client is required to pay towards the cost of the client's services. It works like a monthly deductible. This amount is determined after deducting allowable medical expenses from their countable income. See also "Client Share" and/or "Service Fee".

Covered Services

Services specified in the Department's approved Medicaid Waiver (MW) for Home and Community Based Services (HCBS), Service Payments for the Elderly and Disabled (SPED), Expanded Service Payments for the Elderly and Disabled (Ex-SPED), Medicaid State Plan Personal Care Services, and Targeted Case Management (TCM).

Critical Incident Report (CIR)

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.

Department

The North Dakota Department of Health and Human Services (DHHS).

Dependent

Any individual who the applicant/client is legally responsible to provide support and care: minor child, spouse, anyone placed in the care of the applicant/client by court order.

Disability Due to Trauma

This is a disability that results from an assault (injury) that occurs externally (e.g. blow to head, accident, fall) or internally within the body (e.g. stroke, heart attack).

Disability That Is Acquired

Means a disability that results from an assault that occurs internally within the body.

Disabled (Expanded SPED)

As defined by the Social Security Administration: the inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than twelve (12) months (or, in the case of a child under the age of 18, if suffering from any medically determinable physical or mental impairment of comparable severity).

Disabled (SPED and Medicaid Waiver)

A person under age sixty-five who has a congenital disability, a disability due to trauma, or an acquired disability. (N.D.A.C. [75-03-23](#))

Disqualifying Transfer

As defined in North Dakota Century Code chapter 50-06.2 means a transfer made at any time before or after an individual makes application for SPED benefits by which the individual or the individual's spouse has made any assignment or transfer of any asset for the purpose of making that individual eligible for benefits. Assignment or transfer includes any action or failure to act that effects a transfer, renunciation, or disclaimer of any asset or interest in an asset that the individual otherwise might assert or have asserted, or which serves to reduce the amount that an individual might otherwise claim from a decedent's estate, a trust or similar device, or another individual obligated by law to furnish support.

Emergency Response System (ERS)

An electronic device enabling the client to secure help in an emergency by activating the "help" button he/she is wearing. The system is connected to the client's phone and programmed to signal a response center once a "help" button is activated.

Endorsements

A task that requires special skills and approval.

Environmental Modification

Physical adaptations to the home necessary to ensure the health, welfare and safety of the client or enables the client to function with greater independence in their home.

Expanded Service Payments for the Elderly and Disabled (Ex-SPED)

A state funded program under which Qualified Service Providers are reimbursed by the Department for the provision of certain services provided to eligible elderly and disabled persons. These services are designed to assist individuals to remain in their own homes and communities.

Ex-SPED Program Pool

The list maintained by the department which contains the names of clients for whom Ex-SPED program funding is available when the clients' names are transferred from the Ex-SPED program pool to Ex-SPED program active status.

Exploitation

The act or process of an individual using the income, assets, or person of another individual for monetary or personal benefit, profit, gain, or gratification.

Extended Personal Care Services (EPCS)

Extended Personal Care Services (EPCS) is to complete tasks that are medical in nature and specific to the needs of an eligible individual. Approval to complete these tasks is provided by the Nurse Educator who has provided training to the EPCS Provider and is enrolled with the Department to provide Nurse Education.

Family Caregiver

A Family Caregiver is a person who lives with or provides daily care to an eligible client and may include a spouse, children, relatives, foster family, or in-laws.

Family Home Care (FHC)

The provision of room, board, supervisory care, and personal services daily, to an eligible elderly or disabled person by a qualified service provider, who meets the definition of a family member as defined in N.D.C.C. [50-06.2-02\(4\)](#), in the home of the client or the home of the qualified service provider.

Family Member

Defined as spouse or by one of the following relatives, or the current or former spouse of one of the following relatives, of the elderly or disabled person: parent, grandparent, adult child, adult sibling, adult grandchild, adult niece, or adult nephew. Current or former spouse refers to in-law relationships.

Family Personal Care (FPC)

Assists 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 or qualified family member of a recipient for the provision of personal care or similar services. The qualified family member must be one of the relatives as defined in Family Home Care N.D.C.C 50-06.2-02(4), and must be the provider performing the care to the individual. Family Personal Care can be provided by the "spouse or by one of the following relatives, or the current or former spouse of one of the following relatives, of the elderly or disabled person: parent, grandparent, adult child, adult sibling, adult grandchild, adult niece, or adult nephew."

Fee Setting Authority

The North Dakota Department of Health and Human Services.

Full Financial Information

Such information about a family's assets, income, and medical deductions as is necessary and reasonably requested for the purpose of determining the fee to be charged.

Full Service Fee

The usual and customary fee (maximum) per unit charge assigned to a service.

Functional Assessment

An instrument used to record basic demographic and medical information about an individual, including age, date of birth, spoken language, marital status, individuals residing with, emergency contacts, medical resources, health care coverage, and source and reason for referral; and to secure measurable information regarding

- a. Physical health;
- b. Cognitive and emotional functioning;
- c. Activities of daily living (ADLs);
- d. Instrumental activities of daily living (IADLs);
- e. Informal supports;
- f. Need for twenty-four-hour supervision;
- g. Social participation;
- h. Physical environment.
- i. Financial resources;
- j. Adaptive equipment;
- k. Environmental modification; and
- l. Other information about the individual's condition not recorded elsewhere.

Functional Impairment

The inability to perform, either by oneself or with adaptive aids or with human help, specific activities of daily living or instrumental activities of daily living.

HCBS Program Administration

A unit within Adult and Aging Services. HCBS Program Administration includes the programs of Targeted Case Management, Medicaid Waiver Home and Community Based Services, Medicaid State Plan Personal Care, Service Payments for the Elderly and Disabled, and Expanded Service Payments for the Elderly and Disabled.

Home and Community-Based Services (HCBS)

The array of services under the SPED program and Medicaid Waiver defined in the comprehensive human service plan and the other services

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the department determines to be essential and appropriate to sustain individuals in their homes and in their communities, and to delay or prevent institutional care.

Homemaker

An individual who meets the standards and performs tasks/activities under the provisions of this service chapter.

Homemaker Service (HMK)

Provision of non-personal (environmental) care tasks such as light duty housekeeping, laundry, meal planning and preparation, and shopping that enables the individual to maintain independence.

Household

When determining SPED financial eligibility, individuals to be included in a household count if residing together, include the recipient/applicant of services, spouse of the recipient/applicant, children and stepchildren under the age of 18 of the recipient/applicant, and any other individual that has been designated as a ward or dependent person of the applicant/recipient or the spouse by court order.

Income

Total adjusted gross monthly family income.

Individual Care Plan (ICP)

The document developed by a case manager and the client or legal representative specifying the frequency and intensity of each service to be received as an alternative to institutional care. Under the Medicaid Waiver for Home and Community Based Services, an interdisciplinary team will be involved in the development of the Care Plan of clients who receive the services of TBI Residential, TBI Transitional, and Supported Employment Service.

Individual Program Plan (IPP)

An individualized plan, developed by the QSP, that describes the tasks or training that will be done for a client receiving Residential Habilitation, Community Support Services, Transitional Living Services or Community Transitions Services. The IPP demonstrates how the QSP will work toward the client's goals.

Individual – Qualified Service Provider (QSP)

An individual who enrolls with the department as a Qualified Service Provider, which allows that individual to bill the department for services rendered.

Informal Network

Family, neighbors, friends, church, and other private resources available to meet identified needs of a client.

Institution

Institution means an establishment that makes available some treatment or services beyond food or shelter to five or more persons who are not related to the proprietor. N.D.C.C. [50-24.05-01\(8\)](#).

Instrumental Activities of Daily Living (IADLs)

Includes complex life activities routinely performed by an individual such as housework, laundry, meal preparation, taking medication, shopping, outside mobility, transportation, management of money, and use of a telephone.

Legally Responsible Person

Legal spouse or parent of a minor child.

Legal Representative

Someone who has been given power by law to represent another person.

Level-of-Care (LOC) Determination

A medical screening requested to determine eligibility for the Medicaid Waivers, Medicaid State Plan Levels B & C, or to screen children for the SPED program. The Department contracts with a utilization control management team to establish medical need.

Liquid Assets

Any resource that can readily be converted to cash, and includes cash on hand, checking accounts, savings accounts, stocks, bonds, and other negotiable instruments as well as non-contracted crop in storage. Liquid assets include taxable, tax-exempt, and tax-deferred funds. For purposes of this chapter, liquid assets also include the value of residences of the applicant or individual other than their primary residence.

Living Alone

An applicant or individual who lives alone or with a person(s) who is under the age of 18 or incapacitated is considered to be living alone.

Living Independently

Living independently includes living in congregate housing. The term does not include living in an institution.

Long Term Care Need

A need for the services available under the SPED Program, ExSPED Program, Medicaid Waiver Program, or the Medicaid State Plan Personal Care Option that is anticipated to exceed 30 days.

Medical Services Division

A Division within the department with administrative responsibility to enroll Qualified Services Providers, conduct Qualified Service Provider audits, and set rates for HCBS services.

Medicaid State Plan Personal Care Program (MSP-PC)

Personal care services assist an individual with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), so that the individual is able to live at home. See MSP-PC Policy Manual (535-05).

Medicaid Waiver (MW)

A federal program specifically provided for by Federal law enabling states to deliver, under waiver of several Medicaid requirements, services to aged and disabled persons at risk of institutionalization.

Mental Anguish

Psychological or emotional damage that requires medical treatment or care, or is characterized by behavioral changes, or mental illness.

Monitoring

Overseeing and periodically reviewing the individual's progress, condition, and the quality and quantity of services provided.

Most Integrated Setting

A setting that enables an individual with a disability to interact with non-disabled persons to the fullest extent. The most integrated setting for an individual will usually be a private residence owned or rented by the individual or their family member.

Moving Expenses

Expenses that are necessary to assist an individual to move back to the community under Community Transition Services. See also "One-Time Set-Up Expenses".

Natural Supports

An informal, unpaid caregiver that provides care to an applicant or client.

Neglect

The failure of an individual to provide the goods or services necessary to avoid physical harm, mental anguish, or mental illness.

Non-Medical Transportation (NMT)

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Transportation provided to eligible clients which enables them to access essential community resources/services needed in order to maintain themselves in a home and community setting.

Nursing Facility (Long Term Care Facility)

A facility licensed by the North Dakota Department of Health and Human Services and Consolidated Laboratories to provide residential nursing and medical care.

Obligated Family Member

A spouse, parent of a child under the age of 18, or a guardian (if required by the court to provide care).

Olmstead Decision

U.S. Supreme Court decision held under the Americans with Disabilities Act, that qualified individuals have the right to receive supports and services in the community rather than institutions.

One-Time Set-Up Expenses

Expenses that are necessary to assist an individual to move back to the community under Community Transition Services. See also "Moving Expenses".

Parent

A child's adoptive or biological mother, or father, or stepparent who has legal responsibility for a child.

Payment for Care

A financial arrangement between the provider, the Department, and the county social service agency for services.

Personal Care (PC) Service

Provision of services consisting of a range of human assistance, provided to an individual with disabilities or conditions, that will allow the individual to

live as independently as possible while delaying or preventing the need for institutionalization. Assistance may be in the form of hands-on assistance or cuing so that the individual can perform a task without direct assistance.

Person-Centered Plan of Care

The Person-Centered Plan of Care is a summary of the needs and service options identified in the assessment process and is an outline of the plan developed by the individual, case manager, and the person-centered planning team. The Person-Centered Plan of Care is completed for all individuals served under home and community-based services including HCBS Medicaid waiver, Medicaid State Plan Personal Care Services, Service Payments for the Elderly and Disabled, and Expanded Service Payments for the Elderly and Disabled.

Physical Injury

Damage to bodily tissue which includes fractures, bruises, lacerations, internal injuries, dislocations, physical pain, illness, or impairment of physical function.

Poor Care

Care that does not meet service standards or care that is not acceptable to the client or department.

Primary Caregiver

The responsible person providing continuous care and supervision to an eligible individual that prevents institutionalization.

Primary Residence

The home owned and occupied by the applicant as his/her main place of residence.

Private Family Dwelling

Dwelling is defined in NDCC 14-02.5-01(8) as any structure or part of a structure that is occupied as, or designed or intended for occupancy as, a residence by one or more families.

Not considered a "private family dwelling" is an institution, motel/hotel room, and other similar arrangements rented by the individual. Congregate/group meals may be available or meals may be eaten off site.

Qualified Service Provider (QSP)

An individual or agency that has met all of the standards/requirements and has been designated by the department as a provider.

Qualified Service Provider (QSP) Handbook

A handbook outlining the standards and procedures required for agencies and individuals to qualify as a Qualified Service Provider.

Related by Blood or Marriage

An individual in at least one of the following categories: parent or stepparent; spouse, son or daughter, stepson or stepdaughter, grandson or granddaughter.

Resident

Any adult who is receiving foster care, in an Adult Foster Care Home for Adults or Residential Care for compensation on a 24-hour basis.

Residential Care Service

When personal care, therapeutic, social and recreational programming is provided in conjunction with residing in the facility. Includes 24-hour on-site response staff to meet client-resident needs and to provide supervision, safety and security. Resident is responsible for payment of board and room. Residential facilities must be licensed as Basic Care facilities.

Residential Habilitation

Formalized training and supports provided to eligible individuals who require some level of ongoing daily support. This service is designed to assist with and develop self-help, socialization, and adaptive skills that improve the participant's ability to independently reside and participate in an integrated community.

Residential Services

Residential services are: state institutional facilities, nursing homes, residential child care facilities, developmental disability facilities, family foster homes and adult (foster) homes licensed by the state of North Dakota.

Respite Care Service

Care to an eligible individual for a specified period of time for the purpose of providing temporary relief to the individual's primary caregiver from the stresses and demands associated with daily care or emergencies.

Respite Care Provider

An individual enrolled as a qualified service provider who provides respite care to a client, whose care is funded by the county or state, in the absence of the provider.

Responsible Party

The individual responsible for paying for services.

Service Fee

Monthly amount a SPED client is required to pay towards the cost of the client's services. It works like a monthly deductible. This amount is determined after deducting allowable medical expenses from their countable income. See also "Client Share" and/or "Cost Share".

Service Payment

The payment issued by the Department to the caregiver/qualified service provider.

Service Payments for the Elderly and Disabled (SPED)

A state program under which Qualified Service Providers are reimbursed by the Department for the provision of certain services provided to eligible elderly and disabled persons. These services are designed to assist individuals to remain in their own homes and communities.

Service Payments for the Elderly and Disabled (SPED) Program Pool

The list maintained by the department which contains the names of clients for whom SPED program funding is available when the clients' names are transferred from the SPED program pool to SPED program active status.

Settings Rule

Centers for Medicare & Medicaid Services (CMS) issued a final rule that requires states to review and evaluate HCBS settings. States are required to ensure all HCBS settings comply with the new federal requirements to ensure that all individuals receiving HCBS are integrated in and have full access to their communities.

Sexual Abuse

Conduct directed against an individual which constitutes any of those sex offenses defined in [N.D.C.C. 12.1-20-02, 12.1-20-03, 12.1-20-04, 12.1-20-05, 12.1-20-06](#).

Sliding Fee Schedule

The document used to determine the SPED service fee to be assessed based on family size and income.

Social History

Components of Social History include: Demographics, Who lives in the Home, Health History, Family Structure, Coping Mechanisms, Support System, Educational and Employment History, Behavior/Psychological/Social Information, Financial Resources, Identification of Service Need, and Outcome of Services Provision.

Specialized Equipment and Supplies

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

SPED Personal Care (PC) Service

Provision of services consisting of a range of human assistance, provided to an individual with disabilities or conditions, that will allow the individual to live as independently as possible while delaying or preventing the need for institutionalization. Assistance may be in the form of supervision hands-on assistance or cuing so that the individual can perform a task without direct assistance. While supervision is an allowable task within SPED personal care, it cannot be the sole reason for the care.

Spousal Impoverishment

Spousal Impoverishment applies to the Medicaid Waiver programs only. Allows the spouse at home (the community spouse) to keep additional income and assets so he/she can continue to live independently.

Spousal Support

The income of each spouse is deemed available to the other. When assets are to be considered, all assets of each spouse are deemed available to the other.

Standard

A level of quality or excellence that is accepted as the norm for a specific task.

Structural Changes

Structural changes refer to alterations of the recipient's residence to accommodate specialized equipment or changes in design to facilitate self-care.

Substantial Functional Impairment

A substantial inability, determined through observation, diagnosis, evaluation, or assessment, to live independently or provide self-care resulting from physical limitations.

Substantial Mental Impairment

A substantial disorder of thought, mood, perception, orientation, or memory, which grossly impairs judgment, behavior, or the ability to live independently, or provide for self-care, and which is determined by observation, diagnosis, evaluation, or assessment.

Substitute Caregiver

An individual who meets qualified service provider standards and provides respite care to private pay clients in the absence of the provider.

Supervision

Up to 24 hours of supervision may be provided to eligible individuals who because of their disability need monitoring to assure their continued health and safety.

Supported Employment Services

Provision of intensive, ongoing support to individuals to perform in a work setting with adaptations, supervision, and training relating to the person's disability. This would not include supervisory or training activities provided in a typical business setting. This service is conducted in a work setting, mainly in a work site in which persons without disabilities are employed.

Third Party Payer

An insurance company, Medicare, Medicaid, governmental entity, health maintenance organization (HMO), special education, court, or other resource which is responsible for payment of services.

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.

Transitional Living (TL) Service

Provision of training an individual to live with greater independence in the individual's home. This includes training, supervision, or assistance to the

individual with self-care, communication skills, socialization, sensory/motor development, reduction/elimination of maladaptive behavior, community living, and mobility.

Traumatic Brain Injured Residential Care Service

Assistance with retention or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed-making and household chores, eating the preparation of food, and the social, behavior, and adaptive skills necessary to reside in a non-institutional setting.

Vulnerable Adult

An adult who has substantial mental or functional impairment.

Vulnerable Adult Protective Services (VAPS)

Addresses the safety of vulnerable adults who are at-risk of harm due to the presence or threat of abuse, neglect, or exploitation.

Vulnerable Adult Protective Services (VAPS) Report

Any person who reasonably believes that a vulnerable adult has been subjected to abuse or neglect or observes conditions or circumstances that reasonably would result in abuse or neglect must report the information to the department or to an appropriate law enforcement agency.

Waiver Personal Care (WPC)

This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Such assistance may include assistance in performing ADLs (bathing, dressing, toileting, transferring, maintaining continence) and IADLs (more complex life activities, e.g. light housework, laundry, meal preparation, grocery shopping, using the telephone, medication and money management). Such assistance also may include the provider being at the ready to provide personal care services or the supervision of participants as provided in the service plan.

Willfully

Home and Community Based Services

Division 15
Program 505

Service 525
Chapter 05

Intentionally, knowingly, or recklessly.

Legal Reference/Authority 525-05-10

(Revised 6/1/20 ML #3582)

[View Archives](#)

Legal Reference/Authority

The legal references and authority for the HCBS programs (funding sources and services) administered by the HCBS Program Administration are as follows:

1. Home and community Based Services (Programs)

- a. Medicaid Waivers

The legal authority for the Medicaid Waiver is Section 1915(c) of the Social Security Act.

The Medicaid Waiver is governed by the rules and regulations set forth in 42 CFR, Parts 431, 435, 440, and 441 as amended. For the Medicaid Waiver, see North Dakota Administrative Code (N.D.A.C.) 75-03-23. For legal authority regarding Adult Foster Care (service), see N.D.A.C. 75-03-21.

Waiver services cannot be provided in the following settings:

- A nursing facility; (Institutional Respite care is excluded from this requirement)
- An institution for mental diseases;
- An intermediate care facility for individuals with intellectual disabilities; or
- A hospital.

Section 50-24.1-04 of the North Dakota Century Codes designates the North Dakota Department of Human Services as the single state agency responsible for administering the state's Medicaid Program. The Medical Services Division is primarily

responsible for the waiver program that is administered by the Aging Services Division.

Federal regulations prohibit payment to the following:

- Spouse of the client with the exception of Family Personal Care Service.
- Parent(s) of the client who is a minor. (The client is a minor child.)
- Any person court ordered or having signed a legal document agreeing to provide care to the client;
- Guardians

Effective 12/31/2016 the provision of services under the waiver must ensure an individual's right of privacy, dignity, and respect. Coercion, and or seclusion, of waiver recipients is expressly prohibit in all service settings. Restraint of waiver recipients is also prohibited in all settings with the exception of the limited use of restraints in adult residential service settings as described in N.D.C.C. 50-10.2-02 (1).

b. Service Payments for the Elderly and Disabled

The legal authority for the Department to operate the Service Payments for Elderly and Disabled (SPED) Program is found at N.D.C.C. 50-06.2-01(3) and to reimburse qualified service providers for the delivery of specific services provided to eligible persons is defined in N.D.C.C. 50-06.2-03(5), and 50-06.2-06. See also N.D.A.C. 75-03-23. For legal authority regarding Adult Foster Care (service), see N.D.A.C. 75-03-21.

c. Expanded Service Payments for the Elderly and Disabled

The legal authority for the Department to operate the Expanded SPED Program is found at N.D.C.C. 50-24.7, Expanded Service Payments for Elderly and Disabled. An eligible beneficiary is defined at N.D.C.C. 50-24.7-01(5) and is the same as for persons eligible for the Basic Care Assistance Program. Authority to reimburse qualified service providers for the delivery of specific services provided to eligible persons is

defined in N.D.C.C. 50-24.7-02(2). See also N.D.A.C. 75-03-24. For legal authority regarding Adult Foster Care (service), see N.D.A.C. 75-03-21.

2. Home and Community Based Services (Services)

a. Adult Foster Care

The legal reference/authority for the Adult Foster Care Program is N.D.C.C. 50-11, Foster Care Homes for Children and Adults, and N.D.A.C. 75-03-21, Licensing of Foster Homes for Adults.

Waiver Service Setting Requirements: effective 12/31/2016

All waiver service settings and the delivery of services in those settings must:

1. Be integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
2. Be selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
3. Ensure an individual's right of privacy, dignity, and respect. Coercion, and or seclusion, of waiver recipients is expressly prohibit in all service settings. Restraint of waiver recipients is also expressly prohibited with the exception of the limited use of adult residential service settings described in NDCC 50-10.2-02 (1).
4. Optimize but not regiment, individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact.
5. Facilitate individual choice regarding services and supports, and who provides them.

Provider owned or controlled residential settings must also:

1. Be a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity.
2. Offer privacy in their sleeping or living unit. The unit must have entrance doors lockable by the individual with only appropriate staff having keys to the doors.
3. Offer a choice of roommates within the setting.
4. Allow the recipient the freedom to furnish and decorate their sleeping unit or living units within the lease or other agreement.
5. Allow the recipient freedom and support to control their schedule and activities and have access to food at any time.
6. Allow the recipient to have visitors of their choosing at any time.
7. Be physically accessible to the individual.

Any modification of the additional conditions must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan: Specific individualized assessed need; Prior interventions and supports including less intrusive methods; description of condition proportionate to assessed need; ongoing data measuring effectiveness of modification, established time lines for periodic review of modifications; individual's informed consent; and assurance that interventions and supports will not cause harm.

Note: All currently enrolled adult residential care facilities are working toward compliance with the HCBS waiver settings requirements as described in the Statewide Transition Plan. An evidence package will be submitted for heightened scrutiny to CMS no later than October 31, 2017.

Long Term Services and Supports Option Counseling 525-05-12

(Revised 07/01/22 ML #3688)

[View Archives](#)

Purpose

The purpose of Long Term Services and Supports Options Counseling (LTSSOC) is for the department to ensure the target population member (TPM); individuals, over age twenty-one (21) who are eligible for, or likely will become eligible for Medicaid in the next 90 days, and who are screened for nursing facility level of care (NFLoC), receive comprehensive information on Medicaid funded long-term services and supports (LTSS) in integrated settings.

The intent of LTSSOC is to work directly with the TPM to provide information on LTSS. This allows the TPM to make a decision about their care and support and have their voice heard.

The TPM's wishes is the primary focus of the discussion.

Service Eligibility Criteria for The Target Population Member (TPM) for LTSSOC must meet the following criteria:

1. Individual has physical disability; and are at serious risk of entering a nursing facility.
 - The NFLoC is approved and indicates functional impairment.
 - Individuals may have a co-occurring mental or behavioral health need indicated on the screening.
2. Individuals twenty-one or over meet the TPM definition.
 - If an individual is 18-20 years old and is referred through the LTSSOC process, the referral will be sent to the MFP Program

Administrator to provide information and referral on options for LTSS.

3. The TPM may be eligible or likely to become eligible for Medicaid LTSS.

- Including individuals who have \$25,000 or less in assets or have applied or are planning on applying for Medicaid funded LTSS.

4. LTSS are likely to be required for at least 90 days

- TPM will require either formal or natural supports.
- 90 days includes services in the hospital/nursing facility and in the community.
- Individuals screened with a short-term screening who indicate a high preference for returning to the community, may receive either written.

Examples:

Mary was in the hospital and diagnosed with terminal cancer. Mary's life expectancy is less than 3 months and she is wanting to receive hospice care in the nursing home. LTSSOC would not be completed as Mary does not meet the target population due the LTSS need is expected to last less than 90 days.

Kevin was hospitalized due to a motor vehicle accident that left impaired in toileting/transferring and locomotion. Kevin is expected to spend 60 days in the nursing facility then will return to his apartment. Kevin anticipates he will be able to manage his own care needs after a 60 day stay in the nursing facility. Kevin does not meet the target population criteria due to short term stay and he is anticipated to not need LTSS. An SFN 892, or web-based version, is completed indicating that Kevin does not meet the target population. On day 45 Kevin is rescreened for NFLoC as his rehab is taking longer as he developed an infection. Kevin is on the LTSSOC referral list and now meets the criteria for the TPM. LTSSOC would be completed and a referral would be made to HCBS and MFP as Kevin would like to return home and he agrees that he would like to learn about assistance with transitioning back into the community.

In-reach

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In-reach LTSSOC is completed upon initial referral for LTSSOC on individuals who meet the TPM criteria. The visit is completed by making a face-to-face contact with the TPM and completing the SFN 892 or web-based version. The purpose of the LTSSOC visit is to provide information on LTSS options paid for by Medicaid. The TPM and their legal representative (if applicable) can make an informed decision about where and how they would like to receive LTSS.

- Once the initial LTSSOC visit has been completed the individual will be followed by the LTSSOC worker for annual reviews and completion of the PCP and Risk Assessment and Health and Safety Plan.

The assigned LTSSOC must complete the LTSSOC process with the TPM using a person-centered planning process, LTSSOC Questionnaire, SFN 892, or web-based version.

1. The LTSSOC must make contact with the TPM, and provide information on LTSS.

When a TPM's level of cognitive impairment is such that they cannot participate in discussion and care planning for their LTSS needs, the ND Department of Human Services Aging Services staff member must still communicate with the targeted population member, even if the guardian or legal representative objects. The ND Department of Human Services Aging Services staff members are still responsible to set up a safe person-centered plan to adequately address the targeted population member's care needs including the need for supervision or protective oversight.

- The LTSSOC visits the TPM and engages in light conversation to get to know the individual. Discussion informs the person-centered planning process and may include learning about how the individual is doing, their wants, needs and desires to live their best life, and how and where they would like to receive their LTSS.
- If the TPM's level of cognitive impairment, mental illness or end-stage life conditions is such that they do not understand the questions, a family member, significant other, guardian and/ or legal representative should be asked the LTSSOC questions.
- Legal representative of the TPM may include a guardian, Durable Power of Attorney (DPOA), Power of Attorney (POA), or representative identified on the TPM Living Will.

- Documentation of authority is required and must be verified prior to allowing legal representative to make any decisions on behalf of the TPM.
 - Informed Consent - In some cases, TPM may not understand the question or the questions may result in the TPM being agitated or saddened by being asked the LTSSOC questions. Or if the TPM level of cognitive impairment is such that they do not understand, a family member, significant other, guardian and/ or legal representative should be asked the LTSSOC questions.
 - In instances where there is no legal representative, family or informal support and the TPM cannot participate due to cognitive impairment, the LTSSOC will recommend to the nursing facility social worker to refer supported decision making or other legal representation.
2. The LTSSOC must provide written (Community Living Brochure, DN 1864) and verbal communication with the TPM and/or their legal representative on LTSS in the most integrated setting.
 3. The LTSSOC must contact the TPM as soon as possible, but no later than ten (10) business days from the date of referral.
 - If the visit cannot be completed within the designated time frame the LTSSOC must document why the visit did not take place within the designated timeframe on the SFN 892, or web-based version.
 4. Priority should be given to individuals discharging from the hospital.
 - Best practice is to follow up with the hospital daily and no later than two working days of the LTSSOC referral.
 - Case management must provide face-to-face person-centered planning with the TPM whenever possible.
 5. A virtual or visit by telephone may be completed in circumstances where a face-to-face visit cannot be completed. Such circumstances may include visitation restrictions due to COVID-19.
 - Connection Carts should be used when available.
 - The LTSSOC must document on the SFN 892, or web-based version, why the visit was not completed face-to-face.

6. If the TPM could not be located (ie. they discharged or do not answer their phone), the LTSSOC must mail the DN 1864 and the community living handout to the TPM's address on the NFlOC screening.
 - Contact attempts including mailing of information need to be documented on the SFN 892, or web-based version.
 - At least two attempted contacts must be made to contact the TPM before the LTSSOC information is mailed out.
7. Collateral contact may be made with the screening agency or facility in which the TPM is residing to provide information about the individual's admission/discharge.
 - The public or private agency cannot prevent or impede the LTSSOC process.
 - The collateral contact should not influence the decision of the TPM or their legal representative.
 - Information can be exchanged on a need to know basis under the continuum of care between the facility and the LTSSOC worker without a release of information.
 - The TPM and/or their legal representative should be made aware that information is exchanged between entities
 - LTSSOC is completed for referrals whose NFlOC is 90 days or more. All individuals initially referred through the daily referral list on SFN 892, or web-based version, or Care Plan and Risk Assessment Health and Safety Plan must be submitted to Aging Services.
 - For subsequent daily referrals for the individual the master list will be marked as completed and the individual will be followed by the LTSSOC assigned to the facility the resident resides in. The LTSSOC will complete a person-centered plan of care with the individual annually.
 - The LTSSOC will notify Program Administrator that the LTSSOC referral had been completed within the past twelve months. Program Administration marks the referral as OPEN LTSS.

Referrals

LTSSOC must complete referrals made to other programs/services as discussed in the person-centered planning discussion with the TPM and document the date that the referral was made on the SFN 892, or web-based version.

1. Referrals to MFP must be made to the MFP Program Administrator, or designee will confirm the receipt of the referral.
 - The LTSSOC may include any additional information that might be useful for the MFP and HCBS referral.
 - The LTSSOC may include the most recent History and Physical and the face sheet, medication list and care plan for the referred individual.
 - The LTSSOC must also include the SFN 892, or web-based version, with the referral.
 - MFP and HCBS can follow up with the LTSSOC for a soft hand off.
 - If the individual has been residing in BC and has CM there would not need refer to MFP if the individual plans on returning to BC.
2. Referrals to ND DHS, Developmentally Disability Division

LTSSOC will be completed by the DD Division when the referral is also submitted by the NFLoC contractor for Level II review.

- The DD Division will provide documentation indicating LTSSOC was completed upon the request of HCBS Program Administrator.
- Individuals meeting the TPM criteria and receiving DD services must be referred to the DDPM to complete the LTSSOC referral.

Documentation

Documentation of the LTSSOC exchange must be documented on the SFN 892, or web-based version.

1. Documentation of any referrals must entered on the SFN 892, or web-based version.
 - A signed copy of the SFN 892, or web-based version, must submitted to Aging Services within 5 working days of the LTSSOC visit.

- The individual or legal representative must sign the SFN 892, or web-based version, or give verbal permission for the LTSSOC to sign on their behalf.
2. The LTSSOC must document that the individual gave verbal permission for signature in the narrative section of the SFN 892, or web-based version.
 - Additional notes can be added to the narrative section of the 892, or web-based version.

Continuum of Services

1. Refusal of LTSSOC
 - The individual has the right to refuse LTSSOC. Please document the refusal and obtain a signature indicating the refusal.
 - Upon refusal of LTSSOC, the (Community Living Brochure, DN 1864) must be left with or mailed to the individual.
2. The TPM must be asked if they would like a follow up with an LTSSOC visit at a later date and documented on the SFN 892, or web-based version.
 - A copy of the SFN 892, or web-based version, must be updated and sent to the department with the date that the follow up visit was completed.
3. HCBS Services are requested by individual
 - The LTSSOC completes an initial visit to the TPM when the individual meets the TPM criteria and is on the daily LTSSOC referral list.
 - During the LTSSOC visit the individual may request a follow up visit. The LTSSOC will note the date the LTSSOC visit is requested on the SFN 892 or web-based version.
 - The LTSSOC will complete the follow up visit as requested and indicate on the SFN 892 or web-based version, the completion of the follow-up visit.

Following the initial LTSSOC visit the LTSS-OC worker will complete any referrals as requested and coordinate with the referral entities.

If the individual wishes to continue residing in the nursing facility the LTSSOC worker will follow-up annually and complete the PCP and Risk Assessment and Health and Safety Plan.

Annual visits for TPM's Continuing to Reside in Nursing Facility

For individuals on Medicaid and continuing to reside in the NF with long-term NFLoC approval, an annual level of care will be completed by the nursing facility. The LTSSOC receives a referral for individuals due for an annual review of LTSSOC. During the annual visit the LTSS-OC engages in discussion about options for LTSS paid for by Medicaid.

The intent of LTSS-OC is to work directly with the TPM to provide information on LTSS. This allows the TPM to make a decision about their care and support and have their voice heard.

The TPM's wishes is the primary focus of the discussion.

LTSSOC is completed upon the annual review referral for LTSSOC on individuals who meet the TPM criteria and are living in a nursing facility long-term. The visit is completed by making a face-to-face contact with the TPM and/or their legal representative and other formal and natural supports. The purpose of the LTSSOC visit is to provide information on LTSS options paid for by Medicaid. The TPM and their legal representative (if applicable) can make an informed decision about where and how they would like to receive LTSS.

The LTSSOC must complete the following for all TPM residing in the nursing facility long-term:

1. The Person-Centered Plan of Care (SFN 1265) or web-based version.
2. The Risk Assessment and Health and Safety Plan (SFN 1267) or web-based version.

When a TPM's level of cognitive impairment is such that they cannot participate in discussion and care planning for their LTSS needs, the ND Department of Human Services Aging Services staff member must still communicate with the targeted population member, even if the guardian or legal representative objects. The ND Department of Human Services Aging Services staff members are still responsible to set up a safe person-centered plan to adequately address the targeted population member's care needs including the need for supervision or protective oversight.

- The LTSSOC visits the TPM and engages in light conversation to get to know the individual. Discussion informs the person-centered planning process and may include learning about how the individual is doing, their wants, needs and desires to live their best life, and how and where they would like to receive their LTSS.
- If the TPM's level of cognitive impairment, mental illness or end-stage life conditions is such that they do not understand the questions, a family member, significant other, guardian and/ or legal representative should be asked the LTSSOC questions.
- Legal representative of the TPM may include a guardian, Durable Power of Attorney (DPOA), Power of Attorney (POA), or representative identified on the TPM Living Will.
- Documentation of authority is required and must be verified prior to allowing legal representative to make any decisions on behalf of the TPM.
- Informed Consent - In some cases, TPM may not understand the questions, or the questions may result in the TPM being agitated or saddened by being asked the informed choice questions. Or if the TPM level of cognitive impairment is such that they do not understand, a family member, significant other, guardian and/ or legal representative should be asked the informed choice questions.
- In instances where there is no legal representative, family or informal support and the TPM cannot participate due to cognitive impairment, the LTSSOC will recommend to the nursing facility social worker to refer for supported decision making or other legal representation support.

Referrals

LTSSOC must complete referrals made to other programs/services as requested by the TPM and document the date that the referral was made on the care plan or web-based version of the care plan.

Referrals to for MFP and HCBS must be made to the MFP Program Administrator or designee. The MFP Program Administrator or designee will confirm the receipt of the referral.

- Include any additional information that might be useful for MFP and HCBS in the referral email.
- MFP and HCBS may follow up with the LTSSOC worker for a soft handoff of the referral.
- The transition coordinator and HCBS case manager work together throughout the transition process.
- The LTSSOC may include the most recent History and Physical and the face sheet, medication list and care plan for the referred individual.

Signature Sheet Utilization Policy

Introduction

This document provides guidance for utilization of a signature sheet when completing the Person-Centered Plan of Care (PCP) and/or the Risk Assessment and Health and Safety Plan and the Referral for Long-Term Services and Supports Option Counseling. These documents necessitate signatures from entities such as the individual receiving services, legal decision maker, and provider for the delivery of services. Obtaining necessary signatures is the responsibility of the Case Manager or LTSS Options Counselor originating the document. The signature sheet allows for a non-digital option for individuals to sign the plan. It is required that a signature is obtained for initial, 6-month and annual PCP and the Risk Assessment and Health and Safety Plans. Additionally, signatures are required by the service provider which is obtained when acknowledging the Preauth.

The signature sheet may also be utilized when a change in the Person-Centered Plan of Care (PCP) and/or the Risk Assessment and Health and Safety Plan is initiated by the individual receiving care and a signature is not able to immediately be obtained by an individual or legal decision

maker on the Person-Centered Plan of Care (PCP) and/or the Risk Assessment and Health and Safety Plan.

This policy cannot account for every situation; therefore, the case manager must use their professional judgment when applying this policy.

Guidelines

When completing the Person-Centered Plan of Care (PCP) and/or the Risk Assessment and Health and Safety Plan and the Referral for Long-Term Services and Supports Option Counseling the case manager or LTSS Options Counselor work with the individual and team to discuss and develop the plan. The plan is reviewed with the individual and the team and the individual and team members have the option to sign the signature sheet which is attached to the plan in Therap. The plan with the signature sheet is then mailed out to the individual and team members as documented on the plan within 30 days.

When an individual initiates a change in their PCP or the Risk Assessment and Health and Safety Plan, and a case manager is unable to acquire a necessary signature through direct contact with the individual or the legal representative (e.g., guardian attending meeting by phone), a minimum of 3 attempts must be made to obtain the signature of the individual and/or legal decision maker within 30 calendar days. Methods of contact can be made by mail, email, phone contact, or other communications that are available to the person. Services will continue to be provided as long as the person meets the eligibility requirements, and the service is appropriate.

If verbal consent is given, this can be noted on the document along with the signature of the case manager and date. Attempts to obtain the signed signature are still applicable.

Each attempt to acquire signatures should be documented in case notes and should vary from previous unsuccessful attempts. The attempts should inform the individual of the timeline to respond and that if the documents are not signed and returned, it will be assumed that they are in agreement and understand any rights afforded to them.

Annual Long-Term Services and Supports Options Counseling (LTSSOC) Skilled Nursing Facility Presentations (SNF)

Each SNF has a LTSSOC who is responsible for completing an annual presentation at the SNF. A presentation is completed with residents, staff and any other community members who would like to attend.

The presentation consists of the following activities:

- A short presentation about LTSSOC and options for receiving long-term services and supports.
- Flyers and brochures with information on LTSSOC options are provided.
- Attendance is documented through an attendance roster.
- A follow-up visit to the facility is made to allow anyone who is interested in more information to have a private conversation with the LTSSOC.
- The follow-up visit should be scheduled approximately 2-4 weeks following the LTSS Presentation.
- If the follow-up visit is not completed within 2 to 4 weeks document the reason why in the SNF Presentation record.

Following the presentation, the LTSSOC must;

- Provide the attendance roster to LTSSOC Program Administrator and LTSSOC Supervisor.
- Record the date of the presentation and number of individuals in attendance.
- Record the date of the follow-up visit
- If the follow-up visit is not completed within 2 to 4 weeks document the reason why in the SNF Presentation record.
- Mark the presentation as complete in the SNF Presentation Record.

Purpose of Home and Community Based Services 525-05-15

(Revised 2/5/16 ML #3465)

[View Archives](#)

The purpose of the Medicaid Waiver Program is to prevent or reduce institutional care through the use of Medicaid funding to provide necessary and essential home and community-based services.

The settings where waiver recipients receive services must be integrated in and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

The purpose of the SPED Program is to provide payments for a continuum of in-home and community-based services adequate to appropriately sustain individuals in their homes and community and to delay or prevent institutional care. NDCC 50-06.2-01(3).

The purpose of the Expanded SPED Program is to provide payments for in-home and community-based services to persons who would otherwise receive care in a licensed basic care facility in North Dakota.

Funding Sources 525-05-20

(Revised 6/1/08 ML #3144)

[View Archives](#)

Funding Sources

The Case Management Entity shall use existing and established procedures to determine funding/reimbursement available for services.

Clients who are eligible for federally funded services and programs must utilize the services available under those resources.

Payment sources include:

- Self-Pay
- Third Party Payers
- County Funded Services
- Service Payments for Elderly and Disabled (SPED)
- Expanded Service Payments for the Elderly and Disabled (EXSPED)
- Medicaid Waivers
- Medicaid State Plan

Eligibility Criteria 525-05-25**HCBS Program Eligibility Determination 525-05-25-05
(Revised 05/01/23 ML #3730)**

[View Archives](#)

An individual wishing to apply for benefits under this chapter must have the opportunity to do so, without delay. The HCBS case manager must schedule an appointment for an initial assessment no later than five working days after receiving a request for services and must complete an initial comprehensive assessment no later than ten working days after receiving a request for services. All contacts with an individual must be documented within the narrative in the web-based data collection system.

1. Application for services in service chapter shall be made to the department utilizing "Application for Services," [SFN 1047](#).

An application is a request made to the department or its designee by individual seeking services under this chapter, or by an individual properly seeking services on behalf of another individual. "An individual properly seeking services" means an individual of sufficient maturity and understanding to act responsibly on behalf of the individual for whom services are sought. The case management entity must accept a referral from an individual who is acting in the best interest of the client and cannot require that the client themselves to actually make the initial request for services. However, the actual applicant must agree to a home visit. The applicant or their legal representative must sign the application and participate in the eligibility process.

The department or its designee shall provide information concerning eligibility requirements, available services and the rights and responsibilities of applicants and recipients to all who require it. The date of application is the date the department's designee receives the properly signed application.

The applicant shall provide information sufficient to establish eligibility for benefits, including a social security number and proof of age,

identity, residence, blindness, disability, functional limitation, financial eligibility, and other information required under this chapter.

- The Privacy Act of 1974 requires the following information be provided when individuals are requested to disclose their social security numbers. Disclosure of the social security number is voluntary, and it is requested for identification purposes. Failure to disclose this information will not affect participation in this program.
2. An applicant is eligible for these programs if the Case Management process (assessment of needs and care plan development) determines that the applicant meets functional and financial eligibility criteria for HCBS programs and requires those tasks/activities allowable within the scope of the services.

An initial functional assessment, using the form required by the department, must be completed as a part of the application for benefits under this chapter. A functional assessment must be completed at least semiannually in conjunction with the eligibility redetermination. The functional assessment must include an interview with the individual in the home where the individual resides.

3. Authorization to Provide Services, otherwise known as the PreAuth, identifies the specific tasks/activities the provider is authorized to perform for the eligible client and sets forth the scope of the service the client has agreed and understands will be provided.
4. To be eligible for the Medicaid Waiver for Home and Community Based Services or the Expanded SPED program, the client must be an approved recipient of Medical Assistance. The Medicaid Waiver client must also receive a Waivered service on a monthly basis. HCBS Case Management is not sufficient.
5. The client is eligible for covered services under the Medicaid Waivers, the SPED program, and/or ExSPED program once all eligibility criteria have been met. Continued eligibility is monitored under HCBS Case Management. At any time there is a question as to whether the client continues to meet functional or financial eligibility criterion, the HCBS case manager is to substantiate eligibility.

The authorization of services cannot begin before the date of the client's or legal representative's signature and until a level of care

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screening date, SPED Pool effective date, or ExSPED Pool effective date is processed.

Medicaid Waiver for Home and Community Based Services 525-05-25-10

(Revised 02/01/25 ML #3899)

[View Archives](#)

In order for services to be payable under the provisions of the Medicaid waiver for Home and Community Based Services, the individual receiving the service must meet all of the following:

Recipient of Medicaid Program under the State Plan for Medical Assistance as set forth in Service Chapter 510-05, Medical Assistance Eligibility Factors;

Age 18 or older and physically disabled as determined by the Social Security Administration or the State Review Team, or be at least 65 years of age;

Eligible to receive care in a skilled nursing facility;

Participate to the best of their ability in a comprehensive assessment to determine eligibility and develop a person centered plan for receiving home and community-based services as an alternative to institutional care;

Have a Person Centered Plan of Care, developed and approved by the individual or legal representative and HCBS case manager that adequately meets the health, safety, and personal care needs of the recipient;

Voluntarily choose to participate in the home and community-based program after discussion of available options. This is documented as part of the assurances in the Person-Centered Plan of Care;

Service/care is delivered in the recipient's or family member's private family dwelling (house, apartment, or camper if the camper is located in a long term campground that rents by the month/year etc.) or recipient is receiving a community-based service of adult foster care, adult day care, non-medical transportation, or adult residential

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service. The renter's living area should consist of a bedroom with or without bath and possibly a sitting area. Congregate/group meals may be available or meals may be eaten off site. For unique circumstances, contact the HCBS Program Administrator for consideration.

With the exception of institutional respite, Medicaid Waiver funds may not be used to provide care in any institutional setting i.e. nursing home or hospital.

Must receive services on a monthly basis. If a current recipient has not utilized services within a 30-day period of time, a citation *may* be requested (if appropriate) to terminate the case. However, if the services are expected to resume within 3 months, it is allowable for the case to remain open. This does not require approval from a Program Administrator. (See below for service requirements specific to Spousal Impoverishment cases).

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

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

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

Not receiving services through other Medicaid Waivers.

The individual's impairment is not the result of a mental illness, intellectual disability or a closely related condition.

Financial Information for Medicaid Waiver HCBS:

Spousal Impoverishment

Spousal Impoverishment applies to the Medicaid Waiver programs only. The applicant/recipient must be authorized and receiving a Waiver service on a monthly basis.

Institutional Spouse and Community Spouse (both eligible for Medicaid Waiver Services.

If both of the spouses are residing in the home and are screened at nursing facility level of care (LOC) then spousal impoverishment cannot apply.

When determining spousal impoverishment asset and income limits, see Medicaid Program Service Chapter 510-05. (The amounts change annually.)

Charging for Services

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

Handling of Collections

Accounts Receivable Manual, Service Chapter 115-40 shall be followed for all collection procedures.

Confidentiality of Financial Records

Financial information regarding a Medicaid waiver recipient shall remain confidential except where otherwise provided by law or

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departmental policy. (See Accounts Receivable Manual, Service Chapter 115-40.)

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

Overpayment

If there are credible allegations that an individual or their legal representative concealed or misrepresented financial or functional information with the purpose of obtaining eligibility for HCBS, the Department may recoup the overpayment.

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

(Revised 02/01/25 ML #3899)

[View Archives](#)

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

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

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

Functional Eligibility for the SPED Program

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

The individual is either functionally impaired in at least two (2) Activities of Daily Living (ADLs), OR at least four (4) Instrumental Activities of Daily Living (IADLs), totaling at least four (4) points if living alone, or six (6) points if living with an able-bodied adult.

The impairments must have lasted or can be expected to last three (3) months or more (must be noted in the comprehensive assessment narrative of the source of the evidence).

The applicant/recipient's functional impairments, for which SPED services are being authorized, must be due to a

disability which are not the result of a diagnosis of intellectual disability or a related condition or mental illness.

The individual is living in North Dakota in what is commonly considered a private family dwelling (house, apartment, or camper if the camper is located in a long term campground that rents by the month/year etc.). The renter's living area should consist of a bedroom with or without bath and possibly a sitting area. Congregate/group meals may be available, or meals may be eaten off site. For unique circumstances, contact the HCBS Program Administrator for consideration. The individual must be capable of directing their own care or have a legal representative to act in their behalf. The individual would receive one or more covered services, in addition to Case Management, in accordance with Department policies and procedures for the specific service.

If under age 18, must meet the following:

The applicant has a functional impairment to indicate eligibility.

The applicant's functional impairment has lasted, or can be expected to last, three months or longer.

The applicant's functional impairments for which SPED services are being authorized, are not the result of a mental illness, intellectual disability, or a closely related condition.

The applicant is living in North Dakota in a housing arrangement commonly considered a private family dwelling and not in an institution. For unique circumstances, contact the HCBS Program Administrator for consideration.

The applicant is not eligible for services under the Medicaid waiver program or the Medicaid state plan of personal care services.

The applicant would receive one or more of the covered services under department policies and procedures for the specific service.

The applicant's parent or legal guardian agrees to the plan of care developed for the provision of home and community -based services.

The applicant's parent(s) is not responsible for one hundred percent of the cost of the covered service provided, under the SPED sliding fee scales.

The applicant's parent(s) have not made a disqualifying transfer of assets.

The applicant is unable to regularly attend school or is severely limited in the amount of time the applicant is able to attend school.

The individual must be screened in need of nursing facility level of care. When completing the LOC screening tool, the "HCBS/Other" check box must be completed.

For an infant under 3 months of age and requiring apnea monitoring, see the [Respite Care](#) section.

If applying for [Family Home Care](#) or [Respite Care](#), see the sections for additional requirements that must be met.

SPED Personal Care Service is not available for those under age 18.

Parents are not eligible to be the paid service provider unless prior approval is granted by the HCBS Program Administrator.

Financial Eligibility for the SPED Program

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

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

level.

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

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

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

The individual has not made a disqualifying transfer of assets.

SPED and Medicaid Eligible

It is not necessary that every SPED Program applicant/recipient make an application for Medical Assistance (Medicaid). During completion of the comprehensive assessment, sufficient information may be obtained to determine whether their assets exceed Medicaid limits. Nor is screening for level-of-care mandatory for all Medicaid recipients.

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

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

<u>SPED Fee Schedule</u>	<u>Less the Medicaid Needy Amt</u>	<u>Less \$20 Disregard</u>	<u>Max Service Amt</u>
\$1,383 .00	(\$1130. 00)	(\$20.00)	\$233.00

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

If an individual's services are being paid for at the rural differential rate, determine the cost of the services using the regular rate. If that amount is \$233 or less, they are not required to apply for Medicaid. If at any time an individual's service needs increase and the cost exceeds \$233 per month, they will be required to apply for MA.

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

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

date of the SPED Program will be established to cover those service costs (within the limits of the SPED Program).

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

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

Institutional Spouse and Community Spouse (Spousal Impoverishment)

Income and Medical Deductions:

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

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

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

All household income is counted, which would include the deemed income;

Medical deductions (up to the \$850 maximum)/prescription drugs are counted for all persons in the household;

Household number of two (if there are no other dependents residing in the home);

All liquid assets cannot exceed \$50,000, which includes the deemed assets.

Charging for Services

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

Confidentiality of Financial Records

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

SPED Eligibility & Medicaid Expansion

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

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

Service Fee, SPED Program

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With the completion of the SPED Income and Asset form, [SFN 820](#), and by using the sliding fee schedules, the HCBS Case Manager will determine if a participation fee percentage will be assessed to the service costs.

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

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

Income Verification Method

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

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

Financial Status And Family Size Review

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

If an applicant/recipient has a spouse who is residing in the nursing home and is receiving Medical assistance under spousal impoverishment rules, consider the spouse requesting SPED services as living in a household of

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

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

Financial Disclosure

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

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

Individual Fees Charged For Services

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

Service Fee Changes

Once services have been established and there is a change to the service fee, the HCBS Case Manager must notify the HCBS Program Administration

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

Ineligibility for the SPED Program

Other Funding Sources

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

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

An individual is NOT eligible for SPED if they are eligible for the HCBS Waiver or Medicaid State Plan Personal Care and the cost of their HCBS services to SPED will exceed \$233.

Overpayment

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

Disqualifying Transfer

Per [NDCC 50-06.2-07](#), a disqualifying transfer has occurred if at any time before or after making application, the individual or

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

If a disqualifying transfer occurred five years prior to the date that an individual initially applies for SPED services, the Department will presume that the transfer was not for the purpose of obtaining SPED benefits.

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

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

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

The value of the transferred asset when added to the value of the individual's other assets would not otherwise make them ineligible for SPED or does not decrease the individual's service fee.

The asset transferred was the title to a home and the home was transferred to the individual's spouse, or to a son or daughter who is under age 21, or who is blind or disabled. Assets were transferred to or from the individual's spouse or to another person for the sole benefit of the individual's spouse.

The individual can show that they intended to dispose of the assets at fair market value as defined in [N.D.A.C. 75-03-23-14](#) and the individual had an objectively reasonable belief that fair market value was received.

The individual can show that they transferred the assets for a purpose other than to qualify for SPED benefits.

Where any income or asset is transferred to a relative for services or assistance furnished by the relative, the services or assistance furnished may not be treated as consideration for the transferred income or asset unless:

- The transfer is made pursuant to a valid written contract entered into prior to rendering the services, or in the absence of a valid written contract, evidence is provided the services were required and provided.
- The contract was executed by the individual or the individual's fiduciary who is not a provider of services or assistance under the contract.

There is a presumption that a transfer was made for the purpose of making an individual eligible for SPED if:

- An inquiry about SPED benefits or benefits under this chapter was made by or on behalf of the individual to any other individual before the date of transfer;
- The individual or the individual's spouse was an applicant for or recipient of SPED benefits before the date of transfer;
- A transfer is made by or on behalf of the individual's spouse, if the value of the transferred asset, when added to the value of the individual's other assets would exceed SPED limits; or

The transfer was made, on behalf of the individual or the individual's spouse, by a guardian, conservator, or attorney-in-fact, to the guardian, conservator, or attorney-in-fact or to any spouse, child, grandchild, brother, sister, niece, nephew, parent, or grandparent, by birth, adoption, or marriage, of the guardian, conservator, or attorney-in-fact.

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

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

SPED Pool

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

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

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

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

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

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

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

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

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

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

The reason for delay or pause in services must be documented in the individual's file.

The case manager must document how the need is met while the identified service needs are pending.

The case manager must follow up monthly with the individual to provide support and assistance mitigating the issue causing the delay in service implementation.

If the services do not resume or start within 3 months, approval must be received from the Program Administrator to keep the case open OR the case manager must request a termination to close the case and submit an SFN 474 to Aging Services/HCBS.

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

The case manager must document the admission to the facility.

The case manager must follow up monthly with the individual and collaborate with the nursing facility/discharge planning team to ensure appropriate services are secured for their return to the community.

If the services do not resume within 3 months and approval has not been received, the case manager must terminate the case due to institutionalization.

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

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

- A new Application for Services (SFN 1047) does not need to be completed.
- A new SPED financial assessment (SFN 820) does not need to be completed unless there has been a substantial financial change, or the individual is due for a required annual assessment.
- An SFN 1820 does not need to be completed.
- An SFN 676 does need to be completed and submitted to HCBS/Aging Services. If all information is the same, it is allowable to

use the previously approved SFN 676 and simply indicate the date the individual is to re-open in the field "Date of Application" and select "Re-Open" in the "Application Type" field.

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

SPED Pool Exceptions

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

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

Individual has been off the SPED program for 60 days or less for any reason

The HCBS Case Manager must document the date that SPED services re-should start on the [SFN 676](#), Add New Record to MMIS Eligibility File, in the "Date of Application" field and select "Re-open" in the "Application Type" field. For further instruction, please reference HCBS Policy & Procedure Manual: Closures, Denials, Terminations, Reductions, and Transfer of Services 525-05-40.

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

Expanded Service Payments for the Elderly and Disabled Eligibility (ExSPED) 525-05-25-25

(Revised 02/01/25 ML #3899)

[View Archives](#)

Eligibility for the Expanded SPED Program has two components: financial/Medicaid eligibility and functional eligibility. The applicant/individual must meet BOTH eligibility components before payment can be made by the Department under this Chapter.

Functional Eligibility, ExSPED Program

Is at least 65 years of age, OR is at least 18 years of age and disabled or blind based on Social Security criteria. [N.D.C.C. 50-24.7-01\(5\)\(b\)](#);

Is not severely impaired in ANY of the three activities of daily living (ADLs): Toileting, Transferring to or from a bed, chair or toilet, or Eating as determined by completion of an comprehensive assessment.

Is impaired in at least three (3) of the following four (4) instrumental activities of daily living (IADLs): Meal Preparation, Housework, Laundry, or Taking Medicine based on completion of a comprehensive assessment. The impairments must have lasted or are expected to last, more than three (3) months.

(Note: Or has health, welfare, or safety needs, including a need for supervision or a structured environment, which otherwise require care in a licensed adult family foster home or a licensed basic care facility. (The services of the Expanded SPED Program are provided in the recipient's home or community instead of care in a basic care facility.)

Capable of directing own care or has a legal representative to act in their behalf.

Living in what is commonly considered a private family dwelling (house, apartment, or camper if the camper is located in a long

term campground that rents by the month/year etc.). The renter's living area should consist of a bedroom with or without bath and possibly a sitting area. Congregate/group meals may be available or meals may be eaten off site. For unique circumstances, contact the HCBS Program Administrator for consideration.

The applicant impairment is not the result of an intellectual disability or a closely related condition.

Service/care need is within the scope of services available under this chapter;

Financial Eligibility for ExSPED

The first step is to have a determination of Medicaid eligibility by the Economic Assistance Unit, as an applicant must be receiving Medical Assistance in order to be eligible for ExSPED.

In addition to being eligible for Medical Assistance, the applicant must be receiving Supplemental Security Income (SSI) OR, if not, their income cannot exceed an amount equal to SSI. [[N.D.A.C. 75-02-10-05\(4\)](#)]. Please note that the following income is disregarded:

Recovery Rebates authorized by section 2201 of the Coronavirus Aid, Relief, and Economic Security Act of 2020 [Pub. L. 116-136].

Estate Recovery

Any monies paid from general funds for Ex-SPED services are subject to estate recovery by law, [N.D.C.C. §50-24.7-05](#). This includes the following services:

- Adult Day Care
- Adult Foster Care
- Chore & ERS
- Environmental Modification
- Family Home Care
- Companionship
- Home Delivered Meals
- Homemaker
- Non-Medical Transportation

Respite

Legislation passed during the 1995 session gives the Department the authority to file a claim against an individual's estate to recover payments made under the Expanded SPED Program. The Department can file a claim for all payments made since the inception of the Program in 1994.

Overpayment

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

Ongoing Medicaid Eligibility

Because Medicaid eligibility is part of the financial eligibility for ExSPED, the individual's Medicaid status will need to be verified periodically. The HCBS Case Manager should verify in MMIS that the individual continues to have an active Medicaid case as part of the regularly scheduled quarterly contacts and home assessments.

Expanded SPED Pool

Upon finding the applicant meets the criteria for the Expanded SPED Program through the completion of the comprehensive assessment and verification from the Eligibility worker, forward the following to the HCBS Program Administration:

Expanded SPED Pool Program Data form [SFN 56](#)

Add New Record to MMIS Eligibility File (Expanded SPED) [SFN 676](#)

Services must not be authorized until the HCBS Case Manager is notified the applicant was successfully removed from the ExSPED Pool. HCBS Program Administration will notify the HCBS Case

Manager of the decision by forwarding a copy of the SFN 676 with the ExSPED identification number and start date recorded on the form.

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

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

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

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

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

The reason for delay or pause in services must be documented in the individual's file.

The case manager must document how the need is met while the identified service needs are pending.

The case manager must follow up monthly with the individual to provide support and assistance mitigating the issue causing the delay in service implementation.

If the services do not resume or start within 3 months, approval must be received from the Program Administrator to keep the case open OR the case manager must request a termination to close the case and submit an SFN 474 to Aging Services/HCBS.

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

The case manager must document the admission to the facility. The case manager must follow up monthly with the individual and collaborate with the nursing facility/discharge planning team to ensure appropriate services are secured for their return to the community.

If the services do not resume within 3 months and approval has not been received, the case manager must terminate the case due to institutionalization.

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

If an ExSPED recipient closes due to a skilled nursing facility or swing bed admission, and they re-open SPED within 3 months:

A new Application for Services (SFN 1047) **does not** need to be completed.

An SFN 56 **does not** need to be completed.

An SFN 676 **does** need to be completed and submitted to HCBS/Aging Services. If all information is the same, it is allowable to use the previously approved SFN 676 and simply indicate the date the individual is to re-open in the field "Date of Application" and select "Re-Open" in the "Application Type" field.

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

Expanded SPED Pool Exceptions

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

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

- Individual has been off the Ex-SPED program for 60 days or less for any reason

Financial Information for HCBS Programs 525-05-25-30
(Revised 7/1/19 ML #3553)

[View Archives](#)

Refer to policy Service Payments for the Elderly and Disabled (SPED) 525-05-25-20 regarding financial information for SPED.

Refer to policy Medicaid Waiver for Home and Community Based Services 525-05-25-10 regarding financial information for Medicaid Waiver.

Covered Services 525-05-30

(Revised 5/1/06 ML #3015)

[View Archives](#)

Payment from HCBS funds is available only for the provision of covered services to eligible recipients. The covered services must be specifically identified in the client's plan of care as necessary to avoid institutionalization and to be provided outside a basic care facility, skilled nursing facility, or hospital for the population served. The services must be provided in accordance with the policies and procedures set forth for the respective sections of this service manual.

The Department will pay Qualified Service Providers at the agreed upon rate for the services identified in this service chapter and delivered in accordance with the applicable Department policies and procedures AND provided to clients who meet the eligibility criteria.

HCBS Case Management 525-05-30-05

(Revised 02/01/2025 ML #3899)

[View Archives](#)

Purpose

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

The purpose of HCBS Case Management is to assist an individual to achieve and maintain independent living, in the living arrangement of their choice, until it is no longer appropriate or reasonably possible to maintain or meet the individual's needs in that setting. In order to facilitate independent living, the HCBS Case Manager leads the person-centered planning process that enables individuals and their natural and formal supports to explore and understand long-term service and support (LTSS) options, identify barriers, set goals, and collaborate with stakeholders to assist the individual in accessing needed community-based services. The HCBS Case Manager also advocates for and promotes individual-focused systems of service delivery, exercises an awareness of the larger target population in need, and exercises prudence in each individual's person-centered plan of care to link individuals with resources and services, utilizing those services and resources effectively.

HCBS Case Managers perform waiver functions at the local level. The functions performed by the HCBS Case Managers include:

- Provide information designed to educate people about the availability and services of the HCBS programs.
- Determine eligibility for, and assist individuals in applying for, HCBS benefits.
- Make Qualified Service Provider lists available to Medicaid recipients so that they may exercise free choice of providers to the greatest extent possible.
- Follow all rules, policies, and direction of the Department in administering the Medicaid HCBS waiver programs; and

Determine level of services to be approved against the limits of the programs.

Standards for HCBS Case Managers

HCBS Case Management must be provided by state employed HCBS Case Managers. HCBS Case Managers must be:

Employed by HHS, Aging Services, as an HCBS Case Manager,
Social Worker licensed to practice social work in North Dakota.
Registered nurse, licensed to practice in the North Dakota.
Meet all the requirements.

HCBS Case Management is provided by state employed HCBS Case Managers. Effective 1/1/2025, HHS, Aging Services administratively claims for the service of HCBS Case Management for HCBS Waiver participants.

HCBS Case Management includes assisting individuals in accessing and receiving Home and Community Base Services. HCBS Case Managers are responsible for:

completion of the HCBS comprehensive assessment,
level of care screening,
person-centered planning,
 including care plan development, assessment, monitoring, and
 completing the plan,
monitoring,
reassessment,
implementation of the person-centered plan
 including assisting the eligible individual to explore and understand
 options, make informed choices, solve problems, provide a link
 between community resources and qualified service providers, and
 closure and termination of services.

HCBS Case Managers employed by Aging Services provide the service of Case Management for the Aging Services Programs of Service Payments for the Elderly and Disabled (SPED) and Expanded Service Payments for

the Elderly and Disabled (EXSPED).

Agencies who are enrolled as a QSP for the Service of Case Management are eligible to receive payment for the service of Case Management as HCBS Care Coordination under the HCBS Waiver.

Policy on Case Management provided as HCBS Care Coordination can be found at the services chapter HCBS Care Coordination 525-05-30-07.

Case file documentation must be maintained:

In a secure setting

On each individual, in separate case files

Quarterly Visit Requirements for Medicaid Waiver

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

Any violation of an individual's rights must be reported as complaint to the HCBS Program Administrator and/or Vulnerable Adult Protective Services.

If a restraint or restriction is identified, the case manager must document the restraint or restriction on the Person-Centered Plan of Care and review the need for the restriction at a minimum of every six (6) months.

Standards for Targeted Case Management (TCM) for persons in need of Long-Term Care

The service shall be performed by a social worker or agency that employs individuals licensed to practice social work in North Dakota and who has

met all the requirements to be enrolled as either an Agency Qualified Service Provider (QSP) or an Indian Tribe/Indian Tribal Organization who has met State Plan requirements and requirements to be enrolled as a QSP or Developmental Disabilities Program Manager (DDPM) who is a Qualified Developmental Disabilities Professionals (QDDP) or has one year experience as a DDPM with the Department.

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

Case Managers employed by Aging Services who have sufficient knowledge and experience relating to the availability of alternative long-term care services for elderly and disabled individuals.

Developmental Disabilities Program Manager (DDPM) who is a Qualified Developmental Disabilities Professional (QDDP) or has one year experience as a DDPM with the Department.

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

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

Case Managers employed by Aging Services are eligible to approve services under SPED, EXSPED and Medicaid State Plan - Personal Care (MSP-PC), (see Chapter 535-05).

DDPMs are eligible to approve MSP-PC services.

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

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

HCBS Case Managers, DDPMs and enrolled Indian Tribe or Indian Tribal Organizations.

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

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

Targeted Case Management (TCM)

The individual receiving TCM will meet the following criteria:

Medicaid recipient.

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

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

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

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

Has long-term care need (need anticipated to exceed 30 days). Document the required long-term care need on the Application for Services, SFN 1047. The applicant or legal representative must provide a describable need that would delay or prevent institutionalization.

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

Activities of Targeted Case Management

1-Assessment/Reassessment

2-Person Centered Plan Development

3-Referral and Related Activities,

4-Monitoring and Follow-up Activities

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

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

An assessment must be completed, and a person-centered plan developed. The individual's case file must contain documentation of eligibility for TCM. The HCBS Comprehensive Assessment and narrative must be entered into the web-based data collection system.

The case record must include a HCBS Comprehensive Assessment and narrative (entered into the web-based data collection system) which includes:

Name of the individual

Dates of case management service

Name of the case management provider/staff

Nature, content, units of case management service received, and whether goals specified in the plan are achieved

Whether the individual has declined services in the care plan

Coordination with other case managers

Timeline of obtaining services

Timeline for reevaluation of the plan

Limits:

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

Case file documentation must be maintained:

In a secure setting

On each individual, in separate case files

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

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

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

The case manager must schedule an appointment for an initial assessment no later than 5 business days after receiving a request for home and community-based services (HCBS) and must complete an initial comprehensive assessment no later than 10 working days after receiving a request for HCBS. All contacts with an individual must be documented in the case file.

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

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

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

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

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

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

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

Approval	Description	Frequency
Hospice	Pre-approval is not needed. However, the combination of HCBS services and hospice service requires documentation in the case note that the individual continues to meet eligibility for the service and there is no duplication of services. The hospice service must also be noted on the "other community-based services" section of the person-centered plan. For MSP-PC cases only: The following information must also be sent to provider enrollment:	One-time

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	Name of the individual ND number Date hospice started Provider name provider numbe Document in the email assurance that the hospice plan is on file (the hospice plan must be kept in the individuals HCBS file.)	
FPC	Approval is needed when the Family Personal Care provider is a legal spouse or legal guardian. Include name, county, name of proposed provider, and why the person acting as the FPC provider is in the best interest of the individual.	One-time
Out-of-state care	SPED, ExSPED, and HCBS Medicaid waiver: If you are seeking to continue to authorize services for an individual while they are out of state: Include name, county of residence, funding source, description of situation for consideration, including whether medical treatment is being sought out of state. For MSP-PC: the individual and/or provider must inform the case manager of the dates and location they are traveling out of state for which care is provided. The case manager documents this in the narrative. However, prior approval from administration is not required for MSP-PC.	Each instance
FHC/FPC combined w/ any other service other than Respite, ERS, N-ED, EPCS, EPCS-N	Include name, county of residence, funding source, why the additional service is needed and/or cannot be provided by FHC or FPC provider.	One-time
More than 1 FHC/FPC provider for an individual	Include name, county of residence, funding source, why the individual requires more than one FHC or FPC provider to meet their needs, how cares will be provided daily.	One-time
Waiver Personal Care by live-in family member	If an outside provider is the primary caregiver and the live-in-family member provides supplemental cares only, the live in family member provider may be eligible to	One-time

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	receive WPC unit rate services limited to the cap for live-in family providers with prior approval of Program Administration. Waiver Personal Care unit rate services may be authorized to supplement the care provided by the primary care provider. Include name, county of residence, description of need/functional status, why it is not appropriate for live-in family member to provide Family Personal Care, amount (hours per day) of care provided by outside provider as well as amount (hours per day) of care provided by live-in family member.	
Chore	When the cost of chore labor is over \$500/month, or to approve specific tasks such as professional sanitation, floor care of unusual nature, etc. per policy. Include name, county of residence, funding source, description of need, task, provider, frequency, cost estimate.	Each instance
Residential Habilitation or Community Support	Include name, county of residence, ND number, medical diagnoses, a description and breakdown of all tasks needed, and the number of units needed on average each day or in one month.	One-time, changes
Nurse Education/EPCS	Include name, county of residence, funding source, medical diagnoses, list of medications, list of medical tasks needed.	Each instance
Environmental Modification	Must have prior approval for all. Include name, county of residence, funding source, and description of request. Once approved to proceed, include copy of written recommendation by professional to ensure modification will meet the needs (if cost over \$500), name of who owns/rents home, current value of home if owned, bids, and proposed dates of services.	Each instance
2-person assist	If more than one provider is needed to complete a service or task, include the name, county of residence, funding source, and description of need – why one provider is unable to safely complete the service or task.	Initial, every 6 months
MSP Level C	Include name, county of residence, description of need/functional status, number of personal care units/and assurance that no units are authorized for l/s/h	Initial, every 6 months
Respite when primary caregiver does not reside w/	Include name, county of residence, funding source, and explain why respite care is appropriate (example: the primary caregiver provides frequent on-site visits throughout the day which is essential to allow the	Annual

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

If the individual referred to HCBS appears to potentially meet the criteria for ID/DD waiver, the case manager may contact an HCBS Program Administrator to request an interdisciplinary team staffing to determine the options available to meet the individuals request for services.

Person-Centered Planning

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

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

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

The individual to the fullest extent possible, including when the member has a legal guardian, consistent with state law N.D.C.C. 30-1-28-12. The individual will have the primary role in developing the person-centered plan when possible.

The individual's family and/or friends with permissions and desire of the individual; and

The individual's legal guardian, where applicable, to the extent the guardianship order confers residential and/or medical decision-making upon the guardian per N.D.C.C 30.1-28-04(5).

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

Case managers should facilitate a process to resolve conflicts that arise during the person-centered planning process if the individual and their

family/natural supports or guardians do not agree on where the individual should live and receive services.

Role of Case Manager in Person-Centered Planning

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

Request for an assessment/reaching out for services.

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

Assessment

The case manager will engage in facilitated discussion with the individual requesting services. The case manager utilizes the HCBS Comprehensive Assessment, the Vision Tool and the Risk Assessment and Health and Safety Plan with every individual initially, annually, at six-months and when there are significant changes. When a case manager is completing the assessments and vision tool the individual may be asked to provide information about themselves, such as what is important to the individual, are there community supports or other formal supports that they are involved in? What roles does the individual have in life, such as do they identify as a friend, mother, grandmother, employee, friend, church member, quilter, wood carver, card player, veteran? How

can the case manager support the individual to continue in their role? Through these conversations you will be discussing the life domains that are identified in the Charting the LifeCourse Vision tool. Additionally, the financial assessment and caregiver assessment may need to be completed.

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

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

the reason the individual is unable to complete the task and/or why the individual is impaired,

who is completing the task, how this need is met.

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

Who assists with the task,

What service the task falls under

The overall number of units authorized for this service type

The anticipated outcome or goal.

Developing the plan

Case managers will use the information gathered through the assessment process to coordinate with the individual and team

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

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

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

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

Adult Residential Care

When completing the person-centered plan of care for HCBS Medicaid waiver, service Adult Residential Care: upon receipt of referral, the case manager first completes the initial assessment as well as the level of care screening and the care plan.

If Medicaid is pending determination, the case is pended until notification of Medicaid approval is received by Medicaid eligibility. When Medicaid eligibility notifies case management that Medicaid is approved and the

effective date of Medicaid, the case manager can proceed with opening the waiver services.

The effective date of the waiver service cannot be prior to the date all of the following waiver eligibility criteria are met:

- Medicaid effective date,
- Application for Services,
- Completion of the HCBS Comprehensive Assessment
- Approval of the NFlOC
- HCBS Care Plan is completed and signed.

Example: A referral is received for ARC on January 15th. The individual has applied for Medicaid and eligibility is pending determination. The case manager goes out to see the individual. The case manager completes the Application for Services, HCBS Comprehensive Assessment, NFlOC and HCBS Care Plan on January 25th. The case manager communicates to Medicaid eligibility that the assessment is complete and individual meets functional eligibility, then holds the case as pending until Medicaid eligibility is determined.

The case manager is then notified on February 20th that Medicaid was approved with an effective date of January 1st. The effective date of Medicaid Waiver is January 25th as this is the date that all waiver eligibility criteria is met.

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

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

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

Name, address and telephone number of QSP.

Whether QSP is an agency or individual.

The unit rate per QSP.

If applicable, limitations of the QSP available.

If applicable, endorsements for specialized cares:

Global Endorsements (Only a QSP who carries a global endorsement may provide these activities and tasks. Refer to the QSP list to determine which global endorsements the provider is approved to provide.) Global Endorsements include: Cognitive/Supervision, Exercises, Hoyer Lift/Mechanized Bath Chair, Indwelling Bladder Catheter, Medical Gases, Prosthesis/Orthotics/Adaptive Devices, Suppository, TED Socks, and Temperature/Blood Pressure/Pulse/Respiration Rate.

On the Preauth document the name of the agency or person who is to be contacted to provide the results of the individual's blood pressure, pulse, rate of respiration, or temperature.

Client Specific Endorsements: These activities and tasks may be provided only by a provider who has demonstrated competency and a Request for Client Specific Endorsement, SFN 830, is on file in the individual's file. The provider must obtain documentation that a health care professional has verified the provider's training and competency specific to the individual's need and provide a copy to the Case Management Entity. The Case Management Entity must forward a copy of the SFN 830 to HCBS Program Administration. Client Specific

Endorsements include: Apnea Monitoring, JOBST Stockings, Ostomy Care, Postural/Bronchial Drainage or Nebulizer Treatment, RIK Bed Care (Specialty Beds).

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

When a change in service provider occurs between case management contacts – the individual or legal representative may contact the case manager requesting the change in provider. The contact and approval for the change in provider must be verified in the case manager's documentation and noted on the person-centered plan of care.

A copy of the updated care plan must be sent to the individual or legal representative. However, changes in services or the amount of service must be signed by the individual or legal representative and approved.

The service, amount of each service to be provided, the costs of providing the selected services, the specific time-period, and the source(s) of payment are recorded on the HCBS Care Plan and PreAuth.

Individuals must be made aware of funding caps and documentation must verify that the individual has been informed of the service limits when developing the care plan at a minimum of every 6 months. If an individual's needs exceed the service limit, they would be issued a denial notice and would have the right to appeal. Or contact the HCBS Program Administration to request an exception or reasonable modification to meet the individual need if the individual is at risk of institutional placement.

Contingency plans

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

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

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

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

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

Interim Care Plans

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

Example 1: An individual who is currently in a Nursing Home, has a LOC in place, and is on Medicaid, plans to return home and the Case manager is unable to see the individual on the day of transfer home. An interim care

plan could be written, and services could begin, however, a face-to-face visit would need to be completed within 10 days.

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

Medicaid eligibility redetermination is completed by Economic Assistance. An individual who is receiving service through the HCBS Waiver is required to be receiving Medicaid. If, in the redetermination process, it is determined the individual is not eligible for Medicaid, payment for services stops the day Medicaid terminates. If the individual has an established HCBS Care Plan and PreAuth and the termination is overturned, waiver services could be paid during that period of time.

Implementation/Review

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

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

It is best practice is to have a ROI signed by the individual and/or their legal representative whenever releasing information. A ROI provides proof that the individual agrees and understands what information is being released and the purpose of releasing the information. As a professional, with a professional license or certification, having an ROI on file, also provides guidance and assurance to the professional on the individual wishes to how and what information they have agreed to release to another entity.

Governing Policy; DHHS Confidentiality Manual

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

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

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

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

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

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

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

Activities of health plans are not considered to be treatment.

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

Continuity of Care

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

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Examples, Questions and Answers

Case Managers can share individual information with health care professionals working in these following settings: Home Health Care, Hospitals, Clinics, PACE, and LTC facilities as this communication is part of the continuum of care guidelines under HIPAA. Case Managers can also share information with other case management entities (i.e. DD, VR, Behavioral Health) within the Department of Health and Human Services, as well as Eligibility Workers under the Medical Services Division. Information shared without a release of information must be on a need-to-know basis to coordinate care for the individual, disclosing only the minimum necessary amount of information pursuant to 45 CFR 164.502(b). Disclosure of information related to Psychological or Substance Abuse Treatment requires that the individual sign a Release of Information.

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

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

**medication prescription and monitoring
counseling session start and stop times
the modalities and frequencies of treatment
furnished
results of clinical tests
summaries of: diagnosis, functional status,
treatment plan, symptoms, prognosis, and
progress to date.**

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

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

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

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

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

ROI signed, can HCBS send the requested third-party records to the potential provider?

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

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

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

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

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

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

Answer: This depends.

Are there program federal and state rules and regulations that dictate when and how information can be disclosed?

Is there a business associate agreement in addition to the contract that permits the disclosure of PHI?

Is the disclosure for treatment purposes? Under the "Continuity of Care" law, it talks about info related to "care of the person" so we know we do not releases for HHC or the hospital, but these other entities are more of a gray area.

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

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

Case manager disclosing the PHI of a LTC resident for the purpose of filing a complaint about a LTC facility with the LTC Ombudsman. Case managers are health care providers and are subject to HIPAA. HIPAA permits this disclosure.

Case Manager disclosing the PHI of a LTC resident for the purpose of reporting abuse/neglect of a vulnerable adult to VAPS. Case managers are health care providers and are subject to HIPAA. HIPAA permits this disclosure and NDCC 50-25.2-03 requires the disclosure.

Disclosure by VAPS of information of a LTC resident pursuant to an abuse/neglect report, to the LTC Ombudsman. Neither VAPS nor the LTC Ombudsman are subject to HIPAA. They may receive PHI from a case manager, but once they receive it, it is no longer PHI and is subject to the confidentiality of the VAPS and LTC Ombudsman state confidentiality laws. This disclosure of information from VAPS to the LTC Ombudsman is required under NDCC 50-25.2-04.

Implementing the Person-Centered Plan of Care - The Case Manager assures that services are implemented, and existing services continued as identified in the person-centered plan of care. This activity includes contacting the QSP and issuance of a Preauth.

Monitoring - Service monitoring is an important aspect of case management and involves the case manager's periodic review of the quality and the quantity of services provided to service recipients. The Case Manager monitors the individual's progress/condition and the services provided to the individual. As monitoring reveals new information to the Case Manager regarding formal and informal supports, the care plan may need to be reassessed and appropriate changes implemented. The case management entity is responsible to monitor the service plan and individual's health and welfare. If the individual's care needs cannot be met by the care plan and health, welfare, and safety requirements cannot be assured, case management must initiate applicable changes or request a team staff meeting through the HCBS Program Administrator to discuss possible terminate termination of services. If the case is closed, the individual is made aware of their appeal rights (see Closures, Denials, Terminations, and Reductions in Services 525-05). The case manager shall document all service monitoring activities and findings in the individual's case file.

The HCBS Case Manager must contact the individual after the first 30 days from the initial care plan implementation. This may be via phone or face-to-face. (If the individual is unable to communicate via telephone, a face-to-face visit is required.) The purpose of this contact is to follow up on the implementation of

the person-centered plan of care (PCP), ensure the individual's needs are met and ensure the scope and amount of services authorized are provided.

The HCBS case manager shall monitor the services provided under the PCP on an as needed basis but not less than direct individual contact at least once every three months for Medicaid Waiver, MSP level B and MSP level C.

Residents of basic care facilities under Basic Care Assistance Program must have an initial and annual HCBS Comprehensive Assessment and completion of the SFN 662.

Monitoring contacts and reassessments may be required if there is a change in the individual's condition or critical incident report (CIR) that requires a follow up to ensure health and safety of the individual.

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

In all situations:

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

REPORTING OPTIONS

Online <https://bit.ly/3vbYbEj>

Reporting Form, SFN 1607 sfn01607.pdf (nd.gov) can be emailed to: dhsvaps@nd.gov or faxed to: 701-328-8744

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

exploitation of an HCBS recipient.

The Risk Assessment and Health and Safety Plan may need to be updated and reviewed in the following circumstances.

When there is a risk identified during assessment, reassessment or monitoring visits.

Critical incident report (CIR) has identified a risk to the individual served by HCBS.

The Program
Administrator
responsible for
monitoring and review
of all CIR's will contact
the case manager in the
event there is an event
reported that requires
an update to the Risk
Assessment and Health
and Safety Plan.

QSP complaint has identified a risk to the individual served by HCBS.

The Program
Administrator for
monitoring and review
of all QSP Complaints
will contact the case
manager in the event
that there is a
complaint that requires
an update to the Risk
Assessment and Health
and Safety Plan.

VAPS report has identified a risk to the individual served by HCBS.

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

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

Identify and document in writing the name of the qualified service provider or other individual provider.

Document in writing a complete description of the problem or complaint.

Process:

Immediately report suspected physical abuse or criminal activity to law enforcement.

If you have reasonable grounds to believe the recipient's health or safety is at immediate risk of harm, make a home visit to further assess the situation and take whatever action is appropriate to protect the recipient.

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

If the HCBS Case Manager and Nurse Educator determine that an incident is indicative of abuse, neglect, or exploitation, the HCBS Case Manager must immediately

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report the critical incident to the Department.

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

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

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

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

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

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

Notify the Ombudsman Program Administrator,
Aging Services Division

And

The North Dakota Department of Health Facilities.

If the qualified service provider is an Assisted Living Facility:

Notify the Ombudsman Program Administrator,
Aging Services Division

And

The DHS Program Administrator responsible for
Assisted Living Licensing.

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

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

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

If the individual is living in an AFC Home:

Contact the HCBS Case Manager responsible for AFC licensing,

And

Contact the Aging Services Division Program Administrator.

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

If the case involves an individual who is receiving DD Services, contact the individual's DD Program Manager or the Regional Program Administrator.

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

Reassessing - The case manager reassesses the individual, care plan, and services on an ongoing basis, but must do a reassessment at six-month intervals and the comprehensive assessment annually. At the six month and annual visit, the individual stated goal must be reviewed, and

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

Termination of Service - When documenting that service(s) on the Individual Care Plan or the Person-Centered Plan of Care were terminated, and indicating the reason(s) for termination, refer to Closures, Denials, Terminations, and Reductions in Services (525-05-40) unless the individual is requesting services to be reduced. In situations where the individual has requested the reduction in services, they may sign a statement requesting the services be reduced.

Contacts with Individuals

Virtual Supports -

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

Extenuating circumstances may include instances where the in-person visit poses a health or safety risk to the individual or case manager; public emergency as determined by local, state and federal government.

Examples of extenuating circumstances may include but are not limited to the following instances:

The individual cannot be seen due to having a medical condition, ie., contagious disease, treatments that weaken the immune system,

Natural disasters and or threats,

Weather related road closures, no- travel advisories.

The participant's services may not be delivered via virtual support 100% of the time.

The participant must always have the option to request in-person services.

Instances of visit by virtual mean must be approved by the HCBS CM Supervisor or HCBS Program Administration as a safeguard to ensure virtual supports can help meet the needs of the participant in a way that protects the right to privacy, dignity, respect, and freedom from coercion.

Virtual supports are not a system to provide surveillance or for staff convenience.

Any issues will be addressed prior to the implementation of remote supports and documented in the individual's case record.

In virtual supports, the use of cameras in bathrooms or bedrooms impacting the participant's dignity and privacy is not permitted.

Provider must use a HIPAA compliant service delivery method.

(e.g. Microsoft Teams, Zoom for Healthcare). HIPAA rules apply to all covered entities regarding HIPAA Privacy and Security.

Participant will be given education and support on the use of virtual supports by their chosen provider.

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

The face to face must be scheduled as soon as possible, not waiting until the next required visit.

The required face to face visits provides assurance that the individual is receiving services within the scope and amount authorized.

The face to face also assures a view of possible health, welfare and safety concerns that may not be relayed through the phone or virtual contact.

For SPED and EXSPED -

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

Waiver:

HCBS Waiver Services: An Initial HCBS Comprehensive Assessment is required to establish eligibility for services. Following implementation of the service, a contact (either in person or via telephone) must be made with a NEW individual within the first 30 days of implementation of services. Quarterly contacts with the individual are required, including an annual assessment, six-month reassessment and two quarter contacts. During the annual and six-month assessments, a quality review questionnaire is completed with the individual. **All four contacts must be face to face and take place in the individual residence.**

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

All required contacts must include responses to the following questions:

Date

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

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

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

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

Individual satisfaction

Follow-up plan

Level of Care Determination (LOC)

It is the responsibility of the HCBS case manager to initiate the screening either by submitting information to Maximus.

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

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

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

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

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

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

When an HCBS individual screened for Medicaid Waiver services appears to no longer meet nursing facility (NF) care (Screen Type: HCBS), a re-screening should occur. A significant improvement in the recipient's medical/physical status or a decrease or cessation of services provided are

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

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

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

Case File Contents

For all programs, all case files, or in the web-based case management system should have (at a minimum):

- Application for Service SFN 1047
- A signed copy of Your Rights and Responsibilities brochure (DN 46)
- Preauth for Medicaid Waiver, SPED/Ex-SPED, and MSP (updated every six months)
- Monthly Rate Worksheet (if applicable)(SFN 1012 updated annually)
- HCBS Notice of Denial or Termination SFN 1647 (if applicable)
- HCBS Case Closure/Provider Termination SFN 474 (if applicable)
- An end dated or deleted Preauth (if applicable)

The case file for each Medicaid Waiver individual must contain:

Documentation of verification the person is a Medicaid recipient
Medical information (if applicable)
Record of current level-of-care determination(s) (updated annually)

The case file for each Expanded SPED individual must contain:
Expanded SPED Program Pool Data SFN 56
Add New Record to MMIS Eligibility File, SPED and ExSPED, SFN 676

The case file for each SPED individual must contain the:
SPED Program Pool Data SFN 1820
Add New Record to MMIS Eligibility, SPED and ExSPED, SFN 676
SPED Income and Asset SFN 820, (updated annually)

Claiming for Case Management

Effective 1/1/2025:

HCBS Case Management is provided by state employed HCBS Case Managers.

The state administratively claims for the service of HCBS Case Management for Targeted Case Management for Medicaid State Plan and HCBS Waiver Case Management.

HCBS Case Management activity for Medicaid waiver and Medicaid State Plan-Personal Care, Targeted Case Management, is tracked by HHS for the purpose of administratively claiming.

Case managers are required to track their time in the state time record system on a daily basis.

The state may claim for case management if the individual meets the eligibility criteria of the programs as identified in HCBS Case Management - Service Activities, Standards of Performance, and Documentation of HCBS Case Management Activities.

Such activities include:

- Assisting individuals in accessing and receiving Home and Community Base Services
- Completion of the HCBS comprehensive assessment
- Level of care screening
- Person-centered planning
including care plan development, assessment, monitoring, and completing the plan
- Monitoring
- Reassessment

Implementation of the person-centered plan including assisting the eligible individual to explore and understand options, make informed choices, solve problems, provide a link between community resources, and qualified service providers, and closure and termination of services. HCBS Case Management time must be supported by documentation in the individual's case file and/or web-based case management system that case management service activities were completed. The state will administratively claim for case management services for individuals working towards transition when the individual leaves the institutional setting and enters the waiver program.

Time tracking for individuals working towards transition is categorized as administrative time while the individual is institutionalized. Once the individual has transitioned to the community, case management will be tracked based on the funding source of the HCBS services authorized by case management.

HCBS Case Management for SPED and EXSPED are non-billable

The state must not administratively claim for the time spent working on allowable case management task that involve SPED or Ex-SPED even if that person is a Medicaid recipient.

Case Management time is documented in 15-minute increments in the states time tracking system under EXSPED, SPED.

HCBS Case Management costs are no longer applied to individual cost share or recipient liability.

Case Management billing provided prior to 1/1/2025 may apply to the individual cost or cost share.

Balances owed for services prior to 1/1/2025 still apply.

When providing case management on a new referral for a Medicaid recipient, time tracking would be categorized as MSP, XIX Medicaid as assisting individuals in accessing and receiving Home and Community Base Services.

When a change in funding source occurs, from state funded programming to Medicaid funded programming, Case Management time can be administratively claimed for the following activities for HCBS Medicaid Waiver and MSP:

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Assisting individuals in accessing and receiving Home and Community Base Services
Completion of the HCBS comprehensive assessment,
Level of care screening,
Person-centered planning,
 including care plan development, assessment, monitoring, and completing the plan,
Monitoring,
Reassessment,
Implementation of the person-centered plan
 including assisting the eligible individual to explore and understand options, make informed choices, solve problems, provide a link between community resources and qualified service providers, and closure and termination of services.

Administrative Tasks (Non-billable) Administrative tasks such as those listed below are examples of non-billable activities:

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

HCBS Care Coordination 525-05-30-07
(NEW 02-01-2025 ML #3899)[View Archives](#)**Purpose**

The purpose of HCBS Care Coordination is to improve access to HCBS services and promote health equity, health literacy, and cultural humility in person-centered planning through collaboration with North Dakota's Tribal partners and cultural and community-based entities in North Dakota. This change is a step to strengthen individualized support, assistance, and advocacy in person-centered planning.

Definition

The HCBS Care Coordination tasks defined in the service of Case Management provide additional support to waiver eligible individuals by promoting health equity, health literacy and cultural humility in person-centered planning. HCBS Care Coordination includes assisting waiver eligible individuals to explore and understand options, make informed choices, solve problems, provide a link between the eligible individual and community resources. Additionally, HCBS Care Coordination provides support and coordination of services to meet the needs of eligible waiver participants through collaboration with Tribal organizations, and culturally based or community-based organizations.

HCBS Care Coordination services are necessary to establish or stabilize waiver eligible participants living in their individual or family home or a community-based setting.

Waiver participants are eligible for HCBS Care Coordination services when a participant is at risk due to health, unstable living situation, or the participant is at risk of institutionalization, such as the following:

Frequent institutional contacts (ER visits, SNF stays, hospital admits, etc.).

Frequent turnover of caregivers and/or services resulting in an inability to maintain continuity of care.

Risk of eviction or loss of current living arrangement.

HCBS Care Coordination services are provided in a manner that protects and supports the participant's health and welfare and is appropriate to the participant's physical and cognitive needs by improving access to services or advancing health equity and health literacy.

HCBS Care Coordination services includes:

Identifying needs and locating necessary resources to establish or maintain a stable and safe living arrangement.

Coordinating, educating, and linking the participant to resources which will establish or stabilize community supports, including arrangements with pharmacies, primary care physicians, financial institutions, utility companies, housing providers, social networks, local transportation options, household budgeting, and other needs identified in care plan.

Providing and establishing networks of relevant participant partners: nursing or institutional facility staff, case managers, community providers (including QSP's), medical personnel, legal representatives, paid caregivers, family members, housing agencies and landlords, informal supports, and other involved parties.

Ensuring all necessary paperwork and documentation is completed to establish or maintain a stable and safe living arrangement.

Assisting with the development of a plan for, and when necessary, providing emergency assistance to sustain a safe and healthy community setting.

Assisting the participant in arranging for transportation to effectively connect the participant with the community.

HCBS Care Coordination Service Delivered Remotely

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

the visit in person. Extenuating circumstances may include instances where the in-person visit poses a health or safety risk to the individual or case manager; public emergency as determined by local, state and federal government.

Virtual Support Guidance

The participant's services may not be delivered via virtual support 100% of the time. The participant must always have the option to request in-person services. Instances of visit by virtual means must be approved by the HCBS CM Supervisor or HCBS Program Administration as a safeguard to ensure virtual supports can help meet the needs of the participant in a way that protects the right to privacy, dignity, respect, and freedom from coercion. Any issues will be addressed prior to the implementation of virtual supports and documented in the individual's case record.

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

HCBS Care Coordination Limitations

The provision of HCBS Care Coordination is limited to agency providers.

Provider qualifications allow cultural or community-based organizations, including non-profit, LLCs, and Tribal entities to provide the service.

Waiver case management that includes the task of HCBS care coordination may not claim for the service provided to individuals working towards transition until the individual enters the waiver program.

The state will administratively claim for case management services for individuals working towards transition when the individual enters the

waiver program. Both HCBS Case Management and HCBS care coordination can be delivered simultaneously.

State employed case managers will be responsible for ongoing monitoring of the provision of services in the services plan.

Provider Qualifications

Community-based, non-profit organizations in North Dakota which provide services by and for people with disabilities or entities such as Centers for Independent Living, Community Health Representatives, Community Health Worker, Older Americans Act, Older Americans Act Title VI service providers, Tribal organizations, or other cultural based organizations.

Enrolled Qualified Service Provider [N.D.A.C. 75-03-23-07](#)

Initial/re-enrollment every 60 months for agency providers, and/or upon notification of provider change.

Other Standards

Agency employed HCBS Care Coordinators must have:

An associate degree or higher in Psychology, Social Work, Social Services, Human Services, Behavioral Sciences, or other closely related field including a medical field,
and a minimum of one years' experience in the coordination of community services and supports, e.g., housing, personal assistance services recruitment or management, independent living skills training, etc.

Qualifying education and experience will be considered in lieu of degree requirement. Qualifying education and experience means;

Two years of experience in the coordination or provision of community services and supports in a social service setting under qualified supervision.

Four years of personal experience with a disability and has documented experience in the coordination of community services and supports in a social service setting.

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Provider Training Requirements

Completion of Person-Centered Planning training

Initial and annual HCBS Training on Home and Community Based Services

HCBS Settings Regulation

Adult Day Care 525-05-30-10**(Revised 11/1/21 ML #3640)**[View Archives](#)Purpose

Adult Day Care is a community-based service offered within a group setting designed to meet the needs of functionally impaired adults. It is a structured, comprehensive service that provides a variety of social and related support services in a protective setting during a part of the day. Adult Day care programs shall operate a minimum of three hours per day up to a maximum of ten hours per day. Individuals who participate in Adult Day Care attend on a planned basis during specified hours. Adult Day Care assists its participants to remain in the community, enabling families and other caregivers to continue caring for an impaired member at home.

Adult Day Care emphasizes a flexible program of service activities designed to provide an individualized plan of care. It affords opportunities of personal enrichment and provides a setting for group involvements outside the home. Adult Day Care reduces isolation often associated with frailty and impairment as well as enabling the individual to remain in his or her home and community as long as possible.

Service Eligibility, Criteria for

The individual receiving Adult Day Care will meet the following criteria:

1. Must be eligible for the programs of Medicaid Waiver for Home and Community Based Services, SPED, or ExSPED.
2. The individual is able to function in an ambulatory care setting.
3. The individual is able to participate in group activities.
4. The individual requires assistance in Activities of Daily Living and Instrumental Activities of Daily Living as determined by the Comprehensive Assessment.
5. When the individual is not living alone, the primary caregiver will benefit from the temporary relief of caregiving.

Service Activities, Authorized

The service tasks/activities within the scope of this service chapter are identified on the authorization.

Unallowable Service Activities: Shopping, Housework, and Laundry, are tasks which are not authorized under Adult Day Care Services.

- Non medical transportation may be included as a part of this service and may already be included in the rate, contact a HCBS Program Administrator to determine if non medical transportation has been included the rate for an Adult Day Care Provider.
- Adult Day Care Unit - one unit equal 1/2 day.

Adult Day Care Enrollment (Provider)

Staff to Participant Ratio for Adult Day Care Centers

1. Adult Day Care Center providers shall meet a staff to participant ratio not to exceed a minimum of one to eight.
2. Full-time or full-time equivalent staff shall be considered as those who spend 70 percent of time in direct service with participants.
3. Each adult day care center that is conjointly located within another facility may consider a shared staffing arrangement, however, shared staff must meet specific adult day care staff standards.

Adult Day Care may be provided by the following individual QSP's or employees of a QSP agency: (checked if allowable):

- ☐ Guardian
- ☐ Legally Responsible Person - Legal spouse or parent of a minor child
- ✓ **Relative within the definition of Family Home Care under subsection 4 of N.D.C.C. 50-06.2-02.**

Facility Standards for Adult Day Care Centers

1. Adult Day Care in Hospitals, Nursing Homes, and Basic Care Facilities

- Hospitals, nursing homes, and basic care facilities are considered to have met the standards contained in this section based upon their licensure status.
- 1915(c) Medicaid waiver funds cannot be used to provide adult day care that is located in a nursing home or hospital. Waiver recipients are not eligible to receive an HCBS service in an institutional setting regardless of the funding source. SPED & Ex-SPED recipients may receive adult day services in these settings.

2. Adult Day Care Centers

Adult day care center facilities shall meet the following standards:

- a. The facility shall be designed and furnished with primary consideration given for the special needs and interests of the population to be served and the activities and services to be provided.
 - A facility shall be architecturally designed, in conformance with the requirements of Section 504 of the Rehabilitation Act of 1973, to accommodate handicapped individuals and meet any state and local barrier-free requirements.
 - Illumination levels in all areas shall be adequate, and careful attention shall be given to avoiding glare in order to compensate for visual losses experienced by many older adults.
 - Sound transmission shall be controlled. Methods of sound control include acoustical ceiling surfaces, partitions between activity areas, separation of noisy rooms such as the kitchen, etc.
 - Heating, cooling and ventilation system(s) shall permit comfortable conditions, regardless of the number of participants present, and excessive fan noise and drafts shall be avoided.
 - The design shall facilitate the participants' movement throughout the center and involvement in activities and services.
 - Sufficient furniture shall be available to accommodate the number of enrolled adult day care service participants.

- Furniture and equipment to be used by participants shall be selected for comfort and safety. Furnishings shall promote independence as much as possible and be appropriate for use by persons with visual and mobility limitations and other physical disabilities.
 - A telephone shall be available for participant use.
- b. The facility shall be accessible at street level. Adequate elevators shall be available for center floors not located on street level.
- Each adult day care center, where it is collocated in a facility housing other services, shall have its own separate identifiable space. (The allocation of separate identifiable space is necessary to be able to properly accommodate the number of enrolled day care participants.)
 - The facility shall:
 - Have at least thirty-five (35) square feet of program space for each day care participant. (The square footage excludes hallways, offices, restrooms and storage areas.)
 - Be flexible and adaptable for large and small groups and individual activities and services.
 - The facility shall include toilets for male and female participants (at least one toilet per gender for each fifteen participants), equipped for use by mobility-limited persons and easily accessible from all program areas.
 - At least one restroom with a lockable door/stall is available to recipients to assure recipients privacy.
 - Have rest areas designated to permit privacy and to isolate participants who become ill.
 - A parking area shall be available for the safe daily arrival and departure of participants.
 - Space shall be available for outdoor activities, when appropriate.
 - Space, such as closets and separate lockers, for outer garments and private possessions shall be provided for participants.

- c. The facility and grounds shall be safe, clean and accessible to all participants.
- The facility shall be designed, constructed and maintained in compliance with all applicable local, state and Federal health and safety regulations. The center shall make arrangements as necessary for the security of the participants in the facility.
 - Appropriate and locked storage space for medications shall be provided.
 - At least two well-identified exits to the outside shall be available.
 - Non-slip surfaces or carpets shall be provided on stairs, ramps and interior floors.
 - Outside lighting shall be available at facility entrances and on the facility grounds.
 - The facility shall be free of hazards, such high steps, steep grades, exposed electrical cords, etc. (When necessary, arrangements shall be made with local authorities to provide safety zones for those arriving by motor vehicle and adequate traffic signals for pedestrian crossings.)
 - Safe and sanitary handling, storing, preparation and serving of food shall be assured.
 - Procedures for fire safety shall be adopted and posted, including provisions for fire drills, inspection and maintenance of fire extinguishers.
 - A representative of the local fire department or State Fire Marshal's office shall conduct a fire and safety inspection of the Adult Day Care Center prior to the center being approved for adult day care services. Regular inspections shall be scheduled once every two years thereafter.
 - Emergency first aid kits shall be visible and accessible.
 - Written center policies shall be established on:
 - Assisting adult day care participants in the self-administrator of medications; and
 - For emergency medical care plans.

- Maintenance and housekeeping shall be carried out on a regular schedule and in conformity with generally accepted standards, without interfering with the program.

Standards for Adult Day Care Homes

1. Adult foster care homes which are licensed by the Department of Human Services are considered to have met the Adult Day Care standards contained in this section based upon their licensure status.
2. Adult Day Care Homes

Adult Day Care Home facilities shall meet the following standards:

- a. The home and premises must be clean, neat, and free from hazards that jeopardize health and safety.
- b. A rest area shall be provided separate from activity areas.
- c. The phone numbers of the local police, fire department, and ambulance service shall be posted near every telephone located in areas where services are provided.
- d. Safe storage for medications shall be provided in a central location with each participant's medication clearly labeled with the pharmacist's label.
- e. The home must be equipped with adequate light, heat, ventilation, and plumbing for safe and comfortable occupancy.
- f. All participant-occupied rooms shall have window screens which will keep out flies and mosquitoes.
- g. Food and cooking utensils shall be stored to protect from dust, leakage from pipes, or other contamination.
- h. Trash and garbage outside of participant occupied areas shall be kept in plastic or metal containers with properly fitted covers and disposed of on a daily basis.
- i. A community or rural fire department shall be available to the home.
- j. There shall be no accumulation of highly combustible material in closets, attics, basements, garages or other parts of the dwelling unit.
- k. Fireplaces, steam radiators, and hot surfaces, such as steam pipes, shall be appropriately screened or covered to guard against accidental contact. Space heaters may not be utilized.

- l. Participant occupied areas shall have at least two means of exit, each being at least 30 inches wide, at least one of which shall be a door providing a means of unobstructed travel to the outside of the building at street or ground level.
- m. Heating units shall be inspected prior to the time adult day care service is provided in the home and every two years thereafter. A notice shall be posted on or near the heating unit indicating the last date of inspection.
- n. No stove or combustion heater shall be so located as to block escape in case of fire caused from malfunctioning of the stove or heater.
- o. At a minimum, a five-pound class "ABC" all purpose fire-extinguisher shall be maintained and installed in a location identified by the local fire department. Additional fire extinguishers may be required when warranted by special conditions.
- p. Every adult day care home shall have photo-electric or ionization type smoke detectors which shall be:
 - Mounted adjacent to rest areas and shall be located on or near the ceiling;
 - Clearly audible in adjacent participant occupied areas with intervening doors closed;
 - U.L. approved; and
 - In working order at all times.
- q. All participants shall be trained upon enrollment on how to exit from the home and how to respond to alarm.
- r. If the home has a fireplace or auxiliary free-standing heating unit, it must be properly installed and maintained. It shall be inspected and approved by the local fire department or State Fire Marshal.
- s. A representative of a local fire department or State Fire Marshal's Office shall conduct a fire and safety inspection of the adult day care home prior to the home being approved for adult day care services. Regular inspections shall be scheduled once every three years thereafter. Additional inspections of the home may be requested at any time there are concerns about fire safety aspects of the home.

- t. All dangerous household products, flammable liquids and chemicals shall be stored in a safe manner. Questions as to "safe manner" may be referred to the local fire department.
- u. The use of potentially hazardous materials and tools by a participant shall be supervised.
- v. Exposed light bulbs shall not be used in the immediate area any participant uses.
- w. The fuses in light circuits shall not exceed recommended amperes. Type "S" fuses are recommended, or there shall be a safeguard of approved circuit breakers.
- x. House pets shall have all required shots.
- y. Existing state or local building, fire, or safety codes supersede any of the requirements of this section.
- z. At least one restroom with a lockable door/stall is available to recipients to assure recipient privacy.

Program Standards for Adult Day Care Centers and Adult Day Care Homes

Adult Day Care Center and Home service programs shall meet the following standards:

1. Self- Care Activities: The adult day care program will provide assistance with activities of daily living. Changes in the participant's status shall be noted in the participant's file and appropriate others notified.
2. Social, Leisure, and Educational Activities: Planned individual and group activities, suited to the needs and abilities of the participants as supported by the HCBS comprehensive assessment shall be provided. recipients may not be required to participate in any activity.
3. Nutrition:
 - a. A nutritious meal including the basic four food groups shall be provided to each participant in attendance during mealtime.
 - b. Meals shall be prepared and served in a sanitary manner using safe food handling techniques.

- c. A nutritious mid-morning and mid-afternoon snack shall be offered daily to participants. Recipients must have access to food/ snack at all times.
- d. Fluids shall be available as needed by participants.
- e. A modified diet shall be available for participants requiring a restricted diet. A registered dietitian or nutritionist may be consulted by the provider on special nutritional needs.

Emergencies: Adult Day Care Centers/Homes

A written procedure for handling emergencies shall be posted in the facility. To respond to emergencies:

- 1. The participant's file shall include a written agreement with the participant or family regarding arrangements for emergency care and ambulance transportation.
- 2. A conspicuously displayed notice shall indicate fire procedures plus signs designating emergency evacuation routes; regularly (2 times annually) scheduled fire drills shall be conducted at the center; staff and volunteers shall be trained in evacuation procedures.
- 3. Training shall be provided for program staff and participants in emergency procedures.

Standards for Issuance to Adult Day Care Providers

The HCBS Case Manager shall provide the following information to potential adult day care service providers:

- 1. Community-Based Services: Qualified Service Provider Handbook.
- 2. Adult Day Care Standards Compliance Checklist (SFN 1703).
- 3. Adult Day Care Centers: Facility Standards.
- 4. Adult Day Care Homes: Standards

The potential adult day care center or adult day care home service provider will complete and submit a self-administered Adult Day Care Standards Compliance Checklist, SFN 1703, together with evidence of any required inspections (fire and safety) to the HCBS Program Administrator.

By completing and submitting the Adult Day Care Standards Compliance Checklist, SFN 1703, the adult day care provider is notifying the HCBS Program Administrator that they are ready to have the HCBS Case Manager review their compliance with adult day care standards.

The HCBS Case Manager shall then make an on-site visit to the home or center and verify the compliance with adult day care standards and forward a copy of the final SFN 1703 to the HCBS Program Administrator.

Re-Assessment of Adult Day Care Standards for Compliance

The Adult Day Care Standards Compliance Checklist, SFN 1703, is valid for not more than two years from the date of issuance. If a provider chooses to continue to provide adult day care, the HCBS Case Manager must review all components of the Adult Day Care Program for compliance and complete the Adult Day Care Standards Compliance Checklist, SFN 1703. A copy should be forwarded to the HCBS Program Administrator.

Adult Day Care Recipient Experience Requirements

Individuals have freedom and support to control their schedules at the setting and are not required to participate in activities and have access to food/snack at any time.

Any modifications of the recipient experience requirements must be supported by specific assessed need: justified and documented in the person-centered service plan.

Adult Foster Care 525-05-30-15

(Revised 03/01/2024 ML #3829)

[View Archives](#)

Legal Authority

[Code of Federal Regulations 42 CFR 441.301\(c\)\(4\)](#)

[N.D. Century Code 50-11](#)

[N.D. Century Code 50-25.2](#)

[N.D. Administrative Code 75-03-21](#)

Purpose

The purpose of Adult Foster Care (AFC) is to offer a choice within a continuum of care to adults who could benefit from living in a family environment, as well as to promote independent functioning to the limit of an individual's ability and provide for a safe and secure environment.

The facility must be a specific physical place that can be rented or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at minimum, the same responsibilities, and protections from eviction that tenants under the landlord/tenant law of the State, county, city, or other designated entity.

All adult foster care individuals must have a signed Service and Rental Agreement according to North Dakota Administrative Code Chapter 75-03-21-12. A copy of the agreement must be maintained in the individual's file. Any changes to this agreement must be sent to the HCBS Case Manager and AFC Program Administrator.

Service Eligibility, Criteria for:

The individual receiving Adult Foster Care will meet the following criteria:

1. Must be eligible for the programs of Medicaid Waiver for Home and Community Based Services, SPED, or ExSPED;
2. Be at least eighteen years of age or older;
3. Not be eligible for or receiving foster care for children;

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4. Have needs or a disability that makes a family home environment an appropriate care setting;
5. A licensed Adult Foster Care setting is available;
6. Not be related by blood or marriage to the licensed provider;
7. The care required by the individual of Adult Foster Care does not exceed the documented skill in personal care of the available licensed provider; and
8. The care is provided by a licensed Adult Foster Care facility provider.

Service Payment Procedures

1. If public funds are used for payment, the following criteria applies:
 - a. A rate of no more than the current maximum room and board rate per month shall be paid to the licensed provider by the individual for board and room costs.
 - The first source for the board and room cost is from the individual's income.
 - Another potential source of funds could be county general assistance funds.
 - SPED funds, Ex-SPED funds, and Medicaid Waiver funds cannot be used for room and board. Room and Board is the responsibility of the individual and is not included in the provider's daily rate.
 - b. The service payment for Adult Foster Care is a flat daily rate that is set by the Department.
 - c. Under the SPED program, other funding (i.e. private pay, county funds) may augment the Adult Foster Care Service payment.
2. If the funding source is self-pay, the following applies:
 - a. The service payment is the amount negotiated between the individual or their representative, and the licensed AFC provider.
 - b. Case Management is not a required service.
 - c. The AFC provider is required to notify the HCBS licensor of any individual's receiving AFC in the home, including individual's that are self-pay.

- d. The HCBS licensor is required to notify the AFC Program Administrator of any changes within the licensed home regarding AFC recipients.

Service Tasks

The service tasks/activities within the scope of this service chapter are identified on the Authorization to Provide Services, otherwise known as the Preauth.

To avoid duplication homemaker, chore, emergency response system, residential care, transitional care, attendant care, environmental modification, and non-medical transportation are not allowable service combinations for individuals receiving AFC. Non- medical transportation is a component of AFC and is included in the rate.

Prohibited Activities effective 12/31/2016.

The provision of adult foster care services funder under the waiver, SPED or Ex-SPED must ensure an individual's right of privacy, dignity, and respect. Coercion, seclusion, or restraint of waiver individuals is expressly prohibited in all adult foster care settings.

1. The Code of Federal Regulations 42 CFR 441.301(c)(4) requires that all home and community-based settings meet certain qualifications. These include:
 - a. The setting is integrated in and supports full access to the greater community.
 - b. Is selected by the individual from among setting options.
 - c. Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint.
 - d. Optimizes autonomy and independence in making life choices; and
 - e. Facilitates choice regarding services and who provides them.
 - f. The final rule also includes additional requirements for provider-owned or controlled home and community-based residential settings. These requirements include:

- g. The individual has a lease or other legally enforceable agreement providing similar protections.
 - h. The individual has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit.
 - i. The individual controls his/her own schedule including access to food at any time.
 - j. The individual can have visitors at any time; and
 - k. The setting is physically accessible.
- 2. Any modification to these additional requirements for provider-owned home and community-based residential settings must be supported by a specific assessed need and justified in the person-centered service plan.
- 3. The HCBS Case Manager will monitor all Medicaid individuals residing in an AFC setting during required quarterly visits.
- 4. The first quarterly visit after the initial care plan will include a completion of the Home and Community Based Services (HCBS) Individual Adult Foster Care Setting Experience Interview, SFN 636.
 - a. Any issue identified in the individual experience interview must be reported to HCBS Settings Administrator.
- 5. A copy of the SFN 636 must be sent to the HCBS Settings Administrator by emailing the form to the HCBS email.
 - a. To assure ongoing compliance with HCBS settings rules, the HCBS Program Administrator will review the survey.
 - b. The HCBS Settings Administrator and HCBS Case Manager will then work with the licensed provider to remediate any issues or violations related to the HCBS Settings Rule.
- 6. The HCBS Case Manager will complete an SFN 636 annually thereafter.

Critical Incident Reporting

All critical incidents must be reported according to the Critical Incident Reporting policy (Critical Incident Reporting 525-05-42).

Unauthorized restraints are required to be reported as suspected abuse, neglect, or exploitation per NDCC 50-25.2.

Arranging for Adult Foster Care Service

When arranging for placement, the HCBS Case Manager must consider the following:

1. Care needs of the individual must not be in excess of the capacity of the provider;
2. The physical structure of the facility must allow for the needs of the individual (i.e. individuals who are not independently mobile); and
3. Any physical or mental condition that may deem Adult Foster Care inappropriate.

Service Combinations

Adult Foster Care is an inclusive 24-hour service. Therefore, Respite Care and Extended Personal Care are the only allowable service(s) that can be authorized with the Adult Foster Care Service.

NOTE: There must be more than one QSP identified on the care plan (i.e. there may be two or more licensed providers in the facility) as it is not reasonable to allow one provider to be responsible for 24 hours of care per day. If there is only one licensed AFC provider in the facility, respite must be authorized so that the provider can take necessary breaks away from their caregiving responsibilities.

An individual who is a resident of an Adult Foster Care facility may choose their respite provider and is not required to use a relative of the Adult Foster Care provider for respite. Respite providers must meet the QSP requirements.

When the individual in an Adult Foster Care setting receives overnight care in another adult foster care setting, the care rate is the same as the adult foster care rate and the procedure code used by the respite Adult Foster Care provider will be the Adult Foster Care procedure code.

Individual Out of Facility with Foster Care Provider

A provider may claim payment for care of the individual when the individual vacations with the foster care provider if the individual has continuously lived with the foster family for a substantial period of time, and the individual made an independent choice to vacation with the family. The provider must report the following to the HCBS Case Manager prior to departure:

1. The dates the individual will be vacationing with the foster family;
2. The telephone number(s) where they can be reached;
3. The names and addresses of individuals they will be visiting, if applicable; and
4. A travel itinerary, if applicable.

The individual must remain in the care of the foster care provider. Care of the individual cannot be transferred to other family, friends, or anyone else during that time.

Providers

Adult Foster Care may **NOT** be provided by the following individual QSP's or employees of a QSP agency:

- Guardian
- Legally Responsible Person - Legal spouse or parent of a minor child.
- Relative within the definition of Family Home Care under subsection 4 of N.D.C.C. 50-06.2-02.

Provider Employment Outside of the Adult Foster Care Setting

Adult foster care is an inclusive 24-hour service. Therefore, employment outside of the facility is generally not allowable. An adult foster care provider may be employed outside the facility if the license to provide adult foster care was issued to more than one individual and at least one of the licensed individuals remains in the facility to provide the care.

The HCBS Case Manager must be informed of outside employment.

- The HCBS Case Manager notifies the AFC Licenser and Licensing Program Administrator to evaluate whether individual care would be negatively impacted.

If an AFC individual is enrolled in a day-program (documented in the individual's plan of care) and is out of the facility, outside employment by the AFC provider may be considered during the hours the AFC recipient is away. However, individual care cannot be compromised.

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Employing AFC respite care providers or a substitute caregiver to assist in the daily operation of the AFC home is prohibited. Respite caregivers may provide care only in the absence of the provider.

Adult Residential Care 525-05-30-16

(Revised 03/01/2024 ML #3829)

[View Archives](#)

Legal Authority

[Code of Federal Regulations 42 CFR 441.301\(c\)\(4\)](#)

[N.D. Century Code 50-10.2](#)

[N.D. Administrative Code 75-03-23](#)

Purpose

To provide an array of services to an individual in a 24-hr setting. Adult residential care programs specialize in care of individuals with chronic moderate to severe memory loss or an individual who has a significant emotional, behavioral, or cognitive impairments. It is also a service in which assistance with ADLs/IADLs, therapeutic, social, and recreational programming is provided. Care must be furnished in a way that fosters the maintenance or improvement in independence of the recipient.

The unit or dwelling must be a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity.

For settings in which landlord tenant laws do not apply, the case manager must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

All adult residential care recipients must have a signed lease or other legally enforceable agreement that meets the above standards. A copy of the lease must be maintained in the recipient's file. Any updates to the active lease agreement are required to be kept in the recipient's file. The

provider is responsible for notifying the HCBS Case Manager with any changes to the lease agreement. The provider is required to provide a copy of the updated lease agreement for the recipient's file.

Adult Residential Care services cannot be provided in any setting that is:

- Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or;
- Located in a building on the grounds of, or immediately adjacent to, a public institution.

Service Eligibility, Criteria for

The individual receiving Adult Residential Care service will meet the following criteria:

1. Must be eligible for the Medicaid Waiver for Home and Community Based Services.
2. Be at least age 18.
3. Must not be severely impaired in eating, transferring, or toileting.
4. Does not have medical or behavioral needs that require professional evaluation and management on an ongoing basis.
5. Need the services of, independent living skills training, support and training provided to promote and develop relationships, participate in the social life of the community, and develop workplace task skills including behavioral skill building.
 - Community Integration is provided to enable the individual to promote independence and alleviate social anxiety. Some activities to be considered are community social events (such as fairs, sports leagues, church functions), volunteer or paid employment, educational/vocational activities.
 - Social Appropriateness assists the individual with the development of social skills needed to interact with individuals in the facility or in the community. Such activities include (but are not limited to): respecting others' space and privacy, non-offensive communication, obeying laws and rules, timeliness, safety/risk procedures;

Or

Require protective oversight and supervision in a structured environment that is professionally staffed to monitor, evaluate and accommodate an individual's changing needs.

A rate of no more than the current maximum room and board rate per month shall be paid to the licensed provider by the recipient for board and room costs. Room and Board is the responsibility of the recipient and not included in the provider's daily rate.

Service Tasks

1. This service includes 24-hour, on-site response staff;
2. Transportation may be provided as a component of this service and included in the daily rate paid to providers. Contact a HCBS Program Administrator to determine if transportation has been included in a rate for a specific residential care provider.
3. The Adult Residential Care providers are required to support the recipient with medical coordination;
4. Assistance with ADLs and IADLs within the guidelines of the Basic Care licensure standards;
5. Allowable service tasks as identified on the Preauth.

Limits

Limited to the tasks as in agreement between the Department and the Adult Residential Care facility provider and as authorized by the HCBS Case Manager.

To avoid duplication homemaker, chore, emergency response system, adult day care, adult foster care, respite, transitional care, attendant care, and environmental modification, are not allowable service combinations for individuals receiving Adult Residential Care services.

Adult Residential Care services is an all-inclusive service with the exception of Non-Medical Transportation and Supported Employment Services. Non-Medical Transportation and Supported Employment Services may be combined with Adult Residential care in the following circumstances:

- Non-Medical Transportation (NMT) is allowable as a service combination with adult residential care when NMT is not a component of the ARS rate.
 - The case manager references the list of adult residential care providers who do not have non-medical transportation (NMT) figured into the daily rate.
- Supported Employment Services for an individual who was determined eligible for Adult Residential Care as a result of a need for the services of, independent living skills training, support and training provided to promote and develop relationships, participate in the social life of the community, and develop workplace task skills including behavioral skill building.

Non-emergency Medical Transportation may also be available and utilized through Medicaid for transportation to medical appointments.

Prohibited Activities effective 12/31/16

The provision of adult residential care services under the waiver must ensure an individual's right of privacy, dignity, and respect. Coercion, and or seclusion, of waiver recipients is expressly prohibit in all service settings. The limited use of restraint in adult residential care service settings is allowable but only as described in NDCC 50-10.2-02 (1).

Adult Residential Care facilities must be licensed as Basic Care facilities in accordance with ND Admin Code 33-03-24.1-03. Adult Residential Care facilities must act in accordance with resident rights which comply with NDCC 50-10.2 and ND Admin Code 33-03-24.1-09 (2) (h).

NDCC 50-10.2-02 (1) (k) states that residents have "The right to be free from mental and physical abuse and the right to be free from physical or chemical restraint except in documented emergencies or when necessary to protect the resident from injury to self or to others. Administrative code also dictates that any use of restraints must be authorized and documented by a physician for a limited period of time and, if the restraint is a chemical

one, it must be administered by a licensed nurse or physician. Except as provided in this subdivision, drugs or physical restraints may not be used or threatened to be used for the purposes of punishment, for the convenience of staff, for behavior conditioning, as a substitute for rehabilitation or treatment, or for any other purpose not part of an approved treatment plan.

The HCBS Case Manager monitors all Medicaid individuals residing in an Adult Residential Care (ARC) setting during their required quarterly visits.

1. The first quarterly visit following the initial care plan will include a completion of the Home and Community Based Services (HCBS) Adult Residential Care Setting Experience Interview, SFN 639.
 - a. A copy of this review needs to be sent to Adult & Aging Services by emailing the form to the HCBS email.
 - b. To assure ongoing compliance with HCBS settings rules, the HCBS Program Administrator will review the survey.
 - c. Any issue identified in the client experience interview must be reported to Adult & Aging Services, who will then work with the licensed provider to remediate any issues or violations related to the HCBS Settings Rule.
2. The HCBS Case Manager will complete an SFN 639 annually thereafter.

The HCBS Case Manager will monitor all Medicaid individuals residing in an ARC setting during required quarterly visits.

1. The first quarterly visit after the initial care plan will include a completion of the Home and Community Based Services (HCBS) Individual Adult Foster Care Setting Experience Interview, SFN 636.
 - a. Any issue identified in the individual experience interview must be reported to HCBS Settings Administrator.
2. A copy of the SFN 636 must be sent to the HCBS Settings Administrator by emailing the form to the HCBS email.
 - a. To assure ongoing compliance with HCBS settings rules, the HCBS Program Administrator will review the survey.
 - b. The HCBS Settings Administrator and HCBS Case Manager will then work with the licensed provider to remediate any issues or violations related to the HCBS Settings Rule.
3. The HCBS Case Manager will complete an SFN 636 annually thereafter.

Critical Incident Reporting

Before restrictive emergency procedures can be implemented as described in the administrative code it is the responsibility of the case manager to assess and document the restriction plan on the person-centered plan of care. This plan is reviewed quarterly. The HCBS case manager will document the maladaptive behavior and the identified restriction. Less restrictive methods must be included in the plan and attempted prior to the application of restraint. Previous restriction plans must be identified in the plan. The emergency use of restraints must be developed with the participation of the waiver recipient and/or their legal decision maker who must consent to the plan. The HCBS Program Administrator reviews all plan of care and will approve the plan of care if it contains all of the required information.

Unauthorized restraints are required to be reported as suspected abuse, neglect, or exploitation per NDCC 50-25.2. Waiver participants and/or legal decision makers must approve and agree to the restriction plan on the person-centered plan of care and are made aware that unauthorized use of restraints or restrictive interventions are not allowed and are required by law to be reported. Some Adult Residential Care facilities have a no-restraint policy if a recipient chooses such a facility it must be documented in the plan of care.

The use of all unauthorized restraints (those not written into the individual's plan, or those that do not follow the requirement of NDCC 50-10.2-02 (1) (k)), must be abated or eliminated immediately and meet the criteria of a Serious Event. These situations must be reported according to the Critical Incident Reporting policy (Critical Incident Reporting 525-05-42). The Adult & Aging Services Team will review all incident reports to determine if restraints were used appropriately. If the restraint was used appropriately it will be documented in the recipient's narrative. If it is determined restraints were not used appropriately and in accordance with state law, a formal referral to VAPS and/or ND (licensing entity) will be initiated. VAPS and/or ND Health Facilities Unit will be responsible for independent review and follow up.

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The Adult & Aging Services Team consists of the Adult & Aging Services Director, HCBS Program Administrator, Adult & Aging Services Program Administrator licensed as an RN, Vulnerable Adult Protective Services (VAPS) staff, LTC Ombudsmen, and the HCBS Case Manager. The HCBS Case Manager must also review the plan of care on a quarterly basis to assure the safeguards and requirements are met and to assure that the approval of the individual and/or legal decision maker is documented. This information is recorded in the narrative and any noncompliance or needed follow up regarding the use of restraints must be initiated and documented.

Chore Service 525-05-30-20

(Revised 07/01/24 ML #3847)

[View Archives](#)

Purpose

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

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

Service Location

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

ü The individual's home

- ☐ Workplace
- ☐ Other community service settings

Service Eligibility, Criteria for

The individual receiving Chore Service must meet the following criteria:

1. Must be eligible for Medicaid Waiver for Home and Community Based Services, SPED, or ExSPED.
2. For Emergency Response Service, is limited to installation and monthly rental fee. ERS Service is restricted to individuals living alone.
 - a. Exception: If an individual resides in a multiple person household and there are occasions when the individual may be at risk due to the absence of the other household member(s), it is allowable to authorize (ERS) as long as the case manager documents the need and benefit to the individual.

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3. The individual is not able to complete tasks to maintain his/her residence, lawn, or walkway.
4. The chore activity is a one-time or intermittent task.
5. If the individual is a renter, chore services shall not replace the responsibilities of the landlord to complete tasks to maintain the residence, or walkway.
6. Pre-approval from the department is required if the cost of the service is expected to exceed \$500 per month. See Service Tasks listed below for specific tasks that require additional prior approval.
7. Emergency Response Service is limited to persons cognitively and physically capable of activating the emergency call.

Service Tasks

Professional extermination or sanitation Need prior approval Authorized per job, not units	Snow/Ice removal (when measurable snowfall or drifts present a safety hazard to the individual)
Floor care/cleaning of unusual nature, tacking down loose rugs or tiles Need prior approval	Moving heavy furniture and cleaning on seasonal basis for safety reasons
Cleaning appliances (may include moving to clean around or behind)	Cleaning and garbage removal of unusual nature Need prior approval
Professional ERS installation and monthly rental fees are allowed -- does not include maintenance or repair of ERS	Clean windows (may include seasonal removal of screens or storm windows)
Lawn mowing The purpose of this service is to maintain access and prevent any barriers to safe and appropriate housing. The service is not to be utilized for cosmetic purposes, but instead to comply with city ordinances related	

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to grass control.

Limits:

Limited to seasonal cutting and trimming grass, bagging/dumping.

Does not include landscaping, fertilizing, or weed control.

Maximum service amount is set at once per week.

If a provider is to use an individual's equipment to complete this task, the individual must sign a statement granting permission. The case manager must maintain this statement in the individual's file.

Providers

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

☐ Guardian

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

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

Community Support Services 525-05-30-21

(Revised 02/01/2025 ML #3899)

[View Archives](#)

Definition

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

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

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

Purpose

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

Service Eligibility

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

Must be eligible for Medicaid Waiver for Home and Community Services.

Requires some level of on-going daily support.

The individual is capable of directing their own care or has a legally responsible party to act on the recipient's behalf.

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

Service Tasks/Activities

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

Individual program Plan (IPP) Development, Coordination, Implementation and Evaluation.

Complete tasks such as individual plan development, monitoring the plan and observing to assure that the agency staff are trained, and the program is implemented, assisting with the development of behavior support techniques, assuring appropriate permission and approval is received from the individual and/or the legal decision maker.

Professional services are included in the "care coordination" hours and are not to be included in determination of direct support service hours.

Care coordination functions provided by the QSP agency include:

Management of an individual's property and resources including household budgeting, money management, communicating with creditors and landlords, etc.,

Application for generic services, monitoring status of those services, and maintaining communication with families, guardians, and other involved persons and agencies,

Coordinating medical needs,

Designing and implementing programs to enhance self-direction, independent living skills, community integration, social, recreational, and leisure skills and opportunities, and behavior management,

Facilitating the IPP planning process,

Assessing effectiveness of personal independence development strategies and other support services through analysis of information, consultation

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with the individual and/or guardian and family members, and
observation of the person's programs and service settings,
Asserting and safeguarding the individual's human and civil rights, and
Attending to psychosocial needs of the individual.

Hours for direct staff time for personal supports include:

General supervision for safety and health monitoring and maintenance,
Homemaking which may include home maintenance,
Assistance with activities of daily living and instrumental activities of daily
living

- bathing
- communication
- dressing/undress
- eyecare
- feeding/eating
- hairecare/shaving
- housework
- incontinence
- laundry
- meal preparation
- mobility (inside/outside)
- Money Management
- nailcare (fingernails)
- shopping
- skincare
- teeth/mouth care
- toileting
- transferring/turning/positioning

Global Endorsements tasks

- exercises
- hoyer lift/mechanized bath chairs
- indwelling catheter
- medical gases
- prothesis, orthotics
- suppository, bowel program
- TED socks
- vitals

Client specific endorsements

- apnea monitor
- JOBST stockings
- ostomy care
- postural/bronchial drainage
- RIK bed care

Medication administration

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

The QSP agency must have a training protocol and policy established for the administration of all medications, including PRN medications. The registered nurse is responsible for the training and oversight of all medication administration.

The licensed registered nurse employed by the QSP agency may perform medication set-up.

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

Accompanying individual to medical appointments.

Hours for direct staff time for personal independence development:

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

Authorization for Services

The service tasks/activities within the scope of this service chapter must be identified in the assessment and on the Preauth.

An Individual Program Plan (IPP) as outlined in the Community Supports provider standards must be developed by the authorized QSP agency and maintained in the individual's file. An IPP is an individualized plan that describes the goals, wants, needs, and strengths of the person. It describes in detail how the QSP agency is supporting the individual.

Service task and activities must be tied to an individual's goals as determined through the person-centered planning process.

The IPP must correlate with the person-centered plan and services authorization that is completed by the HCBS Case Manager.

The IPP must be developed by the QSP Agency Program Coordinator within the first 30 days of service provision and forwarded to the case manager and every 6 months thereafter.

The IPP must be approved by the state program administrator.

The IPP must include:

A plan for promotion of the individual's independence in ADLs and IADLs, social, behavioral, and adaptive skills,
Tasks being provided which should match the authorization provided by the HCBS case manager,
A medication list if medication administration is authorized and description of how medications are being managed;
Medical diagnoses;

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A therapeutic goal for community integration activities which would include companionship and socialization activities.

The individual should be involved in goal setting and ideas for these activities;

Temporary absences and requests for retainer payments.

Including any requests for retainer payments and dates of absences submitted to HCBS Program Administration for retainer payment authorization.

Note: Retainer payments cannot exceed 30 days per calendar year.

Signature of the agency care coordinator and date.

Allowable Service Combinations

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

Limits

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

This service shall not be used solely for the purpose of supervision or emergency assistance on a 24-hour basis.

Supervision may not be authorized in excess of what is necessary for health and safety.

For example, the family is requesting that someone stay with their relative 24 hours a day when there is not a safety or health risk other than the possibility that something might happen.

Supervision may not be used to restrict an individual from alcohol or substance use.

Twenty-four hour supervision in a shared living environment- Continuous supervision by paid staff on a one to one basis is not available unless shared staffing arrangements would create a safety threat to the individual or others. This level of service may only be provided as a last

resort. All possible strategies for shared or reduced levels of supervision must be ruled out first.

A 'safety threat' means the individual is so aggressive, self-destructive, or requires such close supervision that any attempt to share one on one staff at any time will place the individual at immediate risk.

Shared tasks will be considered in a shared living environment, and may affect the daily rate for these services (e.g. housekeeping of common areas, shared meals preparation, and overnight supervision).

This service does not include payment for non-medical transportation costs.

Payment for Community Support Services does not include room and board, or the cost of facility maintenance and upkeep.

Rate for this service and any additional waiver services cannot exceed the current highest daily rate for skilled nursing facility care.

Access of services or goods outside of the local area if the same service and goods are available in their local community.

For example, a grocery store is available in the local community, but the consumer wants to drive to a larger community because they prefer that location, even though the product and cost is the same at both locations.

Travel and direct support outside of the individual's community of residence for vacations, family events and socialization unless approval from an HCBS Program Administrator is received.

Direct support time is not available for any time which coincides with the recipients using adult day or other authorized services.

A personal assistance retainer payment is allowed for reimbursement during a participant's temporary absence from the setting. The personal assistance retainer allows for continued payment while a participant is hospitalized (acute hospital stay) or otherwise away from the setting in order to ensure stability and continuity of staffing up to thirty calendar days per year per participant.

Absences do not include absences due to the individual receiving care in a skilled nursing facility (SNF) or Swingbed facility.

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

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

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

Providers

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

Legal spouse

Standards for Providers

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

Community Support Service providers must be:

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

Provider must ensure that staff are adequately trained and qualified as evidenced by:

Written job descriptions for employees that include plans for participation in training and include requirements for education, experience, and skills,

Documentation of competency or employed by a Licensed DD provider according to NDAC 75-04-01,

Department approved training on Traumatic Brain Injury (TBI) and dementia,

In-service training to direct contact staff by the program coordinator on implementation of individual's programs and observation of implementation in the service setting.

To assure staff meet minimum training requirements, TBI and dementia training must be completed within 30 days of providing care to an individual under community supports.

Staff must complete TBI and dementia training every 2 years.

Completion of Minot State University medication modules, testing and practicum. Written test is proctored and completed in person. Practicum is administered by a licensed registered nurse employed or contracted through the Agency Provider.

Staff must complete department-approved training on the administration of routine medications before administering routine medications. This includes cueing/reminding the individual to take medication.

Staff must demonstrate continued competency in medication administration by completing medication practicum with agency RN once yearly and as needed. Staff must complete the practicum checklist specific to the type of medication administration they will be completing (example: if administering an enema, staff must complete the practicum checklist for the administration of an enema prior to administration and yearly).

Agency must name a Program coordinator. Program coordinator requirements:

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

A doctor of medicine osteopathy,

a registered nurse, or
an individual who holds at least a bachelor's degree
and who is licensed, certified, or registered as
applicable, to provide professional services by the
State in which he or she practices (e.g. social worker,
occupational therapist, psychologist, physical
therapist, etc.).

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

Other:

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

Ensures quality programs/services for the people supported
in the employing agency.

Responsible for development of the IPP.

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

Community Support Service cannot be provided by spouses,
Community Support providers or staff cannot live with the care recipient.

The legal guardian or family member must meet all the required
qualifications of a Community Support Service staff member.

If the legally responsible person wants to provide services as an employee of the provider and has decision making authority over the recipient, the case manager must pre-approve the arrangement with the HCBS Program Administrator for Community Support Service.

The case manager is responsible to forward a copy of the narrative that explains why the legally responsible person providing the services is in the best interest of the client to the State Medicaid Agency.

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

Council on Quality & Leadership (CQL) Accredited

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

Involuntary Discharge of an Individual under Community Support Services:

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

In the case of an involuntary discharge, the Community Support Services provider is required to give a thirty (30) day written discharge notice to the individual, unless the individual chooses to discontinue the services earlier, schedule a team meeting with the individual and HCBS case manager, and complete a written discharge summary. The timing of the thirty (30) day notice begins the date that the team meeting occurs. The written discharge notice must include the reason for discharge and why the provider cannot continue to serve the individual. A copy of the thirty (30) day notice and

the written discharge notice must be forwarded to the HCBS Case Manager. The Community Support Services provider must also file a Critical Incident Report. Any opportunities to prevent discharge should be explored prior to discharge by the provider.

Settings where service can be provided

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

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

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

Maximum Room and Board Rate effective 7-1-2024

The current maximum monthly room and board rate that providers may charge community support services recipients is \$1005.00. The maximum room and board rate is equal to the current Medicaid medically needy income level for a one person household less a \$125 personal needs allowance. The rate is reviewed annually.

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

Community Transition Services 525-05-30-22

(Revised 05/01/23 ML #3730)

[View Archives](#)

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 Preliminary Authorization to Provide Medicaid Waiver Services ([SFN 410](#)), must be completed. A Person-Centered Plan of Care must also be

completed, in which the case manager indicates that Transition Coordination is a service that is pending a final service amount.

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 include: security deposits that are required to obtain a lease on an apartment or home; essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; moving expenses; necessary home accessibility adaptations; and activities to assess need, arrange for and procure need resources.
3. 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.
4. Transition coordination is limited to 300 hours or 1200 units per recipient.
5. One-time set-up expenses are limited to \$3000 per recipient.
6. Community Transition Services will require prior approval from the HCBC Program Administrator to prevent any duplication of services.
7. 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, a Person-Centered Plan of Care has been signed, and a Pre-Auth has been issued by the HCBS Case Manager.

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

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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.

Companionship Services 525-05-30-23

(Revised 01/01/2024 ML #3789)

[View Archives](#)

Purpose

Reduces social isolation in older adults and individuals with physical disabilities who are eligible for the home and community-based services waiver, SPED, or EX-SPED and live alone or with an individual who is not capable or obligated to provide care. Companionship services reduce social isolation which can have a negative impact to physical and mental health that can lead to institutional placement.

Service Description

Non-medical care, supervision and socialization, provided to an eligible recipient who is experiencing negative effects of social isolation (e.g. anxiety or depression). The provision of companion services does not entail hands-on nursing care or medication administration. Providers may only perform light housekeeping tasks that are directly related to the companionship activity (example: if the caregiver completes an art project, the caregiver may assist with the cleanup from this companionship activity). This service must be provided in accordance with a therapeutic goal in the care plan and/or service authorization.

Socialization that is therapeutic is directly tied to the individual's goal(s) in the person-centered plan. An example of therapeutic activity could be a game or activity that enhances fine motor skills to help the participant recover from a stroke.

Activities that support therapeutic socialization could also be associated with a care plan goal to reduce social isolation, or help the individual maintain the most inclusive community life.

Service Eligibility, Criteria for

The individual receiving companionship services will meet the following criteria:

1. Must be eligible for the HCBS Medicaid waiver program, OR must be under the age of 60 and eligible for SPED or EX-SPED;
2. Lives alone or with an individual who is not capable or obligated to provide the care. An individual considered to be obligated is defined as a legal spouse or parent of a child under the age of 18;
3. Be at least age 18;

The care needs of the individual must fall within the scope of companionship services as described in this service chapter.

If an individual requires companionship services, the case manager must justify in the narrative/case note why the individual needs the support.

Service Location

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

ü The individual's home

☐ **Workplace**

ü Other community service settings

Service Tasks/Activities

Allowable companionship tasks include but are not limited to supervision which means having the knowledge of, and account for, the activity and whereabouts of the recipient at all times to allow immediate provider intervention as necessary to safeguard the individual from harm. During the time that the provider is providing companionship services to the recipient and is not actively providing Medicaid State Plan (MSP) personal care, SPED personal care, Waiver personal care, or homemaker tasks etc., they may play games, visit, read, go for walks, and participate in activities with the individual. If the individual is physically able, they may also participate in activities within the local community or trade area that supports an identified goal on the person-centered plan.

If the activity is outside of the recipient's local community or trade area and the recipient must travel to the event etc., contact the program administrator for prior approval.

The following tasks are not considered allowable tasks under this chapter because they would be provided under MSP personal care, SPED personal care, Waiver personal care, or homemaker etc. unless they are incidental to the companionship activity:

Bathing, dress/undress, eye care, feeding/eating, hair/care/shaving, incontinence, mobility, nail (finger) care, skin care, teeth/mouth care, toileting, transferring/turning/ positioning. The global endorsements of exercise, hoist lift/mechanized bath chair, indwelling catheter, medical gases, prosthetic, orthotics, suppository, bowel program, TED socks, Temp/BP/pulse/respiration rate. The client specific endorsements of apnea monitor, JOBST stockings, ostomy care, postural /bronchial drainage, RIK bed care. Communication, housework, laundry, meal preparation money management, shopping, and medication assistance are not allowable service tasks under this service unless are incidental to the companionship service.

Companionship services provided outside of the individual's home

Payment can be made for time performing authorized companionship tasks outside of the individual's home/grounds. Non-medical transportation is an allowable service combination.

Service Activity Limits

1. Companionship services do not include hands-on nursing care but may include verbal instruction or cueing;
2. Companionship services do not include activity fees (e.g. movie or event fees);
3. Services can only be provided to individuals who live alone or with someone who is not able or is not obligated to provide the care;
4. Companionship cannot be combined with adult foster care, adult residential care, family personal care, family home care, transitional living, residential habilitation, community support services, and recipients of the senior companion program under the Cooperation for National and Community Service;

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5. Companionship services cannot be provided by an individual who is identified as the recipients relative within the definition of family home care under subsection 4 of N.D.C.C. 50-06.2-02.
6. The task of "visiting" is considered a companionship activity; however, a QSP may only bill for a maximum of 2 hours per week for this task, or 8 hours in one month.
7. Companionship services cannot be provided to residents of a basic care facility, assisted living facility, memory care facility, skilled nursing facility or traumatic brain injury facility.

For unusual or unique circumstances, approval from the HCBS Program Administrator must be obtained.

Authorizing Service

1. The service tasks/activities within the scope of this service chapter must be identified on the Authorization to Provide Service, otherwise known as the PreAuth.
2. The amount of units allocated for companionship services cannot exceed 10 hours of service per month (40 units).
3. The companionship provider may also be the personal care, homemaker provider etc. However, the services cannot be provided at the same time.

Providers

Companionship Services may **NOT** be provided by the following individual QSP's or employees of a QSP agency:

- Guardian
- Legally Responsible Person - Legal spouse or parent of a minor child.
- Relative within the definition of Family Home Care under subsection 4 of N.D.C.C. 50-06.2-02.

Standards for Providers

1. Individuals enrolled as a QSP who meet the standards to provide adult companion services except for individuals who are identified as a

relative of the recipient within the definition of family home care under subsection 4 of N.D.C.C. 50-06.2-02.

2. Agencies enrolled as a QSP that meet the standards for adult companion services.
 - a. Employees of agencies enrolled to provide this service cannot use an employee who is identified as a relative of the recipient within the definition of family home care under subsection 4 of N.D.C.C. 50-06.2-02.
3. Organizations enrolled as a QSP that provide companion service under the Corporation for National and Community Service Senior Companion Programs.
 - a. Employees of organizations enrolled to provide this service cannot use an employee who is identified as a relative of the recipient within the definition of family home care under subsection 4 of N.D.C.C. 50-06.2-02.
 - b. Organization providers must meet all the standards established by the Corporation for National and Community Service National and Community Service Senior Companion program grantees.
4. Verification of organization credentials is done by the national corporation.

All individual companionship providers and the employees of agency providers must also have the global endorsement for cognitive/supervision. Organization employees/ volunteers do not need this endorsement.

Environmental Modification 525-05-30-25

(Revised 4/1/23 ML #3723)

[View Archives](#)

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) or vehicle modifications to enhance the recipient's ability to function as independently as possible in the home or family member's home.

The purpose of Environmental Modification, vehicle modifications is to enhance the recipient's ability to access and function as independently as possible while using the recipient's primary means of transportation to accommodate the special needs of the participant.

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 or rent the home prior to application. If the owner of the property is someone other than the service recipient, the file must include the owner's written approval for the modification, consistent with the property owner's obligations pursuant to section 804(f)(3)(A) under the Fair Housing Act [42 U.S.C. 3604(f)(3)(A)] prior to the installation of the environmental modification.
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 vehicle that is adapted may be owned by the individual, a family member with whom the individual lives or has consistent and ongoing contact. Payment may not be made to adapt vehicles that are owned or leased by non-family paid providers of waiver services.
6. Environmental Modification, vehicle modifications are adaptations or alterations to an automobile or van that is the waiver participant's primary means of transportation in order to accommodate the special needs of the participant.
7. Vehicle adaptations are specified by the service plan as necessary to enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant.
8. 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.
9. Physical adaptations to the home required which are necessary and without which, the recipient would require institutionalization.

Limits

SPED and ExSPED costs are limited to: maximum monthly cost limit for SPED and ExSPED.

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. This cap may be increased as determined by legislative action. Exceptions to this service cap may be approved by program administration. 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. If the recipient's needs cannot be met within the allowed rate case management would explore other service options with the participant and may request a reasonable modification from program administration to exceed the cap. The case manager makes participants aware of the service cap.

Vehicle adaptations specifically excluded:

1. Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the individual.
2. Purchase or lease of a vehicle; and
3. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

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.

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 \$500. 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 Department 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 or unlicensed contractor 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.
- If an unlicensed contractor is providing environmental modification the time and materials of the project may not exceed \$4000.
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 copy of the most recent Comprehensive Assessment, and the Person Centered Plan of Care 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 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 Service 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:

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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 individual.

Extended Personal Care Service 525-05-30-27

(Revised 07/01/2024 ML #3847)

[View Archives](#)

Legal Authority

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

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

Purpose

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

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

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

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

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

Service Eligibility, Criteria for:

The individual receiving EPCS must be:

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

Service Location

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

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

Authorization for Service

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

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

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

Service Delivery

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

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

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

1. Nursing Plan of Care (SFN 807)
 - Completed by RN, initially, and every 6-months while services are in place.

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

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

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

Incidents

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

Limits

1. Units for routine assessments for the health and welfare of the individual, incident reporting, assistance with activities of daily living (ADLs) and instrumental activities of daily living are not part of this service.
2. Due to the complexity of the care provided to individuals receiving Extended Personal Care Services, contingency plans are required as a prerequisite to receive this service to assure that health welfare and safety are maintained if a provider is unavailable to provide the service.
3. The Nursing Plan of Care (NPOC) assessments must be done face to face to assure the health, welfare, and safety needs of the individual are met.
4. Vital signs may only be authorized under EPCS if a written order from an outside agency medical practitioner is obtained with the frequency and parameters listed. The HCBS Case Manager must keep a current order for vital signs in the electronic record.
5. Authorized EPCS approvals are nontransferable between QSP Agencies or individual QSPs.
6. Virtual Supports Option may only be utilized after approval from a EPCS RN Program Administrator. The EPCS RN Program Administrator will document approval.

Providers

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

☐ Guardian

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

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

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

1. The RN will develop a nursing plan of care based on the assessment and diagnoses .

2. The RN provides education on nursing interventions that the QSP Provider has the necessary skills and competence to accomplish safely.

The LPN can:

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

Service Activities, Authorized and Limits

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

(QSP) complaint will be filed with the QSP Complaints Program Administrator.

5. Nurse education service may be provided remotely through virtual supports as determined necessary to ensure services are delivered while considering participant choice, compliance with CMS requirements and identified in the participant's person-centered plan.

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

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

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

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

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

Requirements for utilizations of Nurse Education – Virtual Supports

- Virtual Supports require the initial NPOC has been completed in person with the provider, individual and other team members during the person-centered planning process.
 1. The NPOC will ensure that the planning process has considered service needs and if these needs can be met by using a virtual supports method of service delivery.
 2. The NPOC includes a Virtual Support Checklist will be required to be completed by the Nurse Educator and the team during the person-centered planning process.

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

Family Home Care 525-05-30-30

(Revised 02/01/2025 ML #3899)

[View Archives](#)

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:

- Must be eligible for the SPED or ExSPED program.

- The individual and the family member must reside in the same residence.

- The individual and the family member must mutually agree to the arrangement.

- QUALIFIED SERVICE PROVIDER (QSP) SERVICE AGREEMENT -LIVE IN PAID CAREGIVERS, SFN 1654, is required for all Family Home Care providers.

- The [family member](#) must be one of the relatives as defined in Family Home Care N.D.C.C [50-06.2-02\(4\)](#), and must be the provider performing the care to the individual. Family Home Care can be provided by the "spouse or by one of the following relatives, or the current or former spouse of one of the following relatives, of the elderly or disabled person: parent, grandparent, adult child, adult sibling, adult grandchild, adult niece, or adult nephew."

- The need for services must fall within the scope of tasks that includes bathing, communication, dressing/undressing, eye care, feeding/eating, hair care/shaving, housework, incontinence, laundry, meal preparation, medication assistance, mobility, money management, fingernail care, shopping, skin care, teeth/mouth care, toileting, transferring/turning/positioning, supervision, exercises, hooyer lift/mechanized bath chairs, indwelling catheter, medical gases, prosthesis/orthotics, suppository/bowel program, TED socks, temp/bp/pulse/respiration rate, apnea monitor, jobst stockings,

ostomy care, postural/bronchial drainage, and RIK bed care. The identified tasks for the individual are listed on the service authorization.

The FHC provider is not required to have global endorsements or client specific endorsements.

The FHC provider may be authorized for medication administration even if the individual is not able to self-direct their medications. The individual must have a daily personal care and/or supervision need that is provided by the FHC provider.

The provider for FHC must provide a minimum total of one (1) hour of care to the eligible individual per day. The one hour per day includes the daily personal care or supervision need and any other allowable task under FHC.

a. The one hour of care per day may include homemaker tasks within the limits allowable under SPED.

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

The individual does not qualify for Family Personal Care (FPC). If an individual receives or would be eligible for Medicaid and meets level of care screening, FPC must be sought as opposed to Family Home Care (FHC).

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

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

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

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

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

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

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

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

Service Tasks/Activities - Family Home Care

Tasks of laundry, shopping, housekeeping, meal preparation, money management, and communication are allowed only when the service activity benefits the individual. The service of family home care is not intended to be used primarily for environmental tasks. The individual must have a daily personal care and/or supervision need to qualify for this service.

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

Family Home Care Limitation, Under 18 Years of Age

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

The provider must be either the parent or spouse of the individual who is under the age of 18.

The caregiver/qualified service provider provides continuous care to the child. That is, the individual's/child's disability prohibits his/her participation in programs and/or activities outside the home; the child is unable to regularly attend school OR is severely limited in the amount of time at school. (The relationship to school attendance

applies even when school is not in session; would the child be able to attend school and to what extent if it were in session.) If it appears that the child may be eligible for DD services, an application must be made to the DD Division to make this determination prior to consideration of SPED. There must be documentation that application was made for DD services, and a copy of the denial letter be placed in the individual's file. A letter saying the applicant/child is not receiving DD services is not sufficient.

Service Location

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

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

Out of Home Care

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

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

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

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

This provision does not allow a provider to work full time unless the arrangement has been approved by an HCBS Program Administrator and assures the individual's continued health and safety.

Service Combinations

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

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.

If individuals cannot be safely left alone so that the provider can take necessary breaks away from their caregiving responsibilities respite must be authorized.

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

Respite care must be authorized because FHC providers cannot delegate their care to another individual if the individual cannot be safely left alone.

If informal respite is in place and of benefit to the individual and the family home care provider, the case manager must document that formal respite care was offered and declined.

Emergency response is acceptable if a safety risk (i.e. potential fall risk or sudden illness) has been identified during the FHC provider's short term absence. ERS is not acceptable for individuals who require supervision for cognitive or health related reasons.

For some situations, it may be appropriate for two Family Home Care providers to be authorized to provide care to one individual if both providers meet the Family Home Care definition. However, both Family Home Care Providers cannot bill for the service on the same day. Pre-approval is required for services authorized in this manner. See [Paid Family or Household Members/Qualified Service Provider \(QSP\) Service Agreement - Live in Paid Caregivers 525-05-45-50](#) for instructions on how the QSP Service Agreements are completed for these instances.

See [Paid Family or Household Members/Qualified Service Provider \(QSP\) Service Agreement - Live in Paid Caregivers 525-05-45-50](#) for instructions on how the QSP Service Agreements are completed if one

Family Home Care provider has been approved to provide daily live-in care to more than one individual.

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.

Authorization

When an individual's live-in provider changes from a unit rate service to daily rate service, the case manager ends the unit-rate service the last day of the month and authorizes the daily rate service the first day of the next month.

Example: an individual's provider is authorized for SPED T1019 and the living situation changes to where the individual and provider reside together and are eligible for Family Home Care. The case manager ends T1019 the last day of the month and starts Family Home Care the first day of the next month.

When an individual's live-in provider changes from one daily rate service to another daily rate service, the case manager ends the first service the last day of the month and authorizes the new service the first day of the next month.

Example: An individual's provider is authorized for Family Home Care but becomes approved for Family Personal Care. The case manager ends Family Home Care the last day of the month and starts Family Personal Care the first day of the next month.

Providers

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

- ✓ **Guardian**
- ✓ **Legally Responsible Person - Legal spouse or parent of a minor child.**
- ✓ **Relative within the definition of Family Home Care under subsection 4 of N.D.C.C. 50-06.2-02. (Required)**

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Limits

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

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

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

Family Personal Care 525-05-30-32

(Revised 12/01/2024 ML #3885)

[View Archives](#)

Purpose

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

Service Eligibility, Criteria for

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

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

individual would include a Legal Spouse or Guardian.

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

Service Tasks/Activities

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

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

Service Location

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

ü The individual's home

☐ Workplace

ü Other community service settings

Out-of-Home Care

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

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

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

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

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

Limitations

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

1. The number of reimbursable hours of care cannot exceed 10 hours per day.
 - The provider may provide more care than 10 hours, but the State is not obligated to pay because that care is being provided because

of their close personal relationship and that they share a household with the eligible individual.

2. Under FPC, the tasks of housework, laundry, meal prep, shopping, money management, and community are considered homemaker tasks and are limited to the maximum monthly amount set by the Department.

Providers

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

ü Guardian

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

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

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

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

Service Combinations

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

1. The individual meets the eligibility criteria for Respite Care Services or when the qualified family member provides less than 24-hour per day

care on a routine basis, and the individual can be left alone safely for brief periods of time, respite care is appropriate only when the qualified family member will be gone for an extended period of time, for example, to attend a wedding.

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

- Respite care must be authorized because FPC providers cannot delegate their care to another individual if an individual cannot be safely left alone.
 - If informal respite is in place and of benefit to the individual, the case manager must document that formal respite care was offered and declined.
2. Emergency response is acceptable if a safety risk (i.e. potential fall risk or sudden illness) has been identified during the FPC provider's short term absence. ERS is not acceptable for individuals who require supervision for cognitive or health related reasons.
 3. For some situations, it may be appropriate for two Family Personal Care providers to be authorized to provide care to one individual if both providers meet the Family Personal Care definition. However, both Family Personal providers cannot bill for the service on the same day. Pre-approval by program administration is required for services authorized in this manner. [See Paid Family or Household Members/Qualified Service Provider \(QSP\) Service Agreement - Live in Paid Caregivers 525-05-45-50](#) for instructions on how the QSP Service Agreements are completed for these instances.
 4. See [Paid Family or Household Members/Qualified Service Provider \(QSP\) Service Agreement - Live in Paid Caregivers 525-05-45-50](#) for instructions on how the QSP Service Agreements are completed if one Family Personal Care provider has been pre-approved to provide daily live-in care to more than one individual.
 5. Under unusual or unique circumstances other HCBS service combinations may be appropriate. In such cases, contact the HCBS Program Administrator in writing to obtain approval.

Authorization

When an individual's live-in provider changes from a unit rate service to daily rate service, the case manager ends the unit-rate service the last day of the month and authorizes the daily rate service the first day of the next month.

- Example: an individual's provider is authorized for T1019 but becomes approved for Family Personal Care. The case manager ends T1019 the last day of the month and starts Family Personal Care the first day of the next month.

When an individual's live-in provider changes from one daily rate service to another daily rate service, the case manager ends the first service the last day of the month and authorizes the new service the first day of the next month.

- Example: An individual's provider is authorized for Family Home Care but becomes approved for Family Personal Care. The case manager ends Family Home Care the last day of the month and starts Family Personal Care the first day of the next month.

Home Delivered Meals 525-05-30-33

(Revised 10/01/24 ML #3780)

[View Archives](#)

Purpose

The purpose of home delivered meals is to provide a well-balanced meal to individuals who are unable to prepare an adequate meal for themselves.

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.

One of the first steps in determining eligibility for HCBS-funded home delivered meals is determining whether the individual would be eligible for the meals under the Older Americans Act (OAA). Basic eligibility criteria for home delivered meals under OAA requires that the individual is age 60 or over and homebound. If the individual appears to meet the criteria for OAA, please refer to the section below (Service Eligibility, Criteria for) - lines 3 and 4.

Service Eligibility, Criteria for

The individual receiving the home delivered meal must 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 (SPED), or Expanded Service Payments to the Elderly & Disabled (ExSPED).
2. Live alone and is unable to prepare an adequate meal, or live with someone who is unable or unavailable to prepare an adequate meal.
 - Home Delivered Meals may be authorized if the individual lives with an adult who is not obligated to provide assistance.
 - Home Delivered Meals may be authorized if the individual lives with an obligated adult (able-bodied spouse) who is unavailable

to provide assistance during mealtime (example: spouse who works outside of the home).

3. SPED or ExSPED recipients who are eligible for home delivered meals under the Older Americans Act (OAA) must access their meal through the OAA meal site and not through SPED or ExSPED, **UNLESS:**
 - a. The individual has a dietary restriction such that the meal funded by OAA would not be appropriate in meeting their dietary needs. In this case, the individual is able to choose an alternative home delivered meal provider (such as Mom's Meals) in place of the meal through the local OAA site, and the home delivered meal can be funded by SPED or ExSPED. The HCBS Case Manager must document the individual's dietary restriction and need for an alternative home delivered meal in the assessment and narrative/case note.
 - b. The individual is already receiving OAA meals and would like an *additional* meal authorized under SPED or ExSPED. These individuals can access up to two (2) additional home delivered meals per day, as long as at least one of their meals is provided and paid for under the OAA. For the additional meals, the individual is able to choose from the local OAA meal site OR an alternative home delivered meal provider (such as Mom's Meals).
4. Individuals requesting home delivered meals under the HCBS Medicaid Waiver are not required to use Older American Act meals. The case manager may authorize the home delivered meal under Medicaid Waiver, and the individual is able to choose the home delivered meal provider.

Limits/Service Combinations

- Recipients cannot receive more than two (2) hot or frozen home delivered meals per day under Home and Community Based Services (HCBS).
- Home Delivered Meals cannot be combined with Adult Residential Care, Adult Foster Care, or while the individual is in Adult Day Care (as services cannot be duplicated).
- In some circumstances, the combination of Home Delivered Meals and Family Home Care or Family Personal Care may be appropriate. Contact the Program Administrator for a one-time approval.

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Standards for Home Delivered Meal Providers

See Standards for Qualified Service Providers [525-05-45](#)

Homemaker Service 525-05-30-35

(Revised 07/01/2024 ML #3847)

[View Archives](#)

Purpose

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

Service Eligibility Criteria for

The individual receiving homemaker service will meet the following criteria:

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

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

4. For an individual who lives with an able-bodied adult, the department may pay a provider for homemaker activities involving the individual's personal private space and if the individual is living with an adult, the individual's share of the common living space.
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 individual (e.g. cooking, cleaning).
7. The funding cap applies to a household and may not be exceeded regardless of the number of eligible individuals residing in the home.

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

Service Tasks/Activities

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

Service Location

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

✓ **The individual's home**

- ☐ Workplace
- ☐ Other community service settings

Services Activities, Authorized and Limits

1. The service tasks/activities within the scope of this service chapter are defined on the Authorization to Provide Services.
2. When an individual receives assistance with laundry, shopping, housekeeping, under Medicaid State Plan Personal Care (MSP-PC) in excess of the funding cap allowed for homemaker services under SPED, EXSPED, or HCBS Wavier, additional tasks of Meal Prep, Communication or Managing Money may not be authorized under Homemaker Services.
3. If an individual is receiving MSP-Personal Care assistance for meal prep, communication, and money management, these tasks are not allowable homemaker tasks unless approval is obtained from a HCBS Program Administrator.

4. If an individual is receiving MSP-Personal Cares, the tasks of laundry, shopping, and housekeeping cannot exceed 30% of the entire care plan. When MSP-PC units are authorized, homemaker tasks must be authorized under this funding source (MSP-PC) unless:
 - a. MSP-PC Level C is authorized; or
 - b. The total cost of the maximum number of units that are able to be moved from SPED/Ex-SPED and authorized under MSP-PC is less than \$150. (When calculating whether this cost is under \$150, first determine how many homemaker units you are able to move to MSP-PC. Then, take that number of units and multiply it by the current homemaker rate. If that total is less than \$150, you do not need to move the units from SPED/Ex-SPED over to MSP-PC.)
 - i. If a rural differential (RD) rate is authorized, the RD rate must be used to calculate the laundry, shopping, housekeeping total cost.
 - c. Homemaker is authorized under Medicaid Waiver. In that case, all HMK tasks may be authorized under MSP-PC Levels A and B or Medicaid Waiver since both (MSP-PC and Medicaid Waiver) are Medicaid-funded programs.

Providers

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

☐ Guardian

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

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

Non-Medical Transportation 525-05-30-40

(Revised 04/01/23 ML #3723)

[View Archives](#)

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. The service of Companionship is considered an essential community resource for Non-Medical Transportation.

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.
 - a. Individuals receiving Transitional Living services are limited to eligibility for Non-medical Transportation Driver with Vehicle.
 - b. Individuals who are receiving Non-Medical Transportation Service under the Technology Dependent Waiver are limited to eligibility for Driver with Vehicle.
2. Is unable to provide his/her own transportation and/or requires assistance with the task(s) for which Non-Medical Transportation is being provided.
3. Needs a means of obtaining basic necessary community resources and/or services (i.e. grocery, pharmacy, laundromat).

Service Activities

HCBS Non-Medical Transportation can ONLY be authorized for the individual to access basic necessities (which are non-medical related) required in order for the individual to remain in their own home, or - for the service of Companionship or Transitional Living - community

integration/social appropriateness. 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 (Non-Medical Transportation Local or Out of Town 15-minute unit rate)

HCBS Non-Medical Transportation service is to be provided from the individual's place of residence to the essential service need/access point(s) and/or return.

Non-Medical Transportation Local is authorized for the drive time of transporting the individual to and from their home for essential services.

Non-Medical Transportation Out of Town is also authorized for the drive time of transporting the individual to and from their home for essential services. If essential services are not available to the individual in their local area, it may be appropriate to authorize Non-Medical Transportation Out of Town for drive time to the nearest town or city where essential services can be accessed.

Non-Medical Transportation (Driver with Vehicle Local or Out of Town)

If an individual is utilizing non-medical transportation (NMT) and the QSP needs to use the individual's vehicle, for instance if it's handicapped-accessible, you may authorize Driver with Vehicle. The intent of the Driver with Vehicle is not only the mileage and wear-and-tear on the QSP's vehicle, but also their time.

In order to authorize Non-Medical Transportation Driver with Vehicle (Local or Out of Town), the individual must either be impaired in Transportation or impaired in the task for which Transportation is being authorized.

- a. To determine whether the individual is impaired in Transportation, refer to Instructions for Completion of the HCBS Comprehensive Assessment 525-05-60-10: consider their ability to negotiate entering and exiting of vehicle. Consider their ability to secure appropriate and available transportation and to know locations of home and essential places. Lack of appropriate and available transportation as needed, will increase the score. Consider cognitive as well as physical ability to use transportation.
- b. To determine whether the individual is impaired with the task for which Transportation Driver is being authorized, consider their ability to independently complete the task for which the transportation is being provided (example: Shopping for essential services as part of Non-Medical Transportation).

Case Example:

An individual does not drive, but has access to public transportation and can board without assistance. They would not be considered impaired in Transportation. However, they require human assistance in completing the task of Shopping, which includes the necessary transportation. It may be appropriate to authorize Non-Medical Transportation driver/vehicle for the drive time, as well as Non-Medical Transportation escort for the assistance with the task.

Case Example:

An individual does not drive, but has access to public transportation and can board without assistance. They would not be considered impaired in Transportation. They require transportation to access the bank and the pharmacy, but do not require any assistance with completing those actual tasks. It would not be appropriate to authorize any form of

Non-Medical Transportation for these tasks, as the individual is independent with Transportation and is also independent with the tasks associated with it.

2. Authorization of Non-Medical Transportation Escort

An escort may be authorized to accompany an individual who uses public transportation IF the individual requires assistance in boarding and exiting as well as while being transported AND the escort must be needed by the individual in completing the activity. An example of escort for completing an activity would be an individual who requires assistance with grocery shopping in the store. This type of assistance would be considered the escort component of Non-Medical Transportation.

3. Authorization of Non-Medical Transportation Driver with Vehicle and Non-Medical Transportation Escort

A QSP providing transportation may also be compensated as an escort IF the escort is needed by the individual in completing the activity for which the HCBS Non-Medical Transportation is authorized. Compensation for escort must be separate from the compensation for the transportation (driver with 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 individual 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 an individual to and from work/or school or to facilitate socialization or to participate in recreational activities, (i.e. wellness programs, church activities, etc.) unless it is being authorized in conjunction with the service Companionship or Transitional Living.
- HCBS Non-Medical Transportation CANNOT be used to transport an individual to and from a health care provider or medical facility

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(doctor, dentist, hospital, physical therapy, etc.).

- If the individual is not able to be transported or participate in the activity (such as grocery shopping), this cannot be billed under Non-Medical Transportation. The service may be covered under Homemaker.

Individuals receiving Transitional Living Services are exempt from this limit, service tasks would include transporting individuals 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 living services.

With the exception of Companionship, this service is not available when transportation is provided as a component part of another service.

Providers

Non-Medical Transportation may be provided by the following individual QSP's or employees of a QSP agency (checked if allowable):

- ☐ Guardian
- ☐ Legally Responsible Person - Legal spouse or parent of a minor child.
- ✓ **Relative within the definition of Family Home Care under subsection 4 of N.D.C.C. 50-06.2.02.**

Non-Medical Transportation 525-05-30-40

(Revised 11/1/21 ML #3640)

[View Archives](#)

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. The service of Companionship is considered an essential community resource for Non-Medical Transportation.

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.
 - a. Individuals receiving Transitional Living services are limited to eligibility for Non-medical Transportation Driver with Vehicle.
 - b. Individuals who are receiving Non-Medical Transportation Service under the Technology Dependent Waiver are limited to eligibility for Driver with Vehicle.
2. Is unable to provide his/her own transportation and/or requires assistance with the task(s) for which Non-Medical Transportation is being provided.
3. Needs a means of obtaining basic necessary community resources and/or services (i.e. grocery, pharmacy, laundromat).
4. Transportation alternative is NOT available through the informal network.

Service Activities

HCBS Non-Medical Transportation can ONLY be authorized for the individual to access basic necessities (which are non-medical related) required in order for the individual to remain in their own home, or - for the service of Companionship or Transitional Living - community integration/social appropriateness. 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 (Non-Medical Transportation Local or Out of Town 15-minute unit rate)

HCBS Non-Medical Transportation service is to be provided from the individual's place of residence to the essential service need/access point(s) and/or return.

Non-Medical Transportation Local is authorized for the drive time of transporting the individual to and from their home for essential services.

Non-Medical Transportation Out of Town is also authorized for the drive time of transporting the individual to and from their home for essential services. If essential services are not available to the individual in their local area, it may be appropriate to authorize Non-Medical Transportation Out of Town for drive time to the nearest town or city where essential services can be accessed.

Non-Medical Transportation (Driver with Vehicle Local or Out of Town)

If an individual is utilizing non-medical transportation (NMT) and the QSP needs to use the individual's vehicle, for instance if it's handicapped-accessible, you may authorize Driver with Vehicle. The intent of the Driver with Vehicle is not only the mileage and wear-and-tear on the QSP's vehicle, but also their time.

In order to authorize Non-Medical Transportation Driver with Vehicle (Local or Out of Town), the individual must either be impaired in

Transportation or impaired in the task for which Transportation is being authorized.

- a. To determine whether the individual is impaired in Transportation, refer to Instructions for Completion of the HCBS Comprehensive Assessment 525-05-60-10: consider their ability to negotiate entering and exiting of vehicle. Consider their ability to secure appropriate and available transportation and to know locations of home and essential places. Lack of appropriate and available transportation as needed, will increase the score. Consider cognitive as well as physical ability to use transportation.
- b. To determine whether the individual is impaired with the task for which Transportation Driver is being authorized, consider their ability to independently complete the task for which the transportation is being provided (example: Shopping for essential services as part of Non-Medical Transportation).

Case Example:

An individual does not drive, but has access to public transportation and can board without assistance. They would not be considered impaired in Transportation. However, they require human assistance in completing the task of Shopping, which includes the necessary transportation. It may be appropriate authorize Non-Medical Transportation driver/vehicle for the drive time, as well as Non-Medical Transportation escort for the assistance with the task.

Case Example:

An individual does not drive, but has access to public transportation and can board without assistance. They would not be considered impaired in Transportation. They require transportation to access the bank and the

pharmacy, but do not require any assistance with completing those actual tasks. It would not be appropriate to authorize any form of Non-Medical Transportation for these tasks, as the individual is independent with Transportation and is also independent with the tasks associated with it.

2. Authorization of Non-Medical Transportation Escort

An escort may be authorized to accompany an individual who uses public transportation IF the individual requires assistance in boarding and exiting as well as while being transported AND the escort must be needed by the individual in completing the activity. An example of escort for completing an activity would be an individual who requires assistance with grocery shopping in the store. This type of assistance would be considered the escort component of Non-Medical Transportation.

3. Authorization of Non-Medical Transportation Driver with Vehicle and Non-Medical Transportation Escort

A QSP providing transportation may also be compensated as an escort IF the escort is needed by the individual in completing the activity for which the HCBS Non-Medical Transportation is authorized. Compensation for escort must be separate from the compensation for the transportation (driver with 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 individual 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 an individual to and from work/or school or to facilitate socialization or to participate in recreational activities, (i.e. wellness programs, church activities, etc.) unless it is being authorized in conjunction with the

service Companionship or Transitional Living.

- HCBS Non-Medical Transportation CANNOT be used to transport an individual to and from a health care provider or medical facility (doctor, dentist, hospital, physical therapy, etc.).
- If the individual is not able to be transported or participate in the activity (such as grocery shopping), this cannot be billed under Non-Medical Transportation. The service may be covered under Homemaker.

Individuals receiving Transitional Living Services are exempt from this limit, service tasks would include transporting individuals 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 living services.

With the exception of Companionship, this service is not available when transportation is provided as a component part of another service.

Providers

Non-Medical Transportation may be provided by the following individual QSP's or employees of a QSP agency (**checked if allowable**):

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

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

Nursing Assessment 525-05-30-42

(Revised 05/01/23 ML #3730)

[View Archives](#)

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 and Preliminary Authorization to Provide Medicaid Waiver Services (SFN 410), must be completed. The HCBS Case Manager indicates on the Person-Centered Plan of Care that the service is pending a final service amount. The HCBS Case Manager is responsible to submit the Person-Centered Plan of Care and Preliminary Authorization to Provide Medicaid Waiver Services to the web-based data collection system.

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.

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.

SPED Personal Care Service 525-05-30-45

(Revised 12/01/2024 ML #3885)

[View Archives](#)

Purpose

The philosophy of the Department is that SPED personal care should be provided so as to assist the eligible individual 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. The individual or legally responsible person must direct the care provided and should be involved in training and monitoring the SPED personal care QSP as much as possible and when appropriate.

1. SPED Personal Care differs from adult foster care in that personal care is provided in the individual's home, and adult foster care is provided in the service provider's home. If a non-relative is caring for the individual on a 24-hr live in basis in the provider's home, the service must be Adult Foster Care. It cannot be SPED 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 individual needs and not to relieve the caregiver.

Service Eligibility, Criteria for

The individual receiving SPED 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, Waiver Personal Care, Family Personal Care or Family Home Care;
 - a. Individuals who require less than an average of 1 hours of care per day are not eligible for SPED personal care live-in.
2. Be at least age 18;

3. The care needs of the individual 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 individual must have the ADLs and IADLs needs performed for him/her OR an individual with cognitive impairment 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, if the individual requires supervision/oversight due to physical or cognitive impairment, up to the SPED program cap. Under SPED, the tasks of cog/supervision is considered a personal care and is billed at the same rate/code as the other personal cares authorized. While supervision is an allowable task within SPED personal care, it cannot be the sole reason for the care.
 - b. The tasks that may be included in SPED unit personal cares are as follows: bathing, dressing/undressing, eye care, feeding/eating, hair care/shaving, incontinence, medication assistance, mobility, fingernail care, skin care, teeth/mouth care, toileting, transferring/turning/positioning, cog/supervision, exercises, hoist lift/mechanized bath chairs, indwelling catheter, medical gases, prosthesis/orthotics, suppository/bowel program, TED socks, temp/bp/pulse/respiration rate, apnea monitor, jobst stockings, ostomy care, postural/bronchial drainage, and RIK bed care. The identified tasks for the individual are listed on the service authorization.
4. SPED Daily Personal Cares live-in must be authorized if the non-relative provider and the individual live in the same residence and personal care is needed on a daily basis under SPED. See section on "Limits" for further details.
 - a. SPED 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. The tasks that may be included in SPED daily personal cares live in are as follows: bathing, communication, dressing/undressing, eye care, feeding/eating, hair care/shaving, housework, incontinence, laundry, meal

preparation, medication assistance, mobility, money management, fingernail care, shopping, skin care, teeth/mouth care, toileting, transferring/turning/positioning, cog/supervision, exercises, hoist lift/mechanized bath chairs, indwelling catheter, medical gases, prosthesis/orthotics, suppository/bowel program, TED socks, temp/bp/pulse/respiration rate, apnea monitor, jobst stockings, ostomy care, postural/bronchial drainage, and RIK bed care. The identified tasks for the individual are listed on the service authorization.

- b. Qualified Service Provider (QSP) Service Agreement - Live In Paid Caregiver, SFN 1654, is required for all live in SPED Daily Personal Care Providers.

Service Location

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

ü The individual's residence

ü Workplace

ü Other community service settings

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

The provision of SPED Daily Personal Cares live-in is appropriate ONLY for individuals who can be left alone for routine temporary periods of time (e.g. part-time employment) without adverse impact to the individual's welfare and safety. The individual must agree to be left alone.

Individuals with Cognitive Impairments

For individuals who cannot be safely left alone due to cognitive impairment or high physical needs, the person-centered plan of care must include a plan to ensure continued health and safety of the individual. The plan must identify needs, including personal care assistance, guidance, cueing, prompting, and supervision and how those needs will be met. This information must be documented under the Supervision/Structured Environment section within the functional assessment component of the participant assessment.

Providers

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

ü Guardian

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

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

Limits:

1. Individuals who have a daily personal care and or/supervision need and require an average of at least 1 hour of care per day whose daily live-in providers meet the definition of Family Home care must utilize Family Home Care instead of SPED personal care. See N.D.C.C. 50-06.2-02(4) for the definition of family member.
2. In order to qualify for SPED Daily Personal Cares live-in, the individual must require an average of at least 1 hour of care each day. If the individual requires less than 1 hour of daily care, unit-based SPED personal care and/or SPED homemaker may be considered.
3. If personal care is not needed on a daily basis, SPED Daily Personal Cares live-in should not be authorized. Instead, unit-based SPED personal care and/or SPED homemaker may be considered.
4. If there are multiple personal care providers necessary to meet the individual's need, it is allowable for unit-based personal care to be authorized instead of SPED Daily Personal Cares live-in.
5. Under SPED Personal Care Service, payment can be made for time performing authorized personal care tasks even if performed outside the individual's home as long as the cares are provided in the local trade area. The hours remain based on the care necessary in the individual's home. The care provided outside the home must be within the defined scope (allowable tasks as authorized) of the service.
 - a. Exception: When the individual 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 individual 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. Individuals 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 individuals 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 individuals who receive assisted living SPED personal care services.

Service Activities, Authorized and Limits

1. The service tasks/activities within the scope of this service chapter are identified on the service authorization.

2. For SPED Personal Care unit rate, housework, laundry, communication, money management, shopping, and meal preparation are considered homemaker tasks and cannot be authorized as SPED personal care tasks.
3. For SPED Personal Care unit rate, Community Integration, Social Appropriateness, and Transportation are tasks which cannot be authorized.
4. SPED Daily Personal Cares live-in are limited to those tasks identified within this service chapter.
5. Qualified Service Provider (QSP) Service Agreement - Live In Paid Caregiver, SFN 1654, is required for live in care providers who are a relative or had a close personal relationship with the eligible individual prior to paid care being established.
6. For individuals who require two-person assist with SPED personal cares, approval is required from a HCBS Program Administrator.

Authorization

When an individual's live-in provider changes from a unit rate service to daily rate service, the case manager ends the unit-rate service the last day of the month and authorizes the daily rate service the first day of the next month.

- Example: an individual's provider is authorized for T1019 but becomes approved for T1020. The case manager ends T1019 the last day of the month and starts T1020 the first day of the next month.

When an individual's live-in provider changes from one daily rate service to another daily rate service, the case manager ends the first service the last day of the month and authorizes the new service the first day of the next month.

- Example: An individual's provider is authorized for SPED T1020 but the individual becomes eligible for Medicaid and is approved for MSP T1020. The case manager ends SPED T1020 the last day of the month and starts MSP T1020 the first day of the next month.

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See [Paid Family or Household Members/Qualified Service Provider \(QSP\) Service Agreement - Live in Paid Caregivers 525-05-45-50](#) for instructions on how the QSP Service Agreements are completed if one SPED T1020 provider has been pre-approved to provide daily live-in care to more than one individual.

Residential Habilitation 525-05-30-50
(Revised 02/01/2025 ML# 3899)

[View Archives](#)

Definition

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

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

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

Purpose

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

Service Eligibility

The individual receiving Residential Habilitation will meet the following criteria:

Must be eligible for Medicaid Waiver for Home and Community Services.

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

Service Tasks/Activities

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

Individual program Plan (IPP) Development, Coordination, Implementation and Evaluation.

Complete tasks such as individual plan development, monitoring the plan and observing to assure that the agency staff are trained, and the program is implemented, assisting with the development of behavior support techniques, assuring appropriate permission and approval is received from the individual and/or the legal decision maker.

Professional services are included in the "care coordination" hours and are not to be included in determination of direct support service hours.

Care coordination functions provided by the QSP agency include:

Management of an individual's property and resources including household budgeting, money management, communicating with creditors and landlords, etc.,
Application for generic services, monitoring status of those services, and maintaining communication with families, guardians, and other involved persons and agencies,
Coordinating medical needs,
Designing and implementing programs to enhance self-direction, independent living skills, community integration, social, recreational, and leisure skills and opportunities, and behavior management,
Facilitating the IPP planning process,
Assessing effectiveness of personal independence development strategies and other support services through analysis of information, consultation

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with the individual and/or guardian and family members, and
observation of the person's programs and service settings,
Asserting and safeguarding the individual's human and civil rights, and
Attending to psychosocial needs of the individual.

Hours for direct staff time for personal supports include:

General supervision for safety and health monitoring and maintenance,
Homemaking which may include home maintenance,
Assistance with activities of daily living and instrumental activities of daily
living

- bathing
- communication
- dressing/undress
- eyecare
- feeding/eating
- hairecare/shaving
- housework
- incontinence
- laundry
- meal preparation
- mobility (inside/outside)
- Money Management
- nailcare (fingernails)
- shopping
- skincare
- teeth/mouth care
- toileting
- transferring/turning/positioning

Global Endorsements tasks

- exercises
- hoyer lift/mechanized bath chairs
- indwelling catheter
- medical gases
- prothesis, orthotics
- suppository, bowel program
- TED socks
- vitals

Client specific endorsements

- apnea monitor
- JOBST stockings
- ostomy care
- postural/bronchial drainage
- RIK bed care

Medication administration

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

The QSP agency must have a training protocol and policy established for the administration of all medications, including PRN medications. The registered nurse is responsible for the training and oversight of all medication administration.

The licensed registered nurse employed by the QSP agency may perform medication set-up.

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

Accompanying individual to medical appointments.

Hours for direct staff time for personal independence development:

Development of natural supports,

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

Authorization for Services

The service tasks/activities within the scope of this service chapter must be identified in the assessment and on the Authorization to Provide Service.

An IPP as outlined in the Residential Habilitations provider standards, must be developed by the authorized QSP agency and maintained in the individual's file. An IPP is an individualized plan that describes the goals, wants, needs, and strengths of the person. It describes in detail how the QSP agency is supporting the individual.

Service task and activities must be tied to an individual's goals as determined through the person-centered planning process.

The IPP must correlate with the person-centered plan and service authorization that is completed by the HCBS Case Manager.

The IPP must be developed by the QSP Agency Program Coordinator within the first 30 days of service provision and forwarded to the case manager and every 6 months thereafter.

The IPP must also be reviewed and approved by the state program administrator.

The IPP must include:

- A plan for promotion of the individual's independence in ADLs and IADLs, social, behavioral, and adaptive skills,

- Tasks being provided which should match the authorization provided by the HCBS case manager,

- A medication list if medication administration is authorized and description of how medications are being managed;

- Medical diagnoses;

- A therapeutic goal for community integration activities which would include companionship and socialization activities.

- The individual should be involved in goal setting and ideas for these activities;

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Temporary absences and requests for retainer payments.
Including any requests for retainer payments and dates of absences submitted to HCBS Program Administration for retainer payment authorization.

Note: Retainer payments cannot exceed 30 days per calendar year.

Signature of the agency care coordinator and date.

Allowable Service Combinations

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

Limits

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

This service shall not be used solely for the purpose of supervision or emergency assistance on a 24-hour basis.

Supervision may not be authorized in excess of what is necessary for health and safety.

For example, the family is requesting that someone stay with their relative 24 hours per day when there is not a safety or health risk other than the possibility that something might happen. Supervision may not be used to restrict an individual from alcohol or substance use.

Twenty-four hour supervision in a shared living environment- Continuous supervision by paid staff on a one to one basis is not available unless shared staffing arrangements would create a safety threat to the individual or others. This level of service may only be provided as a last resort. All possible strategies for shared or reduced levels of supervision must be ruled out first.

A safety threat means the individual is so aggressive, self-destructive, or requires such close supervision that any attempt to share one-on-one staff at any time will place the individual at immediate risk.

Shared tasks will be considered in the shared living environment, and may affect the daily rate for these services (e.g. housekeeping of common areas, shared meals preparation, and overnight supervision).

This service does not include payment for non-medical transportation costs.

Payment for Residential Habilitation does not include room and board, or the cost of facility maintenance and upkeep.

Rate for this service and any additional waiver services cannot exceed the current highest daily rate for skilled nursing facility care.

Access of services or goods outside of the local area if the same service and goods are available in their local community.

For example, a grocery store is available in the local community, but the consumer wants to drive to a larger community because they prefer that location, even though the product and cost is the same at both locations.

Travel and direct support outside of the individual's community of residence for vacations, family events and socialization unless approval from an HCBS Program Administrator is received.

Direct support time is not available for any time which coincides with the recipients using adult day or other authorized services.

A personal assistance retainer payment is allowed for reimbursement during a participant's temporary absence from the setting. The personal assistance retainer allows for continued payment while a participant is hospitalized (acute hospital stay) or otherwise away from the setting in order to ensure stability and continuity of staffing up to thirty calendar days per year per participant.

Absences do not include absences due to the individual receiving care in a skilled nursing facility (SNF) or Swingbed facility.

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

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

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

Providers

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

- Legal spouse or parent of a minor child.

Standards for Providers

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

Residential Habilitation providers must be:

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

- Provider must ensure that staff are adequately trained and qualified as evidenced by:

- Written job descriptions for employees that include plans for participation in training and include requirements for education, experience, and skills,

- Documentation of competency or employed by a Licensed DD provider according to NDAC 75-04-01,

- Department approved training on Traumatic Brain Injury (TBI) and dementia,

- In-service training to direct contact staff by the program coordinator on implementation of individual's programs and observation of implementation in the service setting.

- To assure staff meet minimum training requirements, TBI and dementia training must be completed within 30 days of providing care to an individual under residential habilitation.

Staff must complete TBI and dementia training every 2 years.

Completion of Minot State University medication modules, testing and practicum. Written test is proctored and completed in person. Practicum is administered by a licensed registered nurse employed or contracted through the Agency Provider.

Staff must complete department-approved training on the administration of routine medications before administering routine medications. This includes cueing/reminding the individual to take medication.

Staff must demonstrate continued competency in medication administration by completing medication practicum with agency RN once yearly and as needed. Staff must complete the practicum checklist specific to the type of medication administration they will be completing (example: if administering an enema, staff must complete the practicum checklist for the administration of an enema prior to administration and yearly).

Agency must name a Program coordinator. Program coordinator requirements:

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

A doctor of medicine osteopathy,
a registered nurse, or
an individual who holds at least a bachelor's degree and who is licensed, certified, or registered as applicable, to provide professional services by the State in which he or she practices (e.g. social worker, occupational therapist, psychologist, physical therapist, etc.). An individual with a "bachelor's degree in a human service field" means an individual who has received: at least a bachelor's degree from a

college or university (master and doctorate degree are also acceptable) and has received academic credit for a major or minor coursework concentration in a human service field (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology).

Other:

Individuals who have a bachelor's degree; and
Completes the department approved TBI and
Dementia training; and
Has one year experience working with
individuals with a physical disability.

Ensures quality programs/services for the people supported
in the employing agency.

Responsible for development of the IPP.

Council on Quality & Leadership (CQL) Accreditation

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

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

Residential Habilitation Service cannot be provided by spouses,
Residential Habilitation providers or staff cannot live with the care
recipient.

Payment may be made to a legal guardian or family member by the
provider agency if the recipient chooses the legal guardian or family
member as their provider.

The legal guardian or family member must meet all the required
qualifications of a Residential Habilitation Service staff member.

If the legally responsible person wants to provide services as an
employee of the provider and has decision making authority over the
recipient, the case manager must pre-approve the arrangement with
the HCBS Program Administrator for Residential Habilitation.

The case manager is responsible to forward a copy of the narrative that explains why the legally responsible person providing the services is in the best interest of the client to the State Medicaid Agency.

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

Involuntary Discharge of an Individual under Residential Habilitation:

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

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

Settings where service can be provided:

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

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

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

Maximum Room and Board Rate effective 7-1-2024

The current maximum monthly room and board rate that providers may charge residential habilitation recipients is \$1005.00. The maximum room and board rate is equal to the current Medicaid medically needy income level for a one person household less a \$125 personal needs allowance. The rate is reviewed annually.

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

Respite Care Service 525-05-30-55**(Revised 05/01/23 ML #3730)**[View Archives](#)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 individual's home, or outside the individual's home in either a Respite Care Provider's 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. Individuals enrolled in a Hospice program are not eligible for institutional Respite Care but would be eligible for in-home intermittent Respite Care.
6. For an individual 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 individual to live independently, contact the HCBS Program Administrator for prior approval for Respite Care.
7. The individual needs a qualified caregiver, or it would be inappropriate to use an unqualified caregiver in the absence of the primary caregiver.

- a. 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 individual, contact the HCBS Program Administrator for prior approval.
- 10. An individual 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.

Service Location

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

- ✓ **The individual's home**
- ✓ **Respite Care provider's home**
- Other community service settings

Information Provided to the Respite Care QSP:

Case Management documentation should verify that the individual 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 individual's daily routine. This may include strengths and weaknesses of the individual, what the individual 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 Service.

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 <https://www.hhs.nd.gov/sites/www/files/documents/2023-swing-bed-fee-schedule.pdf> 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 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 individual 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 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 individuals receiving and living in the same Family Home Care setting.
7. If multiple individuals live in the same home and have the same primary caregiver, the respite cap must be divided by the number of individuals in the home.
8. The department may grant approval to exceed the service cap if the individual 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.

Providers

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

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

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

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 individual 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 individuals receiving Respite Care 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 case manager and/or representative of the Department.

3. Records: The facility shall maintain such individual 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 individuals 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 an individual who is a current Adult foster Care recipient receives overnight care in another licensed foster care home, the rate for that individual 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 case manager 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 case manager 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.

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3. The case manager shall maintain records of the evaluation, the decision, and the reason for that decision.

Specialized Equipment and Supplies 525-05-30-60**(Revised 04/01/222 ML #3685)**[View Archives](#)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 an individual, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to an individual in the customary environment of an individual;
2. Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for an individual;
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 an individual; 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 an individual.

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 and Assistive Technology Professionals (ATP), etc.). 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.
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>.
9. 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).

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
6. Generic technical devices (tablets, computers, etc) are allowed when they are needed for the functionality of other assistive technology such as smart home devices.

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.

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2. The supplier will ship/mail the item only upon receipt of the preauth or preliminary authorization, [SFN 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 Person Centered Plan of Care if no further need exists for the reimbursable items of this service chapter.

Supervision 525-05-30-63

(Revised 03/01/2024 ML #3829)

[View Archives](#)

Purpose

Supervision may be provided to assist eligible individuals remain in their home and community.

Up to 24 hours of supervision may be provided to individuals who, because of their disability, need monitoring to assure their continued health and safety. Recipients must have a need for supervision as described in this chapter.

Service Description

An individual could be considered to have a need for supervision if, because of their impairment, they have delusions, hallucinations, severe depression, emotionally labile (severe mood swings) and or other behaviors like screaming, hitting, kicking, biting, wandering, hyperactivity, aggression, inappropriateness, elopement (running away), or frequent falls that may require human intervention to safeguard the individual from harm. (The list of behaviors/needs is not an all-inclusive list).

- Payment for supervision cannot be claimed while ADL & IADL supports or homemaker task are being provided. Those tasks would be billed under personal care or homemaker.

Service Eligibility, Criteria for

The individual receiving supervision will meet the following criteria:

1. Must be eligible for the HCBS Medicaid waiver program;
2. Be at least age 18;
3. The care needs of the individual must fall within the scope of supervision as described in this service chapter.
4. If an individual requires supervision 24 hours per day, the case manager must justify in the individual narrative/case note why the individual needs the support of awake staff to assure health and safety needs are met at night. Providers, who provide supervision at

night while the individual is sleeping must stay awake while providing supervision.

Service Location

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

✓ **The individual's home**

- ☐ Workplace
- ☐ Other community service settings

Service Tasks/Activities

Allowable supervision tasks include: Having the knowledge of, and account for, the activity and whereabouts of the individual at all times to allow immediate provider intervention as necessary to safeguard the individual from harm. During the time that the provider is supervising the individual and is not actively providing personal care or homemaker tasks etc., they may play games, visit, read, and participate in activities with the individual. If the individual is physically able, they may also participate in activities on or around the individual's home such as gardening, or going for short walks etc.

The following tasks are not considered allowable tasks under this chapter because they would be provided under SPED personal care, Medicaid State Plan personal care, waiver personal care, or homemaker:

Bathing, dress/undress, eye care, feeding/eating, hair/care/shaving, incontinence, mobility, nail (finger) care, skin care, teeth/mouth care, toileting, transferring/turning/ positioning. The global endorsements of exercise, hoist lift/mechanized bath chair, indwelling catheter, medical gases, prosthetic, orthotics, suppository, bowel program, TED socks, Temp/BP/pulse/respiration rate. The client specific endorsements of apnea monitor, jobst stockings, ostomy care, postural /bronchial drainage, rice bed care. Communication, housework, laundry, meal preparation money management, and shopping are not allowable service tasks under this service. Medication assistance is not an allowable task under this service.

Supervision outside of the individual's home

Payment cannot be made for time performing authorized supervision tasks outside of the individual's home/grounds.

1. Exception: When the individual is required to seek essential services i.e. medical care etc. outside of North Dakota, contact the HCBS Program Administrator for approval.
 - If an individual receiving supervision needs transportation to an essential community service, non-medical transportation with escort may be authorized.

Cognitively Impaired Individuals, Services to

For cognitively impaired individuals who are receiving less than 24 hours of care, the care plan must identify how the daily care needs are being met (including supervision) during the time no provider is in the home. During those periods of time when supervision or other services are not being provided, cooperative and coordinated efforts of meeting the needs of the individual by the family, other informal providers, must be identified.

Service Activities, Authorized and Limits

1. Under Supervision, Community Integration, Social Appropriateness, and Transportation are tasks which cannot be authorized under this chapter. If an individual needs these tasks they must be authorized under Transitional Living, Residential Habilitation, or Community Support Services.
2. Supervision can be combined with adult day care, chore, community transition services, environmental modification, extended personal care, homemaker, home delivered meals, non-medical transportation, non-medical transportation w/escort, unit-based personal care, respite care, transitional living, specialized equipment, and supported employment.
3. Supervision cannot be combined with emergency response system, adult foster care, residential services, and family personal care.
4. For unusual or unique circumstances, approval from the HCBS Program Administrator must be obtained.

Authorizing Service

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1. The service tasks/activities within the scope of this service chapter must be identified on the Authorization to Provide Service.
2. The amount of units allocated for supervision of the individual is determined by subtracting the amount of time the individual is receiving informal supports and authorized services i.e. personal care, homemaker etc. from a 24 hour period.

Example: If an individual requiring 24/7 supports receives 4 hours of informal supports and 6 hours per day of personal care, they would be eligible for 14 hours of supervision.

3. The supervision provider may also be the personal care, homemaker provider etc. However, there must be more than one QSP identified on the care plan as it is not reasonable to allow one provider to be responsible for 24 hours of care per day.

Standards for Providers

Supervision providers must meet the same standards as respite providers that includes having the global endorsement for cognitive/supervision.

Providers

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

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

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

Supported Employment Services 525-05-30-65

(Revised 5/1/19 ML #3551)

[View Archives](#)

Purpose

Paid employment opportunities for persons for whom competitive employment at or above the minimum wage is unlikely without support, and who, because of their disabilities, need the provision of intensive, ongoing support to perform in a work setting with necessary adaptations, supervision, and training appropriate to the person's disability.

Service Eligibility, Criteria for

The individual receiving Supported Employment Services will meet the following criteria:

1. Must be eligible for Medicaid Waiver for Home and Community Services;
2. Must have completed the Vocational Rehabilitation program of Supported Employment for training and stabilization;
3. Must need the provision of intensive, ongoing support to perform in a work setting with necessary adaptations, supervision, and training appropriate to the person's disability;
4. Documentation from Vocational Rehabilitation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.);
5. Service is not otherwise available through the Vocational Rehabilitation program to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and furnished as part of expanded habilitation services; and
6. Must be provided in a competitive employment setting i.e. local businesses, retail establishments, restaurants etc. Services cannot be provided in group homes, training centers or any setting that isolates individuals from the community.

Limitations

Pre-vocational activities are provided through TBI residential or transitional living as a component of promoting independent living skills and social appropriateness. This service would not include supervised or training activities provided in a typical business setting. Nor does it include prevocational skills development.

- Pre-vocational services are delivered for the purpose of furthering habilitation goals that will lead to greater opportunities for competitive and integrated employment and career advancement at or above minimum wage.

Supported employment individual employment supports do not include volunteer work. Such volunteer learning and training activities that prepare a person for entry into the paid workforce are addressed through pre-vocational services.

Employment job site is at a work site in which persons without disabilities are employed, payment will only be made for the adaptations, supervision, and training required by the client as a result of their disability and will not include supervisory activities rendered as a normal part of the business setting.

Service Tasks

1. Supported Employment Activities are individualized and may include any combination of the following services:
 1. Person-centered employment planning;
 2. Job placement;
 3. Job development;
 4. Negotiation with prospective employers;
 5. Job analysis;
 6. Job carving;
 7. Training and systematic instruction;
 8. Job coaching;
 9. Benefits and work-incentives planning and management;
 10. Transportation;
 11. Asset development; and

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12. Career advancement services.
2. Transportation between the client's place of residence and the work site are included in the service provider rate.

Transitional Living 525-05-30-70

(Revised 11/1/21 ML #3640)

[View Archives](#)

Purpose

A program which provides training for the eligible individual 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. The individual must benefit from receiving Transitional Care Living, and it is cost-effective and necessary to avoid institutionalization;
4. The individual must require supervision, training, or assistance with self-care, communication skills, socialization, sensory/motor development, reduction/elimination of maladaptive behavior, community living and mobility;
5. The individual must be disabled as determined by Social Security Disability criteria; and
6. The individual is capable of directing own care as determined by the interdisciplinary ICP team or have a (legally) responsible party to act on their behalf.

Service Location

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

✓**The individual's residence**

✓**Workplace**

✓**Other community service settings**

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.

Service Combinations

1. Non-Medical Transportation Driver w/Vehicle may be combined with Transitional Living Service.
2. Non-Medical Transportation Escort Service is part of Transitional Living and therefore would not be authorized.
3. Respite care may be combined with Transitional Living Service.
4. Adult Day Care may be combined with transitional living.
5. Homemaker, adult foster care, adult residential care and family personal care cannot be authorized with transitional living services.

Providers

Transitional Living may **NOT** be provided by the following employees of a QSP agency (**checked if allowable**):

- Guardian
- Legally Responsible Person - Legal spouse or parent of a minor child.
- Relative within the definition of Family Home Care under subsection 4 of N.D.C.C. 50-06.2-02.

Individual Program Plans

Once an individual begins Transitional Living, 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 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 individual, AND the plan for the promotion of the individual'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.

Waiver Personal Care 525-05-30-75**Revised 12/01/2024 ML #3885)**[View Archives](#)**Purpose**

The purpose of Waiver Personal Care (WPC) is to provide a range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a physical disability.

Service Description

Waiver Personal Care assistance may take the form of hands-on assistance (actually performing a task for the person), cuing to prompt the participant to perform a task or being at the ready to assist with the tasks due to the individuals intermittent need for personal care and supervision. Such assistance may include assistance in performing ADLs (bathing, dressing, toileting, transferring, maintaining continence) and IADLs (more complex life activities, i.e., light housework, laundry, meal preparation, grocery shopping, using the telephone, medication, and money management). Such assistance also may include the supervision of participants as provided in the service plan.

Service Eligibility, Criteria for

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

1. Must be eligible for Medicaid Waiver for Home and Community-Based Services.
2. Requires on-going daily support with the combination of personal care and supervision as defined under waiver services of Waiver Personal Care and Supervision.
3. The individual must be capable of directing their own care or has a legally responsible party to act on the recipient's behalf.

Service Tasks/Activities

The care needs of the individual 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 individual must have the ADLs and IADLs needs performed for him/her OR an individual with cognitive impairment may be able to complete the activity ONLY with supervision, guidance, or prompting.

1. Personal Care tasks that may be included in Waiver Personal Care are as follows: bathing, communication, dressing/undressing, eye care, feeding/eating, hair care/shaving, housework, incontinence, laundry, meal preparation, medication assistance, mobility, money management, fingernail care, shopping, skin care, teeth/mouth care, toileting, transferring/turning/positioning, cog/supervision, exercises, hoier lift/mechanized bath chairs, indwelling catheter, medical gases, prosthesis/orthotics, suppository/bowel program, TED socks, temp/bp/pulse/respiration rate, apnea monitor, jobst stockings, ostomy care, postural/bronchial drainage, and RIK bed care. The identified tasks for the individual are listed on the service authorization.
2. The task of supervision is allowed between other personal care tasks, if the individual requires supervision/oversight due to physical or cognitive impairment, or to be at the ready to provide personal care services when personal cares are required intermittently throughout the day.

Supervision means having the knowledge of, and account for, the activity and whereabouts of the recipient at all times to allow immediate provider intervention as necessary to safeguard the individual from harm.

Supervision includes the provider being immediately available to furnish assistance and direction throughout the performance of and/or at the ready to perform the next personal care task (i.e. bathing, toileting, transferring, locomotion etc.) that is necessary to meet the intermittent personal care need of the participant.

3. Homemaker (laundry, shopping, and housekeeping) tasks are to be included in the service of WPC.
 - The service of waiver personal care is not intended to be used primarily for environmental tasks. The individual must have a daily personal care and/or supervision need to qualify for this service.

Waiver Personal Care (WPC) may be provided on an episodic or on a continuing basis.

WPC is an all-inclusive service that combines personal care services, intermittent personal care, supervision, homemaker and limited to the amount of time that care is provided to the eligible individual while moving from task to task or completing tasks simultaneously within the authorized amount of time.

Example 1: If the provider is providing supervision, PCS at the ready, hands-on PCS, meal preparation and homemaker.

- Such as, a provider may be providing supervision and preparing a meal at the same time then move to assisting with PCS and then completing homemaker tasks. The all-inclusive nature of WPC allows for all the tasks to be completed while the provider is clocked in under the one service of waiver personal care.

Example 2: If the individual requires assistance with personal care, supervision, meal prep, and homemaker all in one day/shift, the provider can provide all of these tasks while remaining clocked in under the service of Waiver Personal Care.

- Such as, an individual requires staff to be in the home and at the ready for PCS tasks and there are homemaker tasks or a meal that needs to be prepared. It is allowable for the QSP to provide the services simultaneously, and does not require units for each task to be authorized independently, however the task itself must be authorized under the service plan and authorization.

Waiver Personal Care Daily Live-in Providers

Live-in waiver personal care (daily) is all inclusive of personal care, supervision and homemaker services.

Waiver Personal Care Daily live-in must be authorized if the non-family provider and the individual live in the same residence and personal care and supervision is needed on a daily basis.

1. If personal care/supervision is not needed on a daily basis, Waiver Personal Care Daily live-in should not be authorized.
2. If there are multiple waiver personal care providers necessary to meet the individual's need, it is allowable for unit-based waiver personal care to be authorized instead of waiver personal care daily.

Qualified Service Provider (QSP) Service Agreement - Live In Paid Caregiver, SFN 1654, is required for all live in WPC Daily Personal Care Providers.

Exception: When a live-in relative meeting the definition of a "family member" or a live-in provider who has a close personal relationship with the individual would like to be hired under an agency to provide Waiver Personal Care Unit Rate, consult with program administration for consideration.

Limits/Service Combinations

1. To avoid duplication, waiver personal care recipients are not eligible for adult residential care, adult foster care, residential habilitation, and community support services.
2. Waiver Personal care differs from adult foster care in that personal care is provided in the individual's home, and adult foster care is provided in the service provider's home. If a non-relative is caring for the individual on a 24-hr live in basis in the provider's home, the service must be Adult Foster Care. It cannot be Waiver Personal Care service.
3. Waiver personal care differs from respite care in that respite care is provided to relieve the primary, live-in caregiver, whereas the primary purpose of waiver personal care is to provide the care an individual needs and not to relieve the caregiver.
4. Homemaker (Laundry, shopping, and housekeeping) tasks when provided as a waiver personal care service limited set by the department, and the cap cannot be exceeded under other waiver services.
5. The number of reimbursable hours of care for an Individual Qualified Service Provider (QSP) of this service cannot exceed 12 hours per day.
6. The state assures WPC being provided to the participant are not duplicative of extended personal care as WPC does not include hands-on care of a medical nature that is specific to the needs of an eligible individual that is provided under extended personal care. The state ensures non-duplication with extended personal care through thorough assessment and monitoring of participant services through person centered planning.
7. Personal care under the waiver differs in scope, nature, supervision arrangements, and/or provider type (including provider training and

qualifications) from personal care services in the state plan. Waiver Personal Care differs in scope and nature from the personal care offered under the State Plan as supervision may be provided under WPC. A participant cannot be authorized to receive both services at the same time.

8. When WPC is provided by a non-agency provider, participants are responsible for overseeing and supervising individual providers on an ongoing basis. Additionally, the case manager performs monitoring of a participant's person-centered plan with the participant. This monitoring includes monitoring of the use or non-use of waiver services. At a minimum, this monitoring occurs on a quarterly basis.
9. The individual or legally responsible person must direct the care provided and should be involved in training and monitoring the WPC QSP as much as possible and when appropriate.
10. Personal care services that can be covered under the state plan should be furnished to waiver participants under the age of 21 as services required under Early and Periodic Screening, Diagnostic and Treatment (EPSDT). If an individual under age 21 is seeking waiver services, the case must be staffed with program administration.

Service Location

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

ü The individual's home

ü Workplace

ü Other community service settings

Waiver Personal Care is furnished both inside and outside the participant's home and community. WPC may be provided outside the participants home when the participant is needing personal cares while outside of their home.

Example: If the individual needs personal care assistance hands on or at the ready to provide services outside of the home to meet their needs. It is allowable under WPC. WPC cannot be used in lieu of Companionship (to include community integration and socialization), Extended Personal Care or Non-medical Transportation-Escort.

Personal care may be furnished in order to assist a person to function in the workplace or as an adjunct to the provision of employment services.

Providers

Waiver Personal Care Daily Rate may be provided by (checked if allowable):

ü Legally Responsible Person

- **Relative**

ü Legal Guardian

Waiver Personal Care Unit Rate may be provided by (checked if allowable):

ü Legally Responsible Person

ü Relative (Live-in relatives meeting the definition of family member under subsection 4 of N.D.C.C. 50-06.2-02 are not eligible to provide this service. See "Standards for Waiver Personal Care Providers" for explanation and exceptions)

ü Legal Guardian

Standards for Waiver Personal Care Providers

All providers of waiver services must be enrolled Qualified Service Provider N.D.A.C. 75-03.23-07.

Qualified Service Provider (QSP) Service Agreement - Live In Paid Caregiver, SFN 1654, is required for all live in Waiver Personal Care Daily Providers.

When WPC is provided by a non-agency provider, participants are responsible for overseeing and supervising individual providers on an ongoing basis. Additionally, the case manager performs monitoring of a participant's person-centered plan with the participant. This monitoring includes monitoring of the use or non-use of waiver services. At a minimum, this monitoring occurs on a quarterly basis.

WPC Daily Rate Providers must:

1. Be live in caregivers of Medicaid Waiver eligible individuals who provide daily personal care (including being at the ready to provide intermittent personal cares and/or supervision.)
2. Have a close personal relationship with eligible individuals.
3. If more than one live in QSP is an authorized provider, do not use a daily rate. The services should remain as WPC unit rate.
4. Complete a Qualified Service Provider (QSP) Service Agreement - Live In Paid Caregiver, SFN 1654.

Live-in Paid Caregivers

-

Live-in relatives meeting the definition of family member under subsection 4 of N.D.C.C. 50-06.2-02 are not eligible to provide Waiver Personal Care service. This service is provided under Family Personal Care.

Exceptions:

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.

Examples of exceptions may include:

- Consideration may be given if the live-in family member does not qualify for Family Personal Care because they are providing less than 3 hours of care per day.
- If an outside provider is the primary caregiver and the live-in-family member provides supplemental cares only, the live in family member provider may be eligible to receive WPC unit rate services limited to the cap for live-in family providers with prior approval of Program Administration.
 - If program administration approves the live-in family member for WPC unit rate service, the number of reimbursable hours of care cannot exceed 10 hours per day. The live-in family member provider may provide more care than 10 hours, but the State is not obligated to pay because that care is being provided because

of their close personal relationship and that they share a household with the eligible individual.

Contact the HCBS Program Administration to request an exception or reasonable modification to meet the individual need if the individual is at risk of institutional placement.

See [Paid Family or Household Members/Qualified Service Provider \(QSP\) Service Agreement - Live in Paid Caregivers 525-05-45-50](#) for instructions on how the QSP Service Agreements are completed if one Waiver Personal Care provider has been pre-approved to provide daily live-in care to more than one individual.

Authorization

When an individual's live-in provider changes from a unit rate service to daily rate service, the case manager ends the unit-rate service the last day of the month and authorizes the daily rate service the first day of the next month.

- Example: an individual's provider is authorized for T1019 and Supervision but becomes approved for Waiver Personal Care Daily. The case manager ends T1019 and Supervision the last day of the month and starts Waiver Personal Care Daily the first day of the next month.

When an individual's live-in provider changes from one daily rate services to another daily rate service, the case manager ends the first service the last day of the month and authorizes the new service the first day of the next month.

- Example: An individual's provider is authorized for T1020 but becomes approved for Waiver Personal Care Daily. The case manager ends T1020 the last day of the month and starts Waiver Personal Care Daily the first day of the next month.

See Standards for Qualified Service Providers 525-05-45

**Maximum Monthly Amount - Aggregate and Per Service
525-05-35****(Revised 02/01/2025 ML #3899)**[View Archives](#)

The maximum amount allowable under the Medicaid Waiver for Home and Community Based Services per Medicaid waiver recipient and per month is an aggregate of the cost and is limited to the highest monthly rate allowed to a nursing facility within the rate setting structure of the Department of Human Services.

See link below:

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

The maximum amount allowable under the SPED and ExSPED Programs per individual and per month is an aggregate of \$4029 for all services excluding Adult Foster Care. If an individual is receiving Adult Foster Care under SPED or ExSPED, the maximum amount allowable is \$6,796.

Homemaker Service	70 units
Respite Care	\$1247 (Daily amount not to exceed daily swing bed rate). Refer to link: https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/swing-bed-fee-schedule.pdf
Respite Care in Homes with Multiple Residents	\$1247 split by the total number of public and private pay residents in the home.

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	Plus \$224.94 per month for each additional (2nd 3rd or 4th) public pay residents in the home, the total amount will need to be divided between the public pay residents. For Example: An AFC provider has a total of 3 residents, 2 are public pay & 1 is private pay. To calculate respite for the public pay residents you should divide the current respite cap (\$1247) by the total number of public & private pay residents living in the home (3) that equals \$415.67 for each resident or \$831.34 for the 2 public pay residents combined. Now add \$224.94 for the 2nd public pay resident that equals \$1,056.28. Now divide that amount between the 2 public pay residents $\\$1,056.28/2 = \\$528.14$. The final step is to allocate \$528.14 on each of the public pay resident's care plan.
Adult Foster Care	\$154.50 flat rate per day
Family Home Care	\$74.68 flat rate per day
Family Personal Care	\$159.54 flat rate per day
Daily Rate for SPED Personal	\$87.76 flat rate per day

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Care	
SPED Personal Care Assisted Living	\$87.76 per day

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

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

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

Service Maximums Per Individual Per Month for Dates of Service.

Extraordinary Costs/Exceed Monthly Aggregate or Service Maximum

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

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

Name, county of residence, and ID number of the individual.

Reason for the request: the individual's circumstances that necessitate the short duration extraordinary costs AND what options were explored as alternatives to meeting individual's need.

The additional dollar amount request, for what funding source, service(s), and for what period of time.

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

Maximum Room and Board Rate effective 7/1/2024

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

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

Rural Differential Rates 525-05-38

(Revised 02/01/2025 ML #3899)

[View Archives](#)

Purpose

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

Standards for Providers

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

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

If the QSP or agency employee resides in another State, the Department will accept another form of address verification i.e. current utility bill etc. If out of state residents submit other forms of identification the decision to accept it for purposes of being eligible to receive the RD rate will be made on a case by case basis.

Service Activities, Authorized

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

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

Rural Differential Rates may not be authorized retroactively from the date the individual requests the RD rate for the provider.

The effective date of the updated authorization will be the date the authorization is entered into the EVV System.

Service Eligibility, Criteria for

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

Individual must be eligible for one of the following services: Medicaid Waiver, Service Payments to the Elderly & Physically Disable (SPED), Expanded Service Payments to the Elderly & Disabled (EX-SPED), Medicaid State Plan personal Care (MSP-PC). For MSP-PC please see Personal Care Services 535-05-40.

Individual must reside outside the city limits of Fargo, Bismarck, Grand Forks, Minot, West Fargo, Mandan, Dickinson, Jamestown, and Williston.

Situations where there is a discrepancy in what is considered city limits must be prior approved by the Rural Differential Coordinator. The HCBS Case Manager must send a written request for verification to the HCBS Program Administer responsible for program oversight.

Exception may be requested to allow a QSP in a rural area to receive a rural differential rate when providing services in the

city limits of Minot, West Fargo, Mandan, Dickinson, Jamestown, and Williston if the following criteria are met.

The individual has at least two ADL impairments and will need at least 100 units of service or supervision needs met to assure health and safety.

The HCBS case manager has reached out to a minimum of three QSPs in the local area who are unable or unwilling to serve the individual. The HCBS CM must outline the efforts made to find a local QSP. Include the name of the three providers and the date the providers were contacted in the case narrative with a brief description of the reason for the denial.

QSP cannot be a family member.

Case Managers must request prior approval from RD Program Administrator.

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

If a referral has been made to the QSP Navigator, and the Navigator sends the CM the name of an agency where RD will be utilized, the CM only needs to send the request to the Program Administrator and include that the Navigators have already followed RD protocol and they do not need to send the detail outlined above to the Program Administrator.

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

Service Delivery

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

Home base is either the individual QSPs physical address, or the Agencies home office, satellite office, or employees physical address (if they are not required to report to the home office each day) whichever is closer. If an agency employee is not required to report to the home office each day and they live 21 or more miles (round trip) from the individual's home, the RD rate may be used. If the employee lives less than 21 miles (round trip) from the individual's home, the RD may not be used. Rural differential rates are based on the distance it takes to travel to each individual's home even if the QSPs serve more than one recipient in the community or in the same home.

If the QSP travels to the individual's home and remains in that community overnight or for a period of days, they are not eligible to claim the RD rate for those dates of service. The RD rate may only be claimed on the day the QSP travels to and from the individual's home.

For example, if a QSP travels more than 21 miles round trip to provide care to their Mother, and then stays with their Mother for a few days, the RD rate would only be claimed on the first and last days they provide the care. The QSP must use the standard QSP rate for the days they do not travel to and from their home base.

Addresses:

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

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

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

If the QSP's new address changes the tier the provider is eligible to bill, the case manager must update the tier and rate on the Rural Differential Unit Rate Authorization/Closure and develop a new authorization with the correct rate and provide it to the client and QSP.

If the QSP no longer qualifies for an RD rate, the Case Manager must complete and submit a Rural Differential Unit Rate Authorization/Closure in the web-based case management system.

Determining Distance:

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

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

Closures, Denials, Terminations, and Reductions of Services 525-05-40**(Revised 02/01/2025 ML #3899)**[View Archives](#)Closures/Terminations

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

If the individual has not received services because a provider has not been secured, and the individual is still eligible and wants to continue pursuing a provider, the case must remain open unless the individual requests, in writing, for the case to close. The case manager must make a quarterly contact with the individual. The case manager is required to continue attempts in securing a provider and work with the QSP Navigator to assist in this process. In doing so, they may need to staff the situation with Aging Services administrators and/or discuss strategies with the individual such as publishing an advertisement for service providers, etc.

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

The reason for delay or pause in services must be documented in the individual's file.

The case manager must document how the need is met while the identified service needs are pending.

The case manager must follow up monthly with the individual to provide support and assistance mitigating the issue causing the delay in service implementation.

If the services do not resume or start within 3 months, approval must be received from the Program Administrator to keep the case open OR the case manager must request a termination to close the case and submit an SFN 474 to Aging Services/HCBS.

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

Any time a Medicaid waiver recipient enters a skilled nursing facility (regardless of if the case remains open or is closed), an SFN 474 must be submitted to HCBS/Aging Services to close out the HCBS LOC screening even if the Medicaid waiver case is to remain open. This is for the purposes of billing, as overlapping screenings in MMIS can interfere with payment. It is acceptable for the Medicaid waiver LOC to close on the same day as the skilled nursing facility LOC opens.

Example: if an individual is admitted to a skilled nursing facility on 11/2, the Medicaid Waiver LOC can close 11/2. If a Medicaid waiver LOC is to close, but the case is to remain open, the case manager must indicate this on the SFN 474 by completing the Waiver LOC Screening Reopen-Closure Section. If/when Medicaid waiver services resume, an SFN 474 must be submitted to re-open the HCBS LOC screening unless a new HCBS LOC screening is due and completed by the case manager.

HCBS Case Managers must notify HCBS Program Administration of HCBS closures using the SFN 474, which is used for all HCBS programs other than Basic Care. The Notification is to be submitted to HCBS/Aging Services within 3 days of closing the case.

Reductions

Reduction in services may include reducing the number of units or reducing the tasks in a specific category. If services are reducing, the case manager must complete the Reduction Notice section of the

Person-Centered Plan of Care, indicating whether a reduction citation was issued to the individual, or whether the individual signed a statement requesting the reduction. A citation and 10-day notice is required unless the recipient is requesting the reduction and has signed a statement stating such. (The recipient agreeing with the reduction is not sufficient, as the reduction must stem from the recipient's request).

If a reduction citation is issued, the case manager completes the Reduction Notice section of the Person-Centered Plan of Care "in accordance with" citing ND Administrative Code and/or ND Century Code, and date the reduction is to be effective. The effective date of the reduction must be at least 10-days after the individual signs the Person-Centered Plan of Care that lists the reduction citation. Appeal rights are included in the Person-Centered Plan of Care.

If an individual chooses to reduce their service(s) and they indicate this request in writing, a citation from the HCBS Program Administrator is not required. The case manager completes the Reduction Notice section of the Person-Centered Plan of Care indicating that the individual requested the reduction, and a signed statement is saved on file. The reduction may become effective upon receipt of the individual's signed statement. Note that any reduction not requiring a citation must be at the individual's request and not a result of programmatic guidelines. While the individual has the right to reduce their services any time, they also have the right to a formal citation and 10-day notice outlying their appeal rights if the reduction is a result of programmatic guidelines.

Example 1: An individual prefers to have just two baths a week instead of the three that are authorized. They can sign a statement requesting the units for this task are reduced, and would then sign a new care plan reflecting that reduction. The case manager must keep the signed statement in the file. A 10-day notice is not required.

Example 2: During an assessment, it is determined that an individual now requires less time for the QSP to assist them in completing their maintenance exercises. This is evidenced by the physical therapist's

instructions outlining the required technique and frequency. The HCBS Case Manager must complete the Reduction Notice section of the Person-Centered Plan of Care, including the reduction citation and 10-day notice, as the reduction is based on programmatic guidelines.

10-day Notice Not Required

Either because the individual has taken action that results in the termination of services (i.e. an individual indicating, in writing, their desire to terminate services; moving out of the area, admitted to a nursing facility, etc.) or it is a change in benefits that is not appealable, a 10-day notice is not required and an HCBS Notice of Denial or Termination (SFN 1647) is not required. The HCBS Case Manager is required to inform the individual of the action taken to close their case. The notice may be a letter stating the effective date of the closure and the specific reason.

Note: If the case closure is due to death and the HCBS Case Manager has factual information confirming the individual's death, a letter is not required to be forwarded to the individual's estate. The source of the information should be documented in the case file.

Any of the reasons below do not require a 10-day notice:

HCBS Case Manager has factual information confirming the death of the individual.

The HCBS Case Manager has received in writing the individual's decision to terminate or reduce services.

Individual has been admitted to a basic care facility, nursing facility, or PACE.

Individual's whereabouts are unknown.

For specific time limited services (Examples such as: Chore Labor, Chore Snow Removal, ERS installation).

State or federal government initiates a mass change which uniformly and similarly affects all similarly situated applicants,

recipients, and households.

Determined the individual has moved from the state.

Denial/Termination Notice

The applicant/recipient must be informed in writing of the reason(s) for the denial or termination. The HCBS case manager completes the [SFN 1647](#), or if allowable, sends a letter with all applicable information to the applicant/recipient or their legal decision maker. The citation used to complete the SFN 1647 must be obtained from a HCBS Program Administrator.

Termination of a service is discontinuing the service. The individual must be informed in writing of the termination by the case manager providing them with a completed SFN 1647, or the individual may provide a written statement indicating they no longer want the service.

Denial of a service may include denying a service to a new applicant or current recipient denying the number of units a new applicant or current recipient requests. If a new applicant or current recipient requests a service, it is not sufficient for the case manager to simply inform them that it is not part of the service array or that it will not be approved. The case manager must contact the Program Administrator for a denial citation or make a formal request for an approval exception or reasonable accommodation.

When denying units or services the individual has requested, the individual must be informed in writing of the denial by providing them with a completed SFN 1647.

When a home visit is completed to assess an applicant for services, an application for service is implied by the individual, and a completed SFN 1647 must be provided informing the individual of the denial, or the individual can provide a written statement indicating they do not want the service. If a home visit is

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completed but an assessment wasn't completed, but information was shared, an SFN 1647 is not required.

When an individual contacts the HCBS Case Manager for general information about the service, the individual applicant must be made aware that a formal determination of eligibility for the service cannot be made without completing a home visit and assessment. The individual must be offered the option of an assessment.

After a formal assessment is completed, the individual must be informed in writing of the denial by providing them with a completed SFN 1647, or the individual may provide a written statement indicating they do not want the service.

The Notice of Denial or Termination is dated the date of mailing. Contact the HCBS Program Administrator to obtain the legal reference required at "as set forth . . ." The legal reference must be based on federal law, state law and/or administrative code; reliance on policy and procedures manual reference is not sufficient.

When an individual is no longer eligible for the HCBS funding, the HCBS Case Manager must terminate services under this funding source. Even if services continue under another funding source, the individual must be informed in writing of the reasons they are no longer eligible under this Service Chapter.

The individual must be notified in writing by completing a SFN 1647 at least 10 days (it may be more) prior to the date of terminating servicesUNLESS it is for one of the reasons stated in this section. The date entered on the line, the effective date field, 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.

The day the citation was issued is not included in the 10-day count. The effective date of the citation is included in the 10-day count. If the effective date of the citation falls on a Saturday, Sunday, or legal holiday, the effective date must be modified so that it is the following business day.

Example:

The citation is issued to the individual on 1/3/24.

The 10-day computation starts on 1/4/24 so the termination effective date would be set to 1/13/24, HOWEVER 1/13/24 falls on a Saturday.

The next business day is 1/15/24, HOWEVER, 1/15/24 falls on a legal holiday. Therefore, the termination effective date is 1/16/24.

The HCBS Case Manager may send a cover letter with the SFN 1647 identifying other public and/or private service providers or agencies that may be able to meet the denied/terminated applicant/recipient's needs.

Former SPED, ExSPED, or Medicaid waiver Recipients

SPED, ExSPED, or Medicaid waiver: if HCBS recipient closed due to admission to a skilled nursing facility or swing bed, and re-opens services within 3 months:

For Medicaid waiver, SPED, and Expanded SPED:

- A new Application for Service (SFN 1047) does not need to be completed.

For SPED:

- A new SPED financial assessment (SFN 820) does not need to be completed unless there has been a substantial financial change, or the individual is due for a required annual assessment.

For SPED or ExSPED:

- An SFN 1820 or SFN 56 does not need to be completed.
- An SFN 676 does need to be completed and submitted to HCBS/Aging Services. If all information is

the same, it is allowable to use the previously approved SFN 676 and simply indicate the date the individual is to re-open in the field "Date of Application" and select "Re-Open" in the "Application Type" field.

SPED or ExSPED: if HCBS recipient closed for any reason, and re-opens services within 60 days:

A former SPED or Expanded SPED Program recipient can be reinstated without going through the SPED or Expanded SPED Program Pool if services are re-established within 60 days from the date of closure. However, the HCBS Case Manager must determine that the former service recipient is still eligible and what the current service needs are.

If an individual will be re-opened for SPED or Ex-SPED, the HCBS Case Manager only needs to complete the Add New Record to MMIS Eligibility File – SPED & Ex-SPED (SFN 676) and submit to Aging Services/HCBS. Neither the SPED Program Pool Data (SFN 1820) nor the Ex-SPED Program Pool Data (SFN 56) need to be completed.

For the SPED and Ex-SPED programs, complete the SFN 676 and forward to the Aging Services/HCBS Program Administration. The MMIS form should indicate the date the individual returned to services in the field "Date of Application" and "Re-Open" should be selected in the "Application Type" field.

Medicaid Waiver Recipients

For the Medicaid Waiver programs, the case manager must include the date of closure of the level of care screening on the SFN 474. Case managers must submit a [SFN 474](#) to Aging Services/HCBS regardless of the reason for the closure i.e. death, going to a nursing home etc.

Submitting a "date of closure" is required in order for the department to have accurate data when submitting federal reports.

Reapplication after Denial or Termination of Services

If an individual requests to reapply for services following the denial or termination of services, the department may rely on the information that was obtained in the most recent assessment, if the individual cannot offer any additional or new information about potential eligibility.

The denial can be issued based on the data we had in the past assessment for up to 6 months following the termination or denial. If the individual applies again after 6 months, the department can no longer rely on the past assessment. A new comprehensive assessment would need to be completed to determine eligibility for services.

Critical Incident Reporting 525-05-42

(Revised 03/01/2023 ML #3706)

[View Archives](#)

[IM 5442](#)

Critical Incident

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 individual receiving HCBS.

In order to assure the necessary safeguards are in place to protect the health, safety, welfare of all individuals 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.

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 an individual and cause (including death by suicide);
7. Report of all medication errors, omissions, or missing medications; and
8. Any event that has the potential to jeopardize the individual's health, safety or security if left uncorrected.
9. Changes in health or behavior that may jeopardize continued services.
10. Illnesses or injuries that resulted from unsafe or unsanitary conditions.

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. 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 an individual, involved, witnessed, or responded to an event that is defined as a reportable incident, is required to report the critical incident.

NOTE: A General Event Report (GER) in the Therap case management system is the same as a Critical Incident Report (CIR) referenced in this policy.

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

1. Reported to the HCBS Case Manager and
2. A Critical Incident Report (CIR) must be completed and submitted using the General Event Report (GER) within Therap.
 - a. The completed CIR is to be submitted within 24 hours of learning or knowing of the incident. The HCBS Case Manager will receive notification of the incident report within Therap.
 - b. If the QSP does not have access to Therap, the GER offline forms will be completed and submitted to the HCBS case manager.
 - i. The offline forms can be accessed here: [Online Forms](#)
 - ii. The GER Event Report along with the GER Event Type form (e.g. medication error, injury, etc.) are to be completed and submitted together.
 - c. The HCBS Case Manager and program administrator will receive the incident report once submitted for review in Therap. If the

GER offline form is used, the HCBS Case Manager will fax the form to (701) 328-4875 or email: dhshcbs@nd.gov. The program administrator will then enter the GER Event Report and Event Type into Therap.

Examples

Example 1: If an individual falls while the QSP is in the room but the individual 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 an individual is in the hospital due to a stroke, a critical incident report is not required because the case manager was made aware of the ER visit and/or hospital admission.

Example 3: If a QSP comes to an individual's home and the individual is found on the floor and the QSP calls 911 so the individual may receive medical attention, a critical incident report is required because the individual required medical attention AND the QSP was notified and aware of the event.

Example 4: If a QSP is present while the individual is participating in illegal activity (e.g. drug use), a critical incident is required as the behavior is jeopardizing services.

Example 5: If the QSP finds bed bugs in the individual's bed and notices the individual has bug bites resulting in the need to seek medical attention, a critical incident would be required as this is an unsanitary condition resulting in illness or injury.

Department Responsibilities

Within 24 hours or 1 business day of receiving the report from the HCBS case manager, the department will submit a medical case incident report for incidents involving suspicious deaths and events that have the potential for litigation or legal involvement into the ND Risk Management Incident Reporting system.

The program administrator will also enter GER offline reports into Therap within 24 hours of receiving report or 1 business day.

The department will hold quarterly critical incident team meetings to review all critical incident reports for trends, need for increased training and education, additional services, and to ensure proper protocol has been followed. The team consists of the ND DHS Aging Services Division Director, HCBS program administrator(s), HCBS nurse administrators, Vulnerable Adult Protective Services (VAPS) staff, LTC Ombudsmen, and the DHS risk manager.

The Department of Justice (DOJ) agreement coordinator (Aging Services Division Director) is responsible to ensure that critical incidents as described in the settlement agreement to the DOJ and the subject matter expert (SME) within 7 calendar days of the receipt of the critical incident.

Remediation Plan

A remediation plan is required to be developed and implemented for each incident except for death by natural causes as required by the DOJ and the Aging Services Department. The department will be responsible to monitor and follow up as necessary to assure the remediation plan was implemented.

The remediation plan will include corrective actions taken, a plan of future corrective actions, and a timeline to complete the plan if applicable. The HCBS case manager and program administrator are responsible to follow up with the QSP to ensure the remediation plan is acceptable.

Home and Community Based Services

Division 15
Program 505

Service 525
Chapter 05

Standards for Qualified Service Provider(s) 525-05-45

Qualified Service Provider Enrollment 525-05-45-10
(NEW 03/01/2024 ML# 3846)

[View Archives](#)

Purpose

The purpose of Provider Enrollment is to ensure that Qualified Service Providers (QSPs) meet the standards and qualifications set by the Department of Health and Human Services (HHS) and Federal Regulations for providing services to eligible Home and Community Based Service recipients.

Legal Authority

Code of Federal Regulations (CFR) Title 42, Chapter IV, Subchapter C, Part 455, Subpart E

Century Code 50-11-02.4

Century Code 50-11-06.8

Century Code 50-11-06.9

N.D. Admin. Code 75-03-23-07

N.D. Admin. Code 75-03-23-08

N.D. Admin. Code 75-03-23-10

N.D. Admin. Code 75-03-21-08

Standards for Qualified Service Providers

1. Must be 18 years of age.
2. Must meet the standards of CFR Part 455-Program Integrity Medicaid.
3. Must meet the provider standards and agreements according to the N.D. Admin. Code and CFR.
4. Per ND Admin. Code 75-03-23-08(1)(n)(2)(o)(p), QSPs must have been actively billing in the past 12 months or have valid reason for inactivity to revalidate or they may be closed for inactivity.
5. No outstanding debts can be owed to the Department.

- If an outstanding debt is owed to the Department, payment arrangements may be considered as an allowance and condition of enrollment approval.
- 6. Documentation of Competency, registered nurse licensure, licensed practical nurse, certified nurse assistant certification, physician, physician assistant, nurse practitioner, physical therapist license, or occupational therapist must be current and up to date. (FHC does not require a documentation of competency)
- 7. Family home care and family personal care providers must have an eligible individual identified by the HCBS Case Manager before enrollment will be completed.
- 8. Bureau of Criminal Investigation background checks and fingerprint screening must be done for Adult Foster Care (AFC) and Respite providers in an AFC home per Admin. Code 75-03-21-08(1)(h) and Century Code 50-11-02.4, 50-11-06.8, and 50-11-06.9.
- 9. QSPs must have an email account to create an account in the QSP Portal and receive correspondence from the Department.
 - Paperless communication is the preferred method of communication. However, individuals who need accommodation can request information to be sent in a different format. Contact the QSP Hub to request accommodation.

For additional information about provider standards refer to the current QUALIFIED SERVICE PROVIDER (QSP) HANDBOOKS, available on the QSP website: <https://www.hhs.nd.gov/human-services/providers/adults-and-aging/qualified-service>.

Standards for Qualified Service Providers (QSP) for Environmental Modification

- Environmental Modification Service may only be provided by a contractor approved by the Department of Health and Human Services as a QSP. Standards for QSPs of Environmental Modification Service are as follows:
- Building contractors must have a current North Dakota Contractor's license, carry liability insurance, be bonded, and maintain good standing with Workforce Safety Insurance. Show verification of an appropriate building permit.

- Electricians must be licensed by the North Dakota State Electrical Board, carry liability insurance, be bonded, and maintain good standing with Workforce Safety Insurance.
- Plumbers must be licensed by the North Dakota State Plumbing Board, carry liability insurance, be bonded, and maintain good standing with Workforce Safety Insurance.
- All licensed and unlicensed contractors must provide a copy of their registration with the Secretary of State; provide a copy of their license, proof of liability insurance/bonding, and proof of enrollment and good standing with Workforce Safety and Insurance. These documents must be submitted with the request to be a Qualified Service Provider (QSP).
- The North Dakota Century Code (NDCC 43-07-02) allows for a handyman to complete jobs not exceeding \$4000 without a contractor's license. If the handyman does not have a contractor's license they must provide a letter of reference showing they meet the qualifications to do minor installs and modifications to the home. The handyman would be allowed to provide installs and modifications to the home not exceeding \$4000 in time and materials. A licensed contractor would qualify as a QSP with their contractor's license and is not limited to the \$4000 threshold.
 - An unlicensed handyman/contractor/tradesman may meet the QSP criteria for Environmental Modification with the following requirements:
 - Verification of good standing with Workforce Safety and Insurance.

Standards for Home Delivered Meal Providers:

- Enrolled as an individual or agency Qualified Service Provider;
- Licensed as a food establishment pursuant to NDCC 23-09, Hospital, nursing facility, basic care facility; or contracted with Aging Services Division as an OAA Nutrition Provider;
- Meet all applicable federal, state, and local laws and regulations regarding the safe and sanitary handling of food, equipment, supplies and materials used in storage, preparation, and delivery of meals to eligible recipients pursuant to the ND Requirements for Food and Beverage Establishments (NDAC 33-33-04).
- Providers licensed as a Hospital must also meet standards pursuant to NDCC 23-16, NDAC 33-07-01.1, & NDAC 33-07-02.1

- Providers licensed as a nursing facility must also meet standards pursuant to NDCC 23-16 & NDAC 33-07-03.2 & NDAC 33-07-04.2
- Providers licensed as basic care must also meet standards pursuant to NDCC 23-09.3 & NDAC 33-03-24.1
- Providers licensed as basic care must also meet standards pursuant to NDCC 23-09.3 & NDAC 33-03-24.1

Provider Enrollment Limitations

1. All verification screenings required by the federal and state laws, rules, or regulations must be complete before enrollment can be finalized.
2. The QSP enrollment effective date cannot be prior to the provider NPI enumeration date, if applicable.
3. The effective date for QSP enrollment for services of Family Home Care (FHC) or Family Personal Care (FPC) may not be prior to individual/member's signature on care plan.

Provider Reimbursement Limitations

1. QSP's will not be paid with public funds until the enrollment requirements are fulfilled and a current authorization is received from the Case Manager.
2. QSP's will not be eligible for payment during the period when their QSP enrollment status lapsed.
3. QSP's are not eligible for payment earlier than the effective date on the authorization to provide services issued by the case manager, therefore the enrollment date **may not** be the date a provider can start billing.
4. QSPs are required to provide a direct deposit account upon initial enrollment and maintain a current checking or savings account for direct deposit at all times. If the QSP does not maintain a current account or update HHS when updated information is requested, the QSPs enrollment status will be closed.

Enrollment Process for New Applicants

1. A complete and accurate application including all forms and required verification checks by QSP Enrollment must be complete before an

enrollment approval will be given (enrollment dates cannot be retroactive).

2. The following provider verifications must be completed by QSP Enrollment according to the CFR and state regulations:
 - Verification of current competency, certification, or licensure and good standing in state
 - List of Excluded Individuals and Entities (LEIE)(OIG)
 - Excluded Parties List System (SAMS)
 - National Sex Offender Site
 - ND Sex Offender Site
 - Check Termination and Denial list
 - Check Certified Nurse Assistance Abuse list
 - Health Market Science (HMS) or equivalent screening check which includes the following:
 - OIG (Office of Inspector General)
 - State Medicaid Exclusion
 - Social Security Administration Death Master File
 - National Plan and Provider Enumeration System (NPPES) or NPI (National Provider Identifier) Registry
 - DEA (Drug Enforcement Administration)
 - Addresses
3. A QSP will be issued an "enrollment expiration date" no longer than 60 months from the date of enrollment approval.

Enrollment Process for Family Home Care (FHC) and Family Personal Care (FPC)

1. The case manager must initiate the application for the FHC or FPC provider in the QSP Enrollment portal.
2. The QSP applicant submits a complete and accurate application, including uploading the required documentation in the QSP enrollment portal.
3. QSP Enrollment must complete required screening and verification checks according to the CFR and state regulations:
 - Verification of current competency, certification, or licensure and good standing in state
 - List of Excluded Individuals and Entities (LEIE)(OIG)
 - Excluded Parties List System (SAMS)
 - National Sex Offender Site
 - ND Sex Offender Site

- Check Termination and Denial list
- Check Certified Nurse Assistance Abuse list
- Health Market Science (HMS) or Accurint check which includes the following:
 - OIG (Office of Inspector General)
 - State Medicaid Exclusion
 - Social Security Administration Death Master File
 - National Plan and Provider Enumeration System (NPPES) or NPI (National Provider Identifier) Registry
 - DEA (Drug Enforcement Administration)
 - Addresses
- 4. Family Home Care does not require an SFN 750- Documentation of Competency.
- 5. Family Personal Care requires a valid proof of competency with the application.
 - Valid proof of competency includes a SFN 750 or current CNA, RN or LPN verification.
- 6. The effective enrollment date for the services of Family Home Care or Family Personal Care may not be prior to the date of the individual/member's signature on the care plan.
- 7. The HCBS case manager verifies the QSP applicant will be providing FHC or FPC with QSP Enrollment before final approval will be granted.
- 8. A start date will be determined by reviewing:
 - The completed application;
 - Provider screening verification date;
 - Individual approval date for service;
- 9. The QSP will be issued an "enrollment expiration date" no longer than 60 months from enrollment approval date.
- 10. Revalidation of QSP enrollment is required every sixty months for an individual enrolled as a FHC or FPC QSP.
- 11. Revalidation of QSP enrollment is required every sixty months for an individual enrolled as a FHC or FPC QSP.

HCBS Case Management Guidance for Family Home Care and Family Personal Care QSP Application

Step 1: Ask the potential QSP what email they want to use to set up their ND Portal account.

If they don't have an email, they should use one of the free email sites (yahoo, google etc.) to set one up. They need to keep track of the email and check it frequently. If they want to use someone else's email for this, they must have written permission from the eligible individual.

If they don't know how to set up an email, they can contact the QSP Hub for assistance. (Please note that they will likely need to schedule a time and help may not be available on demand due to the volume of TA being requested.)

Step 2: The potential QSP should follow the attached user guide for family home care or family personal care and log into their current ND portal or set up a new account in the ND portal. If they need help with this step, they can call the QSP Hub and set up a time.

Step 3: The potential QSP should let you know when they have logged into their ND portal account.

Step 4: The HCBS Case Manager should follow the attached user guide and log into the QSP portal and initiate a FHC or FPC application.

Step 5: The HCBS Case Manager should let the potential QSP know they can log into the QSP portal (using the correct email) and fill out the FHC or FPC application. They will be notified via email when the application is approved. You will be able to see the application and each stage of the process for each application you initiate.

Enrollment Revalidation

A notice will be sent through the QSP Enrollment Portal when QSP revalidation is due.

Note: Paperless communication is the preferred method of communication. However, individuals who need accommodation can request information to be sent in a different format. Contact the QSP Hub to request accommodation.

1. A complete and accurate application including all forms and required verification checks by QSP Enrollment must be complete before revalidation of QSP status can be approved.
2. The following provider verifications must be completed by QSP Enrollment according to the CFR and state regulations:
 - Verification of current competency, certification, or licensure and good standing in state
 - Evidence of competency is required at least every sixty (60) months for an agency enrolled as a qualified service provider or at least thirty (30) months for an individual enrolled as a qualified service provider.
 - List of Excluded Individuals and Entities (LEIE)(OIG)
 - Excluded Parties List System (SAMS)
 - National Sex Offender Site
 - ND Sex Offender Site
 - Check Termination and Denial list
 - Check Certified Nurse Assistance Abuse list
 - Health Market Science (HMS) or Accurant check which includes the following:
 - OIG (Office of Inspector General)
 - State Medicaid Exclusion
 - Social Security Administration Death Master File
 - National Plan and Provider Enumeration System (NPPES) or NPI (National Provider Identifier) Registry
 - DEA (Drug Enforcement Administration)
 - Addresses
3. QSP is given an "enrollment expiration date" no longer than 60 months from enrollment approval date.
4. Individual QSPs will be given a 30-day notice in the Enrollment Portal to revalidate their enrollment.
5. Agency QSPs will be given a 90-day notice in the Enrollment Portal to revalidate their enrollment.
6. If revalidation is not completed by the expiration date, the QSP is given a stop date and sent written notification of 30 extra days to revalidate. A new start date will be given if/when a complete application is received and approved.
7. HCBS Case Manager and/or the DD Program Manager will be sent a written notification of a 30 day stop notice period, allowing the provider 30 extra days to revalidate. If revalidation is not received and processed during the 30 day stop notice period, the QSP must be taken off the care plan.

8. QSP wishing to continue to provide care must have a complete application submitted and approved before the final stop date issued in the 30-day notice. (There will be no retroactive dates after the 30-day notice).

Exceptions

1. Requests for exceptions will be reviewed and considered but will not be granted unless the provider meets all the competency requirements and all required screenings and verifications have been completed.
2. Prior approval is required by the QSP or HCBS Program Administrator.

Competency Revalidations

1. Individual QSP competency is valid for the length of their license if verified by a CNA, LPN or RN or 30 months if verified by an SFN 750, Documentation of Competency. The Individual QSP is required to revalidate their competency by re-establishing proof of competency at least every 30 months or at the expiration of their certificate or licensure.
2. Agency QSP employee competency is valid for the length of their license if verified by CNA, LPN or RN or 60 months if verified by an SFN 749 –Documentation of Competency – Agency QSP Employee. The Agency employee is required to revalidate their competency by re-establishing proof of competency at least every 60 months or at the expiration of their certificate or licensure.
3. QSPs enrolled for a service that is dependent upon a license must submit proof of license renewal to maintain enrollment for the specific service.
4. A notice will be sent through the QSP Enrollment Portal when an updated competency or license renewal/revalidation is due. The QSP must provide updated information as requested or enrollment will be closed.

Provider Addresses

QSP mail returned twice, with no forwarding address, will result in a closure of QSP status. The HCBS Case Manager or DD Program Manager will be notified of closure date.

If the QSP provides a valid address and meets all provider enrollment requirements, the QSP status will be opened; however, there may be a gap in enrollment approval dates.

If the QSP mail is returned notifying the department that the QSP has moved to a state that does not border North Dakota, the QSP will be closed and given a stop notice.

Closure for Inactivity

QSPs with no billing activity within the last 12-15 months will receive a non-billing notice. The notice will allow the QSP time to provide the Department of the reason for inactivity.

If a valid reason for inactivity is not received within 30 days, the QSP status will be stopped.

15 minute unit rates

Providers must deliver at least 8 minutes of service before they can bill for the first 15 minute unit. Providers should not bill for services performed for less than 8 minutes. This applies to all procedure codes billed using a 15 minute unit rate.

The amount of time required to bill for a larger number of units is as follows:

2 units: at least 23 minutes 6 units: at least 83 minutes
3 units: at least 38 minutes 7 units: at least 98 minutes
4 units: at least 53 minutes 8 units: at least 113 minutes
5 units: at least 68 minutes

The pattern remains the same for allowable tasks performed in excess of 8 units (2 hours).

Daily Rate Service Rates

Add Providers must provide one hour of service to bill for daily rate services.

Electronic Visit Verification Requirements

Electronic Visit Verification (EVV) uses a mobile device application on a phone, tablet, or laptop that records the beginning and ending time of services provided to individuals by providers. Data may also be captured using a fixed object device (FOD) issued to the provider by HHS. This electronically verifies the service was provided at a particular location where the service is authorized, as required by the law. EVV is a federal requirement from the 21st Century Cures Act and became effective January 1, 2021, it is used for billing and payment of services you provide as a QSP.

All QSPs are required to participate in an EVV system if they enroll in at least one of the services subject to EVV. QSPs must have access to a FOB, phone, tablet, or laptop to utilize this system. This is necessary to check in and out when providing services, receiving service authorizations, and submitting claims electronically. Not all services require EVV to bill for services provided.

EVV programming under Therap includes the option to enter and store the documentation that is required for QSP services. This programming is called ISP Data and meets the standard for QSP documentation. ISP Data is only available to QSPs using Therap for EVV.

Referrals for Qualified Service Providers 525-05-45-20
(Revised 02/01/2025 ML# 3899)

[View Archives](#)

QSP's may receive referrals from HCBS Case Managers, DD Program Managers (DDPM), Community Support Coordinators (CSC) or QSP Navigators.

Aging Services Qualified Service Provider (QSP) Navigators connect Individual(s) QSP/Agencies with individuals eligible for Home and Community-Based Services (HCBS) and/or working with Community Service Coordinators (CSCs) through the following process:

The HCBS case managers and CSC send referrals for individuals requesting assistance locating a QSP to the QSP Navigator group email by completing and emailing an SFN 1268 to qspnavigator@nd.gov.

If the individual has a provider in mind or know one that will provide the services, the HCBS case manager and CSC a referral is not required to send to the QSP Navigator.

The QSP navigator will review the referral for completeness, paying particular attention to the "Start Date."

The QSP Navigator will reach out to the individual/agency QSPs via the preferred method of communication.

If there is no response back from the QSP individual(s)/agency(ices) after 24 business hours, the QSP Navigator will initiate follow-up calls and email.

When a QSP individual(s)/agency has been located for HCBS or CSC the QSP Navigator will send a message back to the HCBS case manager and the QSP individual/agency (on the same email) with all the information:

QSP individual(s)/agency name and contact information.

What services the QSP individual(s)/agency can provide.

What days the QSP individual(s)/agency are available.

Along with attaching the SFN 1268 referral that was submitted by the HCBS case manager, so the QSP individual/agency has a copy.

The HCBS case manager and/or CSC must follow up with the QSP individual/agency to answer any additional questions they have regarding the SFN 1268 referral.

QSP's Referral Acceptance

Accepting referrals – requires two confirmations that the QSP is ready and able to serve the individuals.

The QSP and individual's meet and greet needs to happen before the final confirmation is given that the QSP accepts the referral.

If the service does not start within the timeframe agreed upon between the individual, QSP and case manager, or within 10 days of accepting the referral, the referral will be rescinded.

Exception: If there has been contact with the case manager, QSP and individual and it is mutually agreed upon that the implementation of the services will be delayed.

NOTE: If QSP shows a pattern of accepting referrals and not setting up care through the QSP Complaint Process, the QSP may be asked to submit proof that they are able to provide the care they have agreed to in the individuals Person Centered Plan Care Plan. (see QSP Complaints)

QSP Required Notice for Involuntary Discharge 24-Hour Support Services

Under North Dakota Admin Code 75-03-23 Agency QSPs who have accepted an authorization to provide 24-hour supports to an eligible individual are required to give a 30-day written notice before they can involuntarily discharge the eligible individual from their care unless otherwise approved by the Department.

The 30-day written notice is required to increase the quality of 24-hour supports and help the providers to understand the commitment they are making when they agree to assist a TPM with this level of need.

If a QSP does not provide a 30-day written notice it will be submitted as a complaint to Aging Services and it may lead to sanctions or termination of a QSPs status.

Qualified Service Provider (QSP) Complaints 525-05-45-30

(NEW 03/01/2024 ML# 3846)

[View Archives](#)

A Qualified Service Provider (QSP) Complaint is any issue that involves a Qualified Service Provider (QSP) that affects an individual's quality of care, health/welfare/safety, inappropriate billing, potential fraud/waste/abuse, or failure to meet/maintain enrollment standards.

Complaints are categorized by the nature of the complaint which include the following areas:

- Absenteeism
- Abuse/neglect/ exploitation
- Breach of confidentiality
- Criminal History/Activity
- Disrespectful
- Inappropriate Billing
- Care Unacceptable to the Department
- Property Damage
- Self-Neglect
- Providing care under the influence of drugs/alcohol
- Medication errors that result in adverse effects
- Not submitting a critical incident report

Complaint Centralized Intake

A complaint can be made by any person with knowledge of misconduct by a Qualified Service Provider (QSP) or QSP agency.

The ADRL is the official QSP Complaint Intake contact.

- A complaint may be made:
 - by email
 - ADRL carechoice@nd.gov

- by phone
 - ADRL 1-855-GO2LINK (1-855-462-5465)
- in writing
 - 237 W Divide Ave, Suite 6; Bismarck ND 58501

Notification of Complaint to QSP

A Notification of QSP Complaint letter must be sent out to the QSP within 14 calendar days, unless the Program Administrator is directed by law enforcement, VAPS, Protection and Advocacy, or the SURS Program Administrator to wait for them to take further action.

1. The letter is sent through the USPS or to the QSP's valid email address via secure mail and with a return receipt request.
 - a. The letter includes:
 - i. A summary of the complaint against the QSP
 - ii. Request for a response to the allegations
 - iii. Any additional information or releases of information
 - iv. Service records
 - v. The provider will be given 20 calendar days to respond to a complaint that does not allege abuse/neglect/or exploitation.
 - vi. If abuse/neglect/or exploitation are alleged, the provider will have 10 calendar days to respond.
2. Response/Service Records from QSP
 - a. QSP Complaint Responses are received.
 - i. by email
 - QSPComplaints@nd.gov
 - ii. in writing
 - 1237 W Divide Ave; Suite 6; Bismarck ND 58501
 - b. If a provider does not respond to the Notification of QSP Complaint Letter,
 - The HCBS Program Administrator must have at least one phone contact or attempt leave two voicemail messages with the provider.
 - If the provider still does not respond the complaint may be staffed for a non-response determination of how to proceed.
 - a. If termination is the outcome,
 - i. All billing for the service months records that were requested is to be recouped.**

ii. If more than \$1000 for an individual provider and \$5000 for an agency provider is being recouped the termination must be staffed with the HCBS/SURS team.

3. Complaint Resolutions
4. Terminated in Progress
 - a. The complaint is ended as without further follow-up by the Complaint Administrator as it is clear the complaint is unsubstantiated or does not meet the criteria of a QSP Complaint, or the complaint is a duplicate of a complaint that has already received.
5. Unsubstantiated Complaints
 - a. If there is a lack of evidence to substantiate poor care or behavior that has direct bearing on the QSPs ability to provide care.
 - i. A letter is sent to the QSP to inform them of the unsubstantiated finding of the allegations in the complaint.
 - b. If there is a lack of evidence to substantiate poor care or behavior that has a direct bearing on the QSP's ability to provide care, but a review of the service records indicates that a portion of the payment for services should be recouped,
 - i. A letter is sent to the QSP noticing the closing of the complaint and recoupment of any inappropriate payments.
6. Substantiated Complaints
 - a. If there is evidence that indicates the complaint is substantiated the state may take the following steps to remedy the situation.
 - b. No Further Action
 - i. If all steps have been taken to remedy the situation no further action will be required.
 - c. Technical assistance
 - i. Corrective Action Plan
 - ii. Recoupment of inappropriate payments.
 - iii. Pre or Post payment review of claims.
 - d. Termination of QSP status.
 - i. QSP may be placed on state and/or federal Medicaid provider exclusion lists.
7. Remediation or Corrective Action Plans
8. Corrective Action Plan
 - a. Program may determine that a corrective action plan with specific interventions may resolve the any outstanding concerns substantiated in the QSP complaint.

- b. Program issue a corrective action plan for the QSP to remediate the substantiated findings.
 - i. A letter outlining the corrective action plan and any payments to be recouped will be sent to the QSP.
- 9. Termination of QSP
 - a. The following steps may occur.
 - i. QSP may be added to State Exclusion List
 - If the provider is to be referred to OIG and/ or put on the state exclusion list the following language must be put in the termination letter to the provider:
 - a. Because of this termination, you are not eligible to provide HCBS services to clients whose care is being reimbursed by Medicaid or State and County funds. In addition, because of the circumstances of your termination, your name has been added to the ND State Exclusion list. Section 6501 of the Affordable Care Act requires each State Medicaid program to terminate the participation of any individual or entity that has been terminated for cause under Medicare or by another State Medicaid program. If your name is on the ND State Exclusion list, entities that receive funding from Medicare or Medicaid may face civil monetary penalties if they employ you. This means that you may not be allowed to participate as a provider in any state or work with any organization whose programs are funded by Federal money.**
 - b. Please be aware this does not impact your eligibility to receive Medicaid or Medicare benefits.**
 - c. Also, per Federal law, you are being referred to the Office of Inspector General (OIG) and may be excluded from participation in any capacity in Medicare, Medicaid, and all Federal health care programs as defined in section 1128B(f) of the Social Security Act.**

Qualified Service Provider (QSP) Overtime 525-05-45-40 (NEW 03/01/2024 ML# 3846)

[View Archives](#)

Purpose

The North Dakota Department of Health and Human Services (HHS) is required to pay individual Qualified Service Providers (QSP) overtime in accordance with the Fair Labor Standards Act (FLSA) In-home care final rule (FLSA Final Rule). In addition, HHS is required to pay at least minimum wage for all authorized hours worked.

Overtime Definition

FLSA Final Rule established that overtime is to be paid at a rate of 1.5 times the regular rate of pay for work in excess of 40 hours in an established seven consecutive day period. Aging Services defines a work week as the seven-day period starting on Saturday at 12:00 a.m. and ending the following Sunday at 11:59 p.m.

- Overtime payments are not required for work completed on weekends or holidays; overtime payments are not automatically paid for care provided on these days unless the time worked on these days otherwise falls within the requirements of overtime.
- The following time may be counted toward weekly hours even though you are not paid for the time spent completing these activities.
 - Drive time, an individual QSP may use Therap to track time spent driving between individual's homes. You may not count the time driving to your first individual's home or driving home after your last individual of the day.
 - Drive time must be tracked in the EVV system.

Who is eligible to receive overtime payments?

Any person enrolled as an Individual QSP who provides care in excess of 40 hours in a work week Saturday through Sunday, may be eligible for an overtime payment.

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QSPs must deliver care within the specified scope and duration outlined in their service authorization to maintain eligibility for overtime payments.

Paid Family or Household Members/Qualified Service Provider (QSP) Service Agreement - Live in Paid Caregivers 525-05-45-50**(Revised 12/01/2024 ML# 3885)**[View Archives](#)

The FLSA Final Rule recognizes the unique nature of programs in which the care provider and the eligible individual live together and have pre-existing family ties or a pre-existing shared household. There is both a familial or household relationship and an employment relationship.

The US Department of Labor Fact Sheet: Application of the FLSA to Domestic Services states the following. "In recognition of the significant and unique nature of paid family and household caregiving in certain Medicaid-funded and certain other publicly funded programs, the Department has determined that the FLSA does not necessarily require that once a family or household member is paid to provide some home care services that all care provided by that family or household member is part of the employment relationship. Where applicable, the Department will not consider a family or household member with a pre-existing close personal relationship with the individual to be employed beyond a written agreement developed with the involvement and approval of the program and the individual (or the individual's representative), usually called a plan of care, that reasonably defines and limits the hours for which paid home care services will be provided."

When an individual is eligible and chooses family home care, family personal care, live in daily rate personal care funded under the Home and Community Based Services (HCBS) waiver, Service Payments Elderly and Disabled (SPED), or Medicaid State Plan - Personal Care (MSP-PC) the HCBS Case Manager must complete a person-centered plan of care and a [service agreement](#) with the eligible individual and their legal decision maker, when the live in paid care provider has a close personal relationship with the eligible individual in need of care.

A close personal relationship includes relative providers and individuals who had a close personal relationship with the eligible individual prior to paid care being established. Examples include but are not limited to relatives, significant other, or former spouse.

Under these programs, the services to be provided and the number of hours of paid services are described in the plan of care, which is based on an assessment of the services the eligible individual requires and is eligible to receive. The person-centered planning process will determine the number of hours care will be provided. That information will be used to create the [service agreement](#) which covers the scope of the employment relationship, and the services paid under the state and federally funded HCBS. Additional services that are provided beyond the number of hours listed in the service agreement are not reimbursable hours but “natural supports” because of the familial or household relationship.

Live-in Paid Caregivers

Live-in relatives meeting the definition of family member under subsection 4 of N.D.C.C. 50-06.2-02 are not eligible to provide Waiver Personal Care service. This service is provided under Family Personal Care.

Exceptions may include:

- Consideration may be given if the live-in family member does not qualify for Family Personal Care because they are providing less than 3 hours of care per day.

- If an outside provider is the primary caregiver and the live-in-family member provides supplemental cares only, the live in family member provider may be eligible to receive WPC unit rate services limited to the cap for live-in family providers with **prior** approval of Program Administration.

- If program administration approves the live-in family member for WPC unit rate service, the number of reimbursable hours of care cannot exceed 10 hours per day. The live-in family member provider may provide more care than 10 hours, but the State is not obligated to pay because that care is being provided because of their close personal relationship and that they share a household with the eligible individual.

Individuals who are hired to reside in the same household and provide care to an eligible recipient as a paid caregiver are not considered to have a close personal relationship with the eligible individual for purposes of the FLSA Final Rule.

- The Maximum number of hours of care per day that can be paid under Family Home Care, Family Personal Care and SPED-PC Daily Rate is 10 hours.

- The maximum number of hours of care per day that can be paid under Waiver Personal Care – unit rate and Medicaid State Plan -

personal care (unit rate) is 12 hours unless prior approval was granted by HHS.

Potential Exclusions from Overtime Payments:

Complaints of Fraud:

If a Qualified Service Provider (QSP) is subject to an open complaint involving a credible allegation of fraud, overtime payments may be withheld until the complaint investigation is complete. Overtime payments will only be released if the complaint is not substantiated, or the number of actual hours worked is not in question.

Outstanding Balances:

Providers with outstanding balances owed to the Department may have overtime payments garnished to settle the balance unless a pre-established payment plan is in effect.

Claims Not Supported by an Authorization:

Overtime will be denied if submitted claims exceed the specified scope and/or duration of services outlined in the pre-authorization and [service agreement](#). Claims must align with the authorized service parameters to be considered for overtime payment.

Safety Considerations for care providers:

HHS Adult and Aging Services Section has determined that personal care exceeding 12 hours per day could be considered unsafe if there is only one Individual QSP authorized to provide that amount of care each day. We recommend that no more than 12 hours of personal care be provided to any one eligible individual by the same Individual QSP when daily care is necessary to ensure health and safety.

HCBS Case Managers have been instructed to include a minimum of two Individual QSPs in these situations so the workload can be shared unless an exception was granted by the Department.

If an exception has not been granted, and an eligible recipient does not want to use an additional provider to receive care beyond the 12 hours of authorized care that information should be documented in the PCP and the risk assessment. In these situations, HHS Adult and Aging Service section is not obligated to

authorize additional hours to the chosen QSP. Services may be impacted if the individual is not in agreement with the plan of care. There may be circumstances where unit rate QSPs may provide more than 12 hours of care per person (or more than 12 hours combined if serving multiple individuals) only if it is determined that the amount of care they are providing ensures the health and safety of the eligible individual(s). The case shall be staffed with case management and program administration for consideration of an approval exception. Unit rate providers must continue to utilize EVV and are subject to audit.

Payment including overtime pay may be denied if a provider exceeds a safe working duration for the individual and the case manager has not received approval for an exception in the person-centered care plan to exceed 12 hours of care per day.

Failure to Submit Documentation:

Payment for overtime may be denied if a provider fails to submit requested service documentation.

Inadequate Documentation:

Overtime payment may be denied if a provider fails to maintain service documentation meeting the Department's outlined requirements.

Service Documentation

Qualified Service Providers (QSPs) are required to maintain required documentation of services provided to eligible individuals. The purpose of this documentation is to verify payment requests and support the quality and integrity of services provided.

The specific elements required in these records are detailed in the provider handbook and must include:

- Individual's name
- Individual's ND# (North Dakota ID number)
- Provider name
- Provider number
- Service location
- Date of service

Time services started
Time services ended
Authorized tasks completed

Documentation Format:

Written or electronic documentation of daily services is mandatory and must be completed when services are provided to ensure accuracy. Providers are encouraged to refer to the provider handbook for comprehensive documentation guidelines and to ensure compliance with these requirements.

Timely Submission of Overtime Claims:

To facilitate the prompt processing of claims and subsequent overtime, claims for overtime should be submitted within 3 months after the delivery of services.

Audits

To ensure clients are receiving the services they need and to ensure the services provided meet standards set by the Department, HHS may complete an audit of any individual who submits claims for overtime.

All QSPs who submits claims for more than 80 hours of care in a week may be subject to an audit of their records.

QSPs will receive a notice of audit via email and mail. It will outline the nature of the audit and any findings. It will include information on how to request a review of the audit if the findings are disputed by the provider.

Sanctions

If HHS finds that any payments made to the QSP were inappropriate the Department may request a refund or file adjustments to recoup funds.

The QSP will receive an email and a letter stating the circumstances around the adjustment and providing the opportunity to set up a payment plan for the balance owed to the Department. If a payment plan is not set up within 30 days of the notice, the Department will proceed with the adjustment.

If it is found that a QSP is not in compliance with the department due to the following examples, all money paid to QSP may be recouped:

Failure to keep appropriate records.

If you did not provide the service

Billing over the authorized amount or billing the wrong code.

Billing for an authorized task that is utilized in an unreasonable time frame.

Failure to comply with a request to send records or information.

Photocopied records, indicating service records were not completed at the time of service.

Other good cause

Formal Review

If a provider is denied overtime, they will receive a denial letter outlining the dates of service overtime was denied and the reason overtime was denied.

The provider may request a formal review of the denial of overtime payments.

A Formal Review may be requested if you disagree with any action regarding provider reimbursement. Per ND Admin Code 75-03-23-12, to request a formal review:

Submit a formal written request in writing within 30 days of notification of the adjustment or request for a refund. The notification of adjustment may be contained in the remittance advice or included in a document sent to you by the Department. Within 30 days of requesting a review, provide to the Department all documents, written statements, exhibits, and other written information supporting your request for review. A provider may not request a formal review of the rate paid for each disputed item. The Department has 75 days from the date we received the notice of a request for review to make a decision.

Qualified Service Provider (QSP) Service Agreement -Live In Paid Care Givers Policy Exceptions:

All live in caregivers who have a close personal relationship to the eligible individual who are currently providing daily unit rate services should be switched to a daily rate. However, [service agreement](#) policy exceptions may be granted by Adult and Aging Services on a case-by-case basis to ensure the health and safety of eligible individuals and access to care in the most integrated environment.

If an eligible individual was receiving one of the affected services before March 1st, 2024, and the new policy might significantly change their service cost, making it hard for them to access care, they will be allowed to keep their current rate without any changes. However, a daily rate and [service agreement](#) should still be established.

Eligible individuals who are using MSP-PC and the QSP is a relative do not have to move to FPC, they can choose what service best meets their needs.

If more than one live in QSP is an authorized provider do not use a daily rate. The services should remain as unit rate.

If an eligible individual needs less than 3 hours of care per day, do not set up a service agreement or authorize FPC. These services should be set up as daily rate personal care under the applicable funding source and a service agreement would be established.

For example, if an eligible individual needs less than 3 hours of care per day, what used to be FHC (with a low daily rate) would now be SPED daily rate PC.

Another example, if an eligible individual lives with their chosen QSP but needs less than 3 hours of care per day, what used to be FPC (with a low daily rate) would now be MSP-PC.

All MSP-PC service providers who have a close personal relationship with the eligible individual are not required to use FPC and remain eligible for MSP-PC. Live in caregivers of this service still need a service agreement and must be switched to the daily rate for easier billing and to comply with FLSA.

Live in caregivers will no longer be subject to EVV for these services.

Daily rate QSPs will be allowed to attendance bill in Therap. FHC and FPC providers can continue to use paper/atypical claim forms or bill through the MMIS portal.

The daily rate for Family Home Care is set at a flat rate as established by legislative action. The number of reimbursable hours of care for this service cannot exceed 10 hours per day. The provider may provide more care than that, but the State is not obligated to pay because that care is being provided because of their close personal relationship.

To avoid overpayments to live in providers of eligible individuals who need minimal daily care, recipients who need less than 1 hour of care should be switched to SPED-PC daily rate.

This service must be billed using attendance billing documentation.

This service must be billed using attendance billing documentation. The daily rate for Family Personal Care is set at a flat rate as established by legislative action.

To avoid overpayments to live in providers of eligible individuals who need minimal daily care, recipients who need less than 3 hours of care should be switched to MSP-PC daily rate.

The Family Home Care and Family Personal Care QSPs use the paper atypical forms or the MMIS portal for billing.

Two Live-in Providers for One Individual

If an individual is pre-approved to receive care from more than one Family Home Care or Family Personal Care provider: the "Number of Hours of Care Provided Per Day" listed on the QSP Service Agreement does not have to be split between the providers. The full hours of daily cares are listed for each provider, not to exceed the maximum. While both providers are providing daily care, they are not allowed to bill for the individual on the same date of service.

For Example: Due to the needs of an individual, it is approved for two Family Personal Care providers to both provide care to an individual. Both may provide daily cares, yet each bill different days out of the month.

Service documentation for the providers must reflect the actual time and tasks provided by each of the providers for the dates of service.

Live-in Providers Caring for more than on HCBS Recipients

If a live-in provider under Family Personal Care, Family Home Care, Medicaid Waiver Personal Care Daily, or SPED or MSP Personal Care Daily is approved to provide live-in daily care to more than one service recipient, the "Number of Hours of Care Provided Per Day" listed on the QSP Service Agreement must be split between the total number of live-in daily care service recipients.

The reason the time is split between the participants is because a provider is limited to the maximum of 10 hours per day of HCBS services. The time is split between the two authorized participants for a total of no more than 10 hours per day.

The ratio of the split in time should be split by the ratio of time that service is provided to each participant.

Example 1: One individual may require 7 hours of care and the other individual may require 3 hours per day, the time would be split to reflect this need.

Example 2: If a provider is authorized for two Family Home Care recipients and both are assessed at needing the maximum of 10 hours of care per day, each individual's service agreement would list 5 hours per day.

Agency Quality Service Provider (QSP) Quality Improvement Program 525-05-45-60

(NEW 08/01/2024 ML# 3859)

[View Archives](#)

Quality Improvement Program

An agency QSP quality improvement program is intended to improve the quality and safety of the services delivered to individuals receiving HCBS. The agency QI program is the framework used to monitor, analyze, and improve processes through standardization.

NDAC § 75-03-23-07.1-13 Agency Quality Service Providers (QSPs) must have a department approved quality improvement program that includes a process to identify, address, and mitigate harm to the clients they serve. The 12.14.2020 Department of Justice (DOJ) Settlement Agreement, Section XVI. Quality Assurance and Risk Management, states that the State will ensure that all licensed agencies or entities employing non-family community providers have a quality program that identifies, addresses, and mitigates harm to Target Population members they serve.

Quality Standards

1. The QSP implements policies and procedures that identify, address, and mitigate harm.
2. QSP staff know how to prevent, identify, mitigate, and report allegations of abuse, neglect, mistreatment, and exploitation.
3. People receiving services from a QSP know how to recognize and report allegations of abuse, neglect, mistreatment, and exploitation (ANME).
4. The QSP maintains a system to promote open communication with case management entities.
5. The QSP maintains documentation of services provided.

Agency Quality Service Providers

Agency QSPs who employ non-family community providers and are approved to deliver any of the following HCBS services may need to provide evidence of a quality improvement program. Agencies that have

obtained CQL accreditation will be considered to have meet the required standards. The following services **require** a quality improvement program:

- Personal Care
- Homemaker
- Adult Day Services
- Extended Personal Care
- Supervision
- Nurse Education
- Nursing Assessment
- ARC
- Institutional Respite
- Respite Care
- Transitional Living
- Supported Employment
- Transition Coordination
- Case Management
- Assisted Living Facility -Personal Care
- Community Support Services (CQL required)
- Residential Habilitation (CQL required)
- Companionship
- Non-Medical Transport (NMT)

If the agency is providing only one of the following services a QI program is **not required**:

- Chore Services
- Emergency Response System
- Environmental Modification
- Home Delivered Meals
- Specialized Equipment

Program Recommendations

Agency policies and procedures should reflect the quality standards. Quality program recommendations may include but are not limited to the following.

1. Required Policies: The following policies are to be developed, implemented, and followed by agencies and their employees:

- a. Critical Incident Reporting
 - b. Reporting Fraud, Waste and Abuse
 - c. Employee/Contractor Screening
 - d. Supervision of Employees
 - e. Referral/Intake Process
 - f. Employee Ill Calls/Leave
 - g. Confidentially
 - h. Client/Individual Complaint Process
 - i. Reporting and investigation of suspected Abuse, Neglect, Mistreatment, and Exploitation
 - j. Analysis/Review of data to include Abuse, Neglect, Mistreatment, and Exploitation Patterns and Trends
 - k. Employee Conduct
 - l. Policy Review/Standard Enforcement
 - m. Billing Integrity and Accuracy
2. Education: Employees must undergo education/training that allows them to maintain competency in providing HCBS services. Training is to be frequent enough to keep individuals free from harm. The organization is to maintain internal documentation of employee training.
3. Certification/Licensure: Licensed/certified providers will initially and continually meet required licensure and/or certification standards. Non-licensed providers must submit necessary documentation upon initial application and at QSP renewal to maintain their QSP status.
4. Mitigation of abuse, neglect, and exploitation: Individuals receiving services are to be provided with information on recognizing and reporting abuse, neglect, mistreatment, and exploitation. Individuals and families are provided a means to provide anonymous feedback.
5. Reporting: Reporting processes are clearly outlined and follow **Critical Incident Reporting 525-05-42**.
6. Documentation: The organization will maintain accurate documentation of HCBS services provided. Employees are to be trained to document accurately. The agency is to have process in place that ensure billing integrity and accurate submission of claims is maintained.

See agency QSP handbook for further specifics on standard requirements.
[qsp-handbook-agency-provider.pdf](#).

Quality Review

An annual quality review will be conducted with HCBS recipients, utilizing recipient interviews and environmental observations. All findings will be submitted and monitored to ensure compliance.

Quality Improvement Program Audits

To maintain assurance that all licensed agencies or entities employing non-family community providers have developed and implemented a quality program the state may conduct audits. Audits will include a thorough review of agency policies and procedures. Frequency of audits may be ongoing as to ensure agencies continue to meet the required quality standards.

1. Initial Request
 - a. Agency may have 30 business days to submit required documentation for review. Reasonable accommodations/extensions may be granted.
 - b. Documentation may be reviewed within 30 business days after received.
 - c. Additional documentation may be requested if the agency does not meet quality standards with provided documentation.
 - i. Request for Additional Documentation
2. Agency may have 10 business days to submit additional documentation requested.
 - a. Reminder may be sent if there is no response after 30 business days from the initial request.
3. No Response to Second Request.
 - a. Agency may be called via phone or meeting scheduled to discuss required compliance to quality standards if no response after 30 business days from the second request (3 attempts will be made).
4. Non-Compliance
 - a. The department may terminate a qualified service provider and/or funds may be suspended and/or recouped from the agency if:
 - i. The agency fails to respond to audit requests.
 - ii. The agency fails to meet the required quality standards.
 - iii. The agency fails to complete required remediation plan.
 - b. If non-compliance determinations will be addressed by the QSP complaint administrator. **Qualified Service Provider (QSP)**
Complaints 525-05-45-30.

Remediation Plan

In the instances that a QSP agency does not meet the QI standards a remediation plan may be implemented. The remediation plan is a means for process improvement through the identification of gaps in QSP agency policies and procedures.

1. Remediation Plan

- a. Agency will be given a remediation plan if documentation provided does not meet quality standards.
- b. A meeting may be scheduled with the agency to review and offer support and guidance in obtaining compliance with quality standards.
- c. Agency may have 30 days to make appropriate changes and submit documentation that supports compliance with quality standards.

2. Remediation Review

- a. Documentation may be reviewed within 30 business days after received to determine if remediation plan and compliance were met.
- b. Ongoing submission of documentation validating compliance of standards may be required.

3. Non-Compliance

- a. The department may terminate a qualified service provider and/or funds may be suspended and/or recouped from the agency if:
 - i. The agency fails to respond to audit requests.
 - ii. The agency fails to meet the required quality standards.
 - iii. The agency fails to complete required remediation plan.
- b. All non-compliance determinations will be addressed by the QSP complaint administrator. **Qualified Service Provider (QSP) Complaints 525-05-45-30.**

Funding for Provider Assistance with Council on Quality & Leadership (CQL) Accreditation 525-05-47

(Revised 11/01/2024 ML #3881)

[View Archives](#)

Purpose

To assist Agency Qualified Service Providers (QSP) in obtaining Council on Quality & Leadership (CQL) accreditation to increase access to residential habilitation and community support services for eligible individuals.

Definition

The CQL accreditation must be obtained by a QSP agency to provide residential habilitation & community supports services. CQL accreditation promotes excellence in person-centered services and provides a framework for the agency to improve the organization's quality of supports.

Requirements

The QSP agency must achieve CQL accreditation prior to enrolling to provide Residential Habilitation and Community Support services.

CQL Levels of accreditation:

1. Systems Level Accreditation
 - a. This level of accreditation requires payment by the QSP agency.
2. Quality Assurance Level Accreditation
 - a. This level of accreditation is eligible for assistance with funding for the first accreditation visits one and two.
 - b. Once the agency has submitted the request for engagement (RFE) to CQL, the agency must obtain accreditation and become enrolled in the residential habilitation and community support services programs within one year or may be required to reimburse the department.

3. Person-Centered Excellence
 - a. This level of accreditation requires payment by the QSP agency.
4. Person-Centered Excellence with Distinction
 - a. This level of accreditation requires payment by the QSP agency.

The QSP agency must contact CQL and fill out the request for engagement (RFE) form. Once Systems level or Quality Assurance level of accreditation is achieved along with requirements per community supports (see policy chapter 525-05-30-21), and residential habilitation (see policy chapter 525-05-30-50), the agency may begin to provide residential habilitation & community supports services. The QSP agency is required to maintain CQL accreditation while enrolled in these services.

Eligibility for additional Aging Services funds includes:

1. Aging Services having funds available to assist providers with CQL accreditation.
2. The QSP Agency must complete orientation to the residential habilitation and community supports programs provided by the Aging Services Program Administrator. Orientation can be completed prior to request for CQL accreditation.
3. The Agency is enrolled as a QSP or has submitted an application to become a QSP Agency. The QSP must adhere to the provider agreement and standards as described in NDAC 75-03-23.
4. The QSP Agency must be in good standing with the Department of Human Services. The agency can be denied additional funding if application for QSP has been denied as described in NDAC 75-03-23-08. The QSP Agency may be denied additional funding if a sanction or termination of services has been issued as described in NDAC 75-03-23-08.1, or there have been substantiated complaints against the agency that involve quality of care.
5. The QSP Agency must have designated staff who will provide these services that completed the Brain Injury modules, Minot State Medication modules and Dementia training modules.
6. The QSP Agency must already employ or contract a Registered Nurse who will assist with the provision of community supports and/or residential habilitation.

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7. The QSP Agency must already employ or contract with a Care Coordinator who will assist with the provision of community supports and/or residential habilitation.
8. If the QSP Agency does not achieve accreditation, the State will not assist with the costs associated with a second accreditation.
9. The QSP is not eligible for funds if they have already received funding from the Department for the initial Quality Assurance accreditation visits one and two.

COVID-19 Service Flexibility 525-05-50

(NEW 6/1/20 ML #3582)

[View Archives](#)

Per [Executive Order 2020-29](#) during the COVID-19 health emergency the regulatory and service flexibilities approved in Appendix K for the HCBS Medicaid waiver [ND.0273.R05-04](#) by the Center for Medicare and Medicaid Services (CMS) <https://www.nd.gov/dhs/info/covid-19/docs/covid-19-faq-appendix-k-hcbs-waiver.pdf> also apply to services provided under:

Service Payments for the Elderly and Disabled

The legal authority for the Department to operate the Service Payments for Elderly and Disabled (SPED) Program is found at [N.D.C.C. 50-06.2-01\(3\)](#) and to reimburse qualified service providers for the delivery of specific services provided to eligible persons is defined in [N.D.C.C. 50-06.2-03\(5\)](#), and [50-06.2-06](#). See also [N.D.A.C. 75-03-23](#). For legal authority regarding Adult Family Foster Care (service), see [N.D.A.C. 75-03-21](#).

Expanded Service Payments for the Elderly and Disabled

The legal authority for the Department to operate the Expanded SPED Program is found at [N.D.C.C. 50-24.7](#), Expanded Service Payments for Elderly and Disabled. An eligible beneficiary is defined at [N.D.C.C. 50-24.7-01\(5\)](#) and is the same as for persons eligible for the Basic Care Assistance Program. Authority to reimburse qualified service providers for the delivery of specific services provided to eligible persons is defined in [N.D.C.C. 50-24.7-02\(2\)](#). See also [N.D.A.C. 75-03-24](#). For legal authority regarding Adult Foster Care (service), see [N.D.A.C. 75-03-21](#).

Requests for Reasonable Modification 525-05-55**(NEW 2/1/22 ML #3663)**[View Archives](#)**Purpose**

Programs and services administered and supervised by the department, directly or through contractual agreements, must be made available without regard to race, color, religion, national origin, age, sex, political beliefs, disability, or status with respect to marriage. These programs and services must also be accessible to persons with disabilities and comply with:

- Title I and Title II of the Americans with Disabilities Act of 1990 as amended
- Section 504 of the Rehabilitation Act of 1973 as amended
- Title VI of the Civil Rights Act of 1964 as amended
- Age Discrimination Act of 1975 as amended
- North Dakota Human Rights Act of 1983

To comply with Title II of the ADA, a public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination based on disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.

Requirements

Case Managers who identify that an individual has an anticipated or unmet community service need that would prevent them from living in the most integrated setting must notify an Aging Services Program Administrator promptly so that the Department can determine whether, with a reasonable modification, the need can be met.

Case managers should send an email to an Aging Services Program Administrator that includes the individuals name, a description of the unmet need and request for modification. The email should also state whether the individual is a Medicaid, Service Payments for the Elderly and

Disabled, or Expanded Service Payments for the Elderly and Disabled recipient and if they meet the nursing facility level of care criteria.

Approvals and Denials

An Aging Services Program Administrator will notify the case manager if a request for reasonable modification is approved or denied.

The applicant/recipient must be informed in writing of the reason(s) for the denial/termination/reduction. The case manager is required to assist the individual to request an appeal. See Closures, Denials/Terminations, and Reductions of Services 525-05-40.

The State will track all requests for reasonable modification to identify trends in service gaps, location, utilization, or provider capacity.

Accommodation Questions or Complaints

Persons needing accommodation or who have questions regarding accommodations, or the complaint process may also contact the following Civil Rights Offices:

Program Civil Rights Office
North Dakota Department of Human Services
Legal Advisory Unit
600 E Boulevard Avenue Dept 325
Bismarck, ND 58505-0250
701-328-2311
711 TTY
FAX 701-328-2173
Email: dhs1au@nd.gov

U.S. Department of Health and Human Services
Office for Civil Rights, Region VIII
1961 Stout Street, Room 08-148

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Denver, Colorado 80294
1-800-368-1019
TDD 1-800-537-7697
FAX (202) 619-3818
Email: ocrmail@hhs.gov

U.S. Department of Agriculture
Director, Office of Adjudication
1400 Independence Avenue SW
Washington, D.C. 20250-9410
1-866-632-9992
TTY 800-877-8339
FAX (202) 690-7442
Email: program.intake@usda.gov

U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue SW
HHH Building, Room 509-F
Washington, D.C. 20201
1-800-368-1019
TDD 1-800-537-7697
FAX (202) 619-3437
Email: ocrmail@hhs.gov

To File A Complaint

A valid civil rights complaint MUST:

- Be filed in writing by mail, fax, or e-mail for the N.D Program Civil Rights Office; or
- Be filed in writing by mail, fax, e-mail, or via the federal online portal at <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>
- Written complaints MUST contain:

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- Your Name, Full Address, Telephone Number with Area Code, and E-mail address if applicable;
 - Name of the Healthcare Agency or Social Service Provider, Full Address, and Telephone Number with Area Code;
 - Basis of the discrimination (e.g., race, age, religion or political beliefs, national origin, color, sex, disability, or status with respect to marriage or public assistance)
 - Where and when the discrimination took place;
 - How the alleged discrimination occurred, what occurred;
 - Who discriminated against you, provide the name of the individual(s);
 - Any other important facts you would like to disclose; and
 - Your Signature and date
- Be filed within 180 days of the date of the incident, or show 'good cause' to have the 180 day requirement extended.

Appendix 525-05-60

Application for Service, SFN 1047 525-05-60-05 (Revised 05/01/23 ML #3730)

[View Archives](#)

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

- Applicant's Name – print the name of the applicant (one [SFN 1047](#) per applicant);
- Date – date of application;
- Agency – HCBS Case Management agency;
- County of Residence - applicant's physical county of residence;
- 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;
- 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).

**Instructions for the Completion of the HCBS
Comprehensive Assessment 525-05-60-10****(Revised 02/01/2025 ML #3899)**[View Archives](#)

An application for services must include a complete functional assessment that was conducted by the HCBS Case Manager with the individual in the home where the individual resides. THIS ASSESSMENT IS FOR INDIVIDUALS 18 YEARS OF AGE OR OVER. The HCBS Comprehensive Assessment enables the HCBS case manager to record the individual's functional impairment level and correlate that to the need for in-home and community-based services.

The HCBS Comprehensive Assessment is intended to collect information based on the individual's response(s), information reported by significant other, individual's natural supports (such as family or friends) person-centered planning team members, and the HCBS case manager's observation. In most cases, the individual is the respondent of choice, and the HCBS case manager should make every attempt to conduct the interview with the individual.

Individuals must actively participate in the functional assessment to the best of their ability. Case managers must document in the narrative if there is a medical reason why the individual cannot participate in the assessment or answer questions directly. If a third party (including family) reports that the individual cannot participate in the assessment, but the case manager questions if this information is accurate, the case manager may request medical documentation to confirm that the individual is not capable of participating before eligibility can be established.

It is the responsibility of the individual to provide all information necessary to establish eligibility per NDAC 75-03-23-15. Proof of blindness, disability, and functional limitation may include, but is not limited to, complying with all requests for medical records or an evaluation, such as from physical therapy, occupational therapy, speech, neuro-psychological evaluation etc. The case manager may use the supporting records and evaluations in

completing the comprehensive assessment and/or determining eligibility for HCBS.

Eligible individuals will not be required to rely on natural supports if they choose not to do so or if the proposed support person is unable or unwilling to provide natural supports.

KEY FACTORS:

Participant Assessment

Section A. Demographics

Assessment Information
Consumer Demographics
Emergency Contacts

Vision Tool

Section B. Health Conditions

Physical Health Information
Nutrition
Cognition/Behavior

Section C1. Functional Assessment - ADL

Activities of Daily Living (ADL)

Section C2. Functional Assessment - IADL

Instrumental Activities of Daily Living (IADL)
Individual Specific Needs
Specialized Support
Supervision/Structured Environment

Section D. Quality Review

Section E. SPED Financial

Section F. Caregiver Assessment

Risk Assessment/Health and Safety Plan
Narratives and Signatures/Dates

The HCBS case manager must document the following information in either the HCBS Comprehensive Assessment or case notes.

Record related comments which the individual's or family member offers. Document if comments are self-reported, reported by family, collateral contacts, or observation.

HCBS case managers are not expected or qualified to make medical diagnoses. Through observation and interviews, the HCBS case manager must obtain pertinent medical information and any collateral information regarding the individuals wellbeing, physical and behavioral health needs. This information can be from self-reported information, collateral contacts, or medical information.

All questions on the HCBS Comprehensive Assessment must be answered if they apply to the individual in any way.

The HCBS Comprehensive Assessment Form and completion instructions are as follows:

Participant Assessment. HCBS case managers should be sure to confirm the accuracy of the information in the participant assessment during annual and six-month reviews and as changes occur.

Section A. Demographics

Assessment Information
Consumer Demographics
Emergency Contacts

Section B. Health Conditions

Physical Health Information

An individual's physical health is an important indicator of overall well-being. The purpose of this section is three-fold:

Enables the HCBS case manager to identify areas which require the attention of skilled medical personnel including history of hospitalizations, skilled nursing facility placements and rehabilitative nursing facility placements.

Assists the HCBS case manager in assessing the individual's rehabilitative potential and in establishing the goals of the service plan.

Provides information that will be useful in indicating a need for personal care assistance.

Nutrition
Cognition/Behavior

This section collects basic information related to the individual's cognitive and emotional functioning. Both emotional health and cognitive capacity have an impact on ability to maintain a level of self-care, and consequently have an impact on the individual's ability to remain at home.

Section C1. Functional Assessment

Activities of Daily Living (ADL)

Section C2. Functional Assessment - IADL

Instrumental Activities of Daily Living (IADL)
Individual Specific Needs
Specialized Support
Supervision/Structured Environment

Life Domain Vision Tool

Developed by the Charting the LifeCourse Nexus - LifeCourseTools.com • © 2020 Curators of the University of Missouri | UMKC IHD • March2020

The completion of the vision tool is required for all service programs except Basic Care.

The Vision Tool must be completed initially, every six months and to reflect any changes in the needs and preferences of the member and caregiver(s), including the individual's desire to move to a community setting.

The Charting the LifeCourse Vision tool is a working document that allows the individual and the person-centered planning team to discuss and explore the eight (8) life domains. The vision tool becomes part of the individual's person-centered plan of care and must be included in the individual's copy of the care plan.

The Vision Tool is used as a discovery tool that it utilized and expanded upon throughout the continuum of HCBS services, including transition supports through Money Follows the Person (MFP) and Aging Services HCBS programming. The initial vision tool is completed by the entity who is leading the transition and then built on throughout the care planning process.

The Life Domain Vision Tool encompasses discussion on 8 life domains; Daily Life & Employment, Community Living, Social and Spirituality, Healthy Living, Safety & Security, Advocacy & Engagement, Supports for Family, and Supports and Services. The Vision Tool is used as a tool to explore what a "good life" means to the individual.

The process of completing the Vision Tool includes an assessment through conversation with the individual. The conversation is centered around identifying the individual's strengths, needs and positive attributes in addition to an assessment of financial concerns, legal issues, fire safety, falls, access to health care, family issues, natural, community, and social supports, mental health/behavioral health needs, cognitive decision making, nutrition, medication, employment, education, and housing. Through assessment, planning and goal setting, the Vision Tool provides an opportunity for the person-centered plan to focus on the individual as a whole and explore what the individual views as their strengths, needs and goals moving forward. The vision tool serves as a portion of the person-centered plan that follows the individual through their life and can be flexible to the needs and aspirations of the individual. Individuals may be

asked to describe their preferences, and goals as part of the 8 life domains of the vision tool.

The process of completing the vision tool can be very personal and bring up subjects that the individual may not wish to discuss. If an individual does not wish to engage in conversation about one or more of the domains, the case manager must document in the relevant life domain the individual did not wish to discuss this domain.

The case manager may need to engage other community partners and supports as part of the person-centered planning process to meet the identified needs, barriers, or goals of the individual.

Daily Life & Employment

The Daily Life and Employment domain encompasses school and education, life-long learning, employment, volunteering, routines and life skills.

The case manager engages the individual in facilitated discussion about what their vision is to have a good life regarding to employment, education or volunteering. Discussion focuses on the individual's daily routine and if they are living the life they desire.

Examples of questions that may be asked to facilitate discussion can be found under the Daily Life and Employment section of the HCBS Comprehensive Assessment Companion Guide.

Community Living

The Community Living domain encompasses housing, home adaptations, home modifications, community access, and transportation.

The case manager engages the individual in facilitated discussion centered on what the individual sees as important in their lives in relation to housing, community living, access to the community, and any transportation needs.

Home Environment. Physical environment may impact positively or negatively on an individual's overall well-being, and thus, an evaluation of physical environment is an essential portion of the assessment process. This section presents some key areas which require the HCBS case manager's evaluation. It may elicit information useful in determining whether specialized housing equipment, home adaptations, relocation, or home repair are necessary to enable the individual to remain in the most integrated setting desired.

Social and Spirituality

The Social Support and Spirituality domain encompasses friends, relationships, leisure activities, personal networks and faith community. The case manager facilitates discussion about community integration and social supports to assist the individual in exploring options and desires the individual has for having their social and spiritual needs met. The case manager and the individual discuss formal and natural supports along with the individual's vision for what they would like to have for a support system.

Healthy Living

Healthy living is inclusive of medical, mental and behavioral health needs, nutrition, wellness, access to health care, health care needs, physical health information, functional impairments, current health status, medication use, health risk factors, falls, and cognitive decision making. The case manager facilitates discussion on the fore mentioned subcategories to build an understanding of the individual's view of healthy living.

Safety & Security

The safety and security domain encompasses emergencies, legal rights and issues, legal representative issues, financial concerns, mental/behavioral health related safety concerns, cognitive issues, fire safety. Through assessment, visual observation, collateral conflict and facilitated discussion the case manager and the individual explore the individual's safety and security.

Advocacy & Engagement

Advocacy and engagement include assessment and facilitated discussion on citizenship, valued roles, making choices, setting goals, the individual's views and responsibilities, leadership, and peer support. The case manager engages the individual to explore strengths, needs, barriers, and risks that are identified. The case manager may need to engage community partners and supports to provide supportive decision making, peer supports, or other supportive services identified to meet the individual's needs.

Supports for Family

Supports for family and/or natural supports includes understanding what the individual wants regarding to family involvement and engagement in their supports and services. Facilitated discussion encompasses understanding who the individual views as family and who the individual views as support. Family may include both biological family or chosen family as part of their family network. The case manager may consider the caregiver assessment and any identified needs or barriers identified through the assessment. Discussion may include both formal and natural support systems along with options (such as peer support, support groups, or respite care) to alleviate caregiver stress.

Supports and Services

All providers and services that will best meet the individual's needs and from whom the individuals receive cares are documented in the Services and Supports Domain. The case manager facilitates discussion around what support the individual needs and/or wants to live as independently as possible, and what the possibilities are for securing the needed supports.

Functional Assessment

Activities of Daily Living

HCBS case managers require specific information regarding the activities an individual can perform in order to arrange for services which enable the client to remain at home.

This section allows the HCBS case manager to determine the level of impairment an individual's is experiencing, based on specific medical,

emotional and cognitive status. It is based on standard scale which have been tested and validated in programs serving the individuals with physical disabilities.

The questions measure the degree to which an individual can perform various tasks that are essential to independent living. These tasks, called Activities of Daily Living (ADLs), include: bathing, dressing/undressing, eating, toileting, continence, transfer in/out of bed or chair, and indoor mobility.

The scale used to measure independence in ADLs uses ratings from 0 to 3. A score of zero represents complete independence (no impairment), while 3 represents complete dependence (impairment). Each item measures the level of impairment of the individual, regardless of how much help they might be receiving at present. In completing the section, the HCBS case manager should check the number which best corresponds to the individual's impairment level. The following general definitions must determine the ratings.

Information on each of the ADLs can be collected by observation, from the individual, a significant other, or collateral contact.

HCBS case managers will want to know how the individual usually performs a task, i.e., most of the time. An individual who has occasional difficulty should be coded based on their usual performance. However, occasional difficulties should be noted in the corresponding narrative/note.

Barthel Scale Scoring (as defined by C.V. Granger, July, 1974) Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-61. Used with permission. Permission is required to modify the Barthel Index or to use it for commercial purposes.

0:	Completely Able - Activity completed under ordinary circumstances without modification, and within reasonable time. (A "reasonable time" involves an amount of time the client feels is acceptable to complete the task and
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	an amount which does not interfere with completing other tasks, as well as the professional judgment of the Case Manager based on the client's age, health condition, (e.g. arthritis) and situation.
1:	Able with Aids/Difficulty - Activity completed with prior preparation or under special circumstances, or with assistive devices or aids, or beyond a reasonable time.
2:	Able with Helper - Activity completed only with help or assistance of another person, or under another person's supervision for safety, or by cuing. ANOTHER HUMAN IS INVOLVED IN ACTIVITY; but client performs at least half the effort him/herself.
3:	Unable - Client assists minimally (less than half of effort), or is totally dependent.

Some general concepts govern the manner in which an individual is compared with the assessment criteria: The individual is considered as a "whole entity." The Case Manager does not measure physical capacity, cognitive ability, or affective state separately, but rather one's functioning as a whole. For example, if one has ample physical strength and skill to complete a task, but also has cognitive limitations which prevent the individual from doing so, that person cannot complete it. The Case Manager also measures the individual's level of functioning in the present. What the individual could or could not do in the past is not an issue nor is what the individual, under hypothetical conditions, might be able to do in the future. Each task must be looked at as the sum of its parts. One must be able to complete all parts of a task in order to complete the task.

Further information to assist with evaluating the functional impairment includes the following; the case manager indicates the level of impairment in the Functional Assessment by choosing one of the four (4) selections (the number behind the description of the impairment indicates the points associated with the level of impairment). The total impairments and associated points are automatically added on the final screen of the functional assessment in the assessment tool. A Rating 2 OR 3 ON THE ASSESSMENT OF AN ADL INDICATES AN IMPAIRMENT.

The four (4) options for level of impairment under each ADL task is as follows:

Completely able: Able to complete the task independently and without difficulty.

Able with aids/difficulty: Able to complete the task without the assistance of another person, but does so with difficulty, use of equipment, or takes an inordinate amount of time to complete.

Able with helper: Needs another person to assist with the activity, but the individual is able to perform at least half the effort of completing the task.

Unable: Unable to complete, or assists minimally (less than half the effort), or is totally dependent on another person to complete the activity.

For each ADL the case manager must note the reason individual is not able to independently complete the ADL task as follows:

If an ADL is scored a 0 or 1, skip to next ADL.

If scored a 2 or 3 and informal supports assists, complete a and b, and c just stating who assists.

If formal HCBS supports are authorized to assist, complete a,b, c, d and outcomes fully

I need support with this activity because [justify impairment score]

In the narrative box provided, indicate the justification for the impairment in sentence form.

Example: I need support with bathing due to overall weakness and unsteadiness getting in and out of the shower.

The note may include:

The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.

Type of equipment used, if any. Any problems with equipment?

I like to [task] [frequency] times a week/day in the [morning/night/afternoon/no preference].

In the box provided describe the individuals request for when they would like the task completed and the frequency.

Example: I want assistance with bathing three times a week before bedtime.

The note may include:

Is individual able to complete the task as frequently as needed or wanted?

(Helpful hint: this is where the case manager starts to calculate how many units are needed for the overall service that the task fits under. Which will be noted under (c.) of the ADL. Such as bathing, dressing and nail care are all personal care tasks and would be authorized under the overall service of personal care.

For example: The frequency of the task for bathing would be as follows: The individual needs assistance with bathing for 30 minutes three times a week, and there are 5 weeks in a month. The individual would need 30 units of personal care services (PCS) for bathing.

Additionally, the individual needs one unit three times a week for dressing (frequency of bathing indicates 15 units a month) and 1 unit a week for nail care (5 units a month). This would add up to 50 overall units of PCS for the individual would need to be authorized. In letter (c.) the overall units for the authorized service (ie. PCS) will be noted.

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[Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

Who assists with the task?

What service does this task fall under.

Indicate the overall number of units authorized for this service type.

Example: QSP will support me with this task as part of the overall service of personal care. Total units authorized for personal care services are **not to exceed** 50 units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

To maintain hygiene and prevent injury/burning

To prevent skin breakdown and keep odor free

Other (3)

[if Other] Describe

Other information you should know about my [ADL]:

In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

Example: I get anxious and panicky when water runs over my face in the shower. It makes me feel like I am going to suffocate.

A full description of the specific ADL and required documentation in the assessment is as follows:

Bathing

This item measures the individual's applicant's/client's ability to bathe or shower or take sponge baths independently for the purpose of maintaining adequate hygiene as needed for the client's individual's circumstances. Consider minimum hygiene standards, medical prescription, or health related considerations such as incontinence, skin ulcer, lesions, cognitive ability, and balance problems. Consider ability to turn faucets, regulate water temperature, wash and dry completely.

Completely able: Able to complete the task independently and without difficulty.

Able with aids/difficulty: Able to complete the task without the assistance of another person, but does so with difficulty, use of equipment, or takes an inordinate amount of time to complete.

Able with helper: Needs another person to assist with the activity, but the individual is able to perform at least half the effort of completing the task.

Unable: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity.

For each ADL the case manager must note the reason individual is not able to independently complete the task in section a. of the ADL as follows:

I need support with this activity because [justify impairment score]

In the narrative box provided, indicate the justification for the impairment in sentence form.

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Example: I need support with bathing due to overall weakness and unsteadiness getting in and out of the shower.

The note may include:

The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.

Type of equipment used, if any. Any problems with equipment?

I like to [task] [frequency] times a week/day in the [morning/night/afternoon/no preference].

In the box provided describe the individuals request for when they would like the task completed and the frequency.

Example: I want assistance with bathing three times a week before bedtime.

The note may include:

Is individual able to complete the task as frequently as needed or wanted?

[Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

Who assists with the task?

What service does this task fall under.

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Indicate the overall number of units authorized for this service type.

Example: QSP will support me with this task as part of the overall service of personal care. Total units authorized for personal care services are **not to exceed** 50 units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

To maintain hygiene and prevent injury/burning

To prevent skin breakdown and keep odor free

Other (3)

[if Other] Describe

Other information you should know about my [ADL]:

In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

Example: I get anxious and panicky when water runs over my face in the shower. It makes me feel like I am going to suffocate.

Eating

This item refers to the individual's ability to feed themselves, including cutting meat and buttering bread. Consider individual's ability to chew, swallow, cut food into manageable size pieces, and to chew and swallow hot and cold foods/beverages. It does NOT refer to meal preparation. (This is covered in Meal Preparation).

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Completely able: Able to complete the task independently and without difficulty.

Able with aids/difficulty: Able to complete the task without the assistance of another person, but does so with difficulty, use of equipment, or takes an inordinate amount of time to complete.

Able with helper: Needs another person to assist with the activity, but the individual is able to perform at least half the effort of completing the task.

Unable: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity.

I need support with this activity because [justify impairment score]

In the narrative box provided, indicate the justification for the impairment in sentence form.

Example: I need support with eating due to overall weakness and limited dexterity.

The note may include:

The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.

Type of equipment used, if any. Any problems with equipment?

I like to [task] [frequency] times a week/day in the [morning/night/afternoon/no preference].

In the box provided describe the individuals request for when they would like the task completed and the frequency.

Example: I need assistance with eating three times a day for breakfast, lunch and dinner.

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The note may include:

Is individual able to complete the task as frequently as needed or wanted?

[Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

Who assists with the task?

What service does this task fall under.

Indicate the overall number of units authorized for this service type.

Example: QSP will support me with this task as part of the overall service of personal care. Total units authorized for personal care services are not to exceed 50 units a month.

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Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

To ensure adequate nutrition
To prevent choking or other safety concerns
Other

[if Other] Describe

Other information you should know about my [ADL]:

In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

Example: I
prefer to eat soft
foods due to
mouth soreness.

Mobility Inside

This item measures an individual's indoor mobility. The HCBS case manager may ask an applicant/client, "How do you usually get around inside?"

Do not consider transferring in and out of bed or chair.

Completely able: Able to complete the task independently and without difficulty.

Able with aids/difficulty: Able to complete the task without the assistance of another person, but does so with difficulty, use of equipment, or takes an inordinate amount of time to complete.

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Able with helper: Needs another person to assist with the activity, but the individual is able to perform at least half the effort of completing the task.

Unable: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity.

I need support with this activity because [justify impairment score]

In the narrative box provided, indicate the justification for the impairment in sentence form.

Example: I need support with mobility inside due to overall weakness.

The note may include:

The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.

Type of equipment used, if any. Any problems with equipment?

I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].

In the box provided describe the individuals request for when they would like the task completed and the frequency.

Example: I need assistance with ambulating around the house 5 times a day.

The note may include:

Is individual able to complete the task as frequently as needed or wanted?

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[Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

Who assists with the task?

What service does this task fall under.

Indicate the overall number of units authorized for this service type.

Example: QSP will support me by providing stand by assistance and a gait belt as part of the overall service of personal care. Total units authorized for personal care services are not to exceed 50 units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

To prevent falls, to maintain independence or access within home environment

To have no or minimal discomfort

Other

[if Other] Describe

Other information you should know about supporting me with mobility in my home:

In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

Transfer in/out of bed/chair

This item measures the level of assistance the individual needs in transfers.

Include the ability to reach assistive devices and appliances necessary to ambulate, and the ability to transfer (to/from) between bed and wheelchair, walker, etc.; the ability to adjust the bed or place/remove handrails, if applicable and necessary. Do not consider ambulation, itself, as this is considered under Get Around Inside.

Completely able: Able to complete the task independently and without difficulty.

Able with aids/difficulty: Able to complete the task without the assistance of another person, but does so with difficulty, use of equipment, or takes an inordinate amount of time to complete.

Able with helper: Needs another person to assist with the activity, but the individual is able to perform at least half the effort of completing the task.

Unable: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity.

I need support with this activity because [justify impairment score]

In the narrative box provided, indicate the justification for the impairment in sentence form.

Example: I need support with mobility inside due to overall weakness.

The note may include:

The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.

Type of equipment used, if any. Any problems with equipment?

I like to [task] [frequency] times a week/day in the [morning/night/afternoon/no preference].

In the box provided describe the individuals request for when they would like the task completed and the frequency.

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Example: I need assistance with ambulating around the house 5 times a day.

The note may include:

Is individual able to complete the task as frequently as needed or wanted?

[Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

Who assists with the task?

What service does this task fall under.

Indicate the overall number of units authorized for this service type.

Example: QSP will support me by providing stand by assistance with a gait belt as part of the overall service of personal care. Total units authorized for personal care services are not to exceed 50 units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

To prevent falls, to maintain independence or access within home environment

To have no or minimal discomfort

Other

[if Other] Describe

Other information you should know about supporting me with transferring:

In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

Dress/Undress

This item measures the individual's ability to dress or undress. Consider individual's needs of appropriate dress for weather or street attire. Consider ability to get clothes from closets and drawers as well as putting them on. Also include ability to put on prosthesis or assistive devices. Consider fine motor coordination for buttons and zippers, and strength for undergarments or winter coat. Do not include style or color coordination. Do not include tying shoes.

Completely able: Able to complete the task independently and without difficulty.

Able with aids/difficulty: Able to complete the task without the assistance of another person, but does so with difficulty, use of equipment, or takes an inordinate amount of time to complete.

Able with helper: Needs another person to assist with the activity, but the individual is able to perform at least half the effort of completing the task.

Unable: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity.

I need support with this activity because [justify impairment score]

In the narrative box provided, indicate the justification for the impairment in sentence form.

Example: I need support with dressing after my shower due to overall fatigue and unsteadiness.

The note may include:

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The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.

Type of equipment used, if any. Any problems with equipment?

I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].

In the box provided describe the individuals request for when they would like the task completed and the frequency.

Example: I need support with dressing after my shower three days a week.

The note may include:

Is individual able to complete the task as frequently as needed or wanted?

[Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

Who assists with the task?

What service does this task fall under.

Indicate the overall number of units authorized for this service type.

Example: QSP will support me by providing stand by assistance with dressing as part of the overall service of personal care. Total units authorized for

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personal care services are not to exceed 50 units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

To maintain appearance and keep odor free
To dress appropriately for weather
To maintain prevent injury

[if Other] Describe

Other information you should know about supporting me dressing/undressing:

In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

Toileting

This item deals with the individual's ability to get to the bathroom, get on/off the toilet, clean him/herself, manage clothes, and flush.

Consider frequency of need and need for reminders.

Completely able: Able to complete the task independently and without difficulty.

Able with aids/difficulty: Able to complete the task without the assistance of another person, but does so with difficulty, use of equipment, or takes an inordinate amount of time to complete.

Able with helper: Needs another person to assist with the activity, but the individual is able to perform at least half the effort of completing the task.

Unable: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity.

I need support with this activity because [justify impairment score]

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In the narrative box provided, indicate the justification for the impairment in sentence form.

Example: I need support with dressing after my shower due to overall fatigue and unsteadiness.

The note may include:

The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.

Type of equipment used, if any. Any problems with equipment?

I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].

In the box provided describe the individuals request for when they would like the task completed and the frequency.

Example: I need support with toileting 7 times a day.

The note may include:

Is individual able to complete the task as frequently as needed or wanted?

[Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

Who assists with the task?

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What service does this task fall under.
Indicate the overall number of units authorized
for this service type.

Example: QSP will support me by physical
assistance on and off of the toilet and
assisting with readjusting clothing as part of
the overall service of personal care. Total
units authorized for personal care services are
not to exceed ?? units a month.

Indicate the appropriate outcome of the service authorized, if other
indicate in the text box the appropriate outcome.

Outcomes

To maintain dryness, keep odor free, and prevent falls
To prevent skin breakdown and keep odor free
To maintain prevent injury

Other information you should know about supporting
me with toileting:

In this box indicate any other information that the
individual may want the provider to know about how
or why they prefer cares a certain way.

Bowel and Bladder Continence

Indicate the individual's bowel and bladder continence level.

Completely able: Able to complete the task independently and
without difficulty.

Able with aids/difficulty: Able to complete the task without the
assistance of another person, but does so with difficulty, use of
equipment, or takes an inordinate amount of time to complete.

Able with helper: Needs another person to assist with the activity,
but the individual is able to perform at least half the effort of
completing the task.

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Unable: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity.

I need support with this activity because [justify impairment score]

In the narrative box provided, indicate the justification for the impairment in sentence form.

Example: I need support continence to include assistance with changing undergarments and incontinence supplies due to limited strength and impaired ability to bend or move body.

The note may include:

The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.

Type of equipment used, if any. Any problems with equipment?

I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].

In the box provided describe the individuals request for when they would like the task completed and the frequency.

Example: I need support with continence three times a day in the morning, afternoon and at bedtime.

The note may include:

Is individual able to complete the task as frequently as needed or wanted?

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[Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

Who assists with the task?

What service does this task fall under.

Indicate the overall number of units authorized for this service type.

Example: QSP will support me by providing physical assistance to change incontinence products and assisting with readjusting clothing as part of the overall service of personal care. Total units authorized for personal care services are not to exceed ?? units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

To be clean, dry and odor free

To maintain dignity

To prevent skin breakdown

Other information you should know about supporting me with continence:

In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

If support person cannot assist me with these ADLS, (contingency plan).

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

This section deals with an individual's ability to carry out tasks which may not need to be done every day but are important for living independently. Intervention may be required to help an individual adapt to difficulties experienced in performing IADL activities. IADL items include meal preparation, housework, laundry, shopping, taking medicines, getting around outside, transportation, money management, and communication. Performance of IADL items requires mental as well as physical capacity. For example, taking medications and managing money require memory, judgment, and intellectual ability. The IADL scale measures the functional impact of emotional, intellectual, and physical impairments.

Not all individuals have the opportunity to perform IADL tasks. For example, an individual who lives with a relative or spouse might not prepare meals simply because another person routinely does this task. Similarly, some individuals do not manage their own money because a spouse does it. However, the IADL scale is designed to measure an individual's physical and cognitive ability to perform these tasks, regardless of the individual's opportunity to perform them. In asking individuals about IADL tasks, HCBS case managers must stress what the person can do rather than what he/she is doing, for example: "Can you prepare meals, do housework, shop, etc.?"

The HCBS Case Manager will want to know how the individual usually performs a task, i.e., most of the time. Individuals who have occasional difficulty should be scored based on their usual performance, noting occasional difficulties in the narrative/note.

The HCBS case manager obtains information regarding IADL impairments by observation, interview with family or friends, or by direct self-report of the client. The scale used to rate each IADL task differs slightly from the ADL scale.

It includes three basic categories of functioning:

0:	Without help. Applicant/client is able to perform task independently, without
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	supervision, reminder or assistance.
1:	With help. Applicant/client is able to perform task only with assistance, reminder, cuing or supervision.
2:	Cannot do at all. Applicant/client is not able to perform task at all, even with assistance.

In IADL score it is especially valuable to look at each task as the sum of its parts. Doing the laundry, for example, includes requirements of the physical ability to carry the wash to the washing machine, the cognitive ability to operate the washing machine including the measuring of soap and setting of controls, the physical ability to move clothes from washer to dryer, the cognitive ability to operate the dryer, the skill to fold and physical ability to carry the clean laundry back from the machine. If one can operate the washer and dryer but cannot carry the clothes to or from the machines, this person rates a #1, "with help."

SCORES OF 1 OR 2 IN ASSESSMENT OF AN IADL INDICATES AN IMPAIRMENT

Standard Definitions for each IADL item are as follows:

Meal preparation

The HCBS case manager may ask the individual, "Can you prepare your own meals?" Regardless of whether the individual actually does prepare meals, ask whether they can.

Consider the individual's ability to prepare hot and/or cold meals that are nutritionally able to sustain the client or therapeutic, as necessary. Consider individual's cognitive ability, such as ability to remember to prepare meals, individual's ability to prepare food, to open containers, to properly store and maintain foods, and to use kitchen appliances. Do not consider clean up because it is part of housework. Do not include canning of produce or baking of such items as cookies, cakes, and bread.

Without help: Able to complete the task without the assistance of another person.

With help: Needs some assistance from another person to complete the task.

Cannot do at all: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity.

a. I need support with this activity because [justify impairment score]

In the narrative box provided, indicate the justification for the impairment in sentence form.

Example: I need support with meal preparation due to overall fatigue and I cannot stand for any length of time.

The note may include:

The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.

Type of equipment used, if any. Any problems with equipment?

I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].

In the box provided describe the individuals request for when they would like the task completed and the frequency.

Example: I need support with meal preparation, the need for meal preparation is met by receiving home delivered meals for 7 days a week.

The note may include:

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Is individual able to complete the task as frequently as needed or wanted?

[Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

Who assists with the task?

What service does this task fall under.

Indicate the overall number of units authorized for this service type.

Example: HDM's supports me by providing a meal 7 days a week. Total units authorized for home delivered meals 31 units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

To maintain proper nutrition & hydration.

To ensure compliance with special diet or weight control.

To prevent injury

Other information you should know about supporting me eating:

In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

Communication

This item refers to the individual's ability to use the telephone, as well as comprehend oral and written communication. Include getting

telephone numbers and placing calls. The individual must be able to reach and use the telephone, answer the telephone, dial, articulate and comprehend. If the individual uses special adaptive telephone equipment, score the client based on the ability to perform this activity with that equipment.

In scoring communication, the case manager must look at each task as the sum of its parts. In determining an individual's functional impairment, we must consider whether the individual is impaired in communication using their primary language. For example, an individual who may not be able to fluently speak or understand English, but is able to communicate in their primary language, would not be considered impaired. However, if the individual's physical and cognitive ability to perform these tasks in their native language is impaired, the individual would be scored according to their level of impairment.

Special equipment in common use includes:

- amplifiers for people with speech and hearing impairments.
- enlarged dials or number stickers for the visually impaired.
- modified telephones for those with hearing aids.
- telephones hooked up to teletypewriters for those with speech impairments.
- signals (tone ringers, loud bells or lights) to indicate that the telephone is ringing.
- speaker telephones and headsets for persons who cannot hold receivers.

(NOTE: The use of an emergency response system device should not be considered when scoring this item because it can only be used for emergencies and does not enable its user to make or receive other essential calls such as arranging physician appointments or grocery deliveries.)

The tasks of routine writing/reading fall within the scope of the IADL of communication. Include the ability to understand and effectively respond to business mail, such as insurance mailings, applications for benefits, etc. If the individual needs a routine regimen of assistance with routine writing or reading of correspondence, this functional

impairment may be documented within the scope of the IADL of communication. Again, when determining whether an individual is scored as impaired in communication, the case manager must consider the ability of the individual to complete related tasks involving their primary language.

If an individual has no telephone, ask about his/her ability to use a telephone elsewhere (i.e., at a neighbor's home).

Without help: Able to complete the task without the assistance of another person.

With help: Needs some assistance from another person to complete the task.

Cannot do at all: Unable to complete or assists minimally (less than half the effort), or is totally dependent on another person to complete the activity. (2)

I need support with this activity because [justify impairment score]

In the narrative box provided, indicate the justification for the impairment in sentence form.

Example: I need support with communication to organize my mail and assist with arranging appointments as it is challenging to organize my thoughts and tasks since my last hospitalization.

The note may include:

The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.

Type of equipment used, if any. Any problems with equipment?

I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].

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In the box provided describe the individuals request for when they would like the task completed and the frequency.

Example: I need support twice weekly with mail and arranging appointments.

The note may include:

Is individual able to complete the task as frequently as needed or wanted?

[Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

Who assists with the task?

What service does this task fall under.

Indicate the overall number of units authorized for this service type.

Example: QSP will support me by providing assistance with mail and making appointments as part of the overall service of homemaker. Total units authorized for homemaker services are not to exceed 70 units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

To maintain social interaction with family and friends.

To access emergency assistance and maintain independent living

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To maintain services

Other information you should know about supporting me communication:

In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

Laundry

This item measures the individual's ability to do his/her laundry.

Can the applicant/client sort, carry, load and unload, fold and put away clothes? Consider the ability to work a coin-operated machine. Do not score if the only problem is that laundry facilities are located outside the home as the need for transportation is covered in Transportation. Consider the individual's cognitive ability to complete these tasks. Consider individual's physical and cognitive ability to complete these tasks even if applicant/client lives with others who do them for the individuals.

Without help: Able to complete the task without the assistance of another person.

With help: Needs some assistance from another person to complete the task.

Cannot do at all: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity. (2)

I need support with this activity because [justify impairment score]

In the narrative box provided, indicate the justification for the impairment in sentence form.

Example: I need support with laundry due to overall weakness and difficulties bending, lifting and carrying laundry.

The note may include:

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The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.

Type of equipment used, if any. Any problems with equipment?

I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].

In the box provided describe the individuals request for when they would like the task completed and the frequency.

Example: I need support with laundry on.

The note may include:

Is individual able to complete the task as frequently as needed or wanted?

[Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

Who assists with the task?

What service does this task fall under.

Indicate the overall number of units authorized for this service type.

Example: QSP will support me washing laundry once a week. Total units authorized for homemaker are not to exceed 70 units a month.

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Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

To keep clothing and linens clean and odor free
To maintain health and hygiene
To prevent injury

Other information you should know about supporting me with laundry:

In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

Taking medication

This item measures the ability of the individuals to take medicine by oneself. This is defined as: remembering to take medicine; getting the medicine from the place it is kept within the home; measuring the proper amounts; swallowing the pill; applying the ointment; or giving oneself injections (including the filling of syringe).

Score 0 for individuals who has no needs for medication or who perform tasks independently. Score according to client's ability to perform the task even if commonly done by others. Score need for service monitoring of medications due to possibility of overdose as a (2.) Do not include obtaining of medication from pharmacy as this is covered under Transportation.

Without help: Able to complete the task without the assistance of another person.

With help: Needs some assistance from another person to complete the task.

Cannot do at all: Unable to complete or assists minimally (less than half the effort or is totally dependent on another person to complete the activity. (2)

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I need support with this activity because [justify impairment score]

In the narrative box provided, indicate the justification for the impairment in sentence form.

Example: I need with medication due to overall weakness and diminished dexterity.

The note may include:

The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.

Type of equipment used, if any. Any problems with equipment?

I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].

In the box provided describe the individuals request for when they would like the task completed and the frequency.

Example: I need support with medication twice a day.

The note may include:

Is individual able to complete the task as frequently as needed or wanted?

[Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

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In the box provided describe how this need is met.

Who assists with the task?

What service does this task fall under.

Indicate the overall number of units authorized for this service type.

Example: QSP will support me opening my pill container and bringing me a glass of water.

Total units authorized for personal care services are **not to exceed ??** units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

To ensure access to medications

To maintain medication health

To prevent injury

Other

Other information you should know about supporting me with medications:

In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

Shopping

This item measures the individual ability to shop for groceries and other essentials assuming transportation or delivery is available.

Consider ability to make shopping lists, to function within the store, to locate and select items, to reach and carry purchases, to handle shopping carts, to communicate with store clerks, and to put purchases away. Do not consider banking, posting mail, monetary exchanges, or availability of transportation in scoring this item. Individual's ability to access transportation is measured under

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Transportation and ability to manage money is measured under Management of Money.

Without help: Able to complete the task without the assistance of another person.

With help: Needs some assistance from another person to complete the task.

Cannot do at all: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity. (2)

I need support with this activity because [justify impairment score]

In the narrative box provided, indicate the justification for the impairment in sentence form.

Example: I need support carrying my items with shopping as I cannot bend lift and carry due to pain and overall weakness.

The note may include:

The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.

Type of equipment used, if any. Any problems with equipment?

I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].

In the box provided describe the individuals request for when they would like the task completed and the frequency.

Example: I need support with shopping one times a week.

The note may include:

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Is individual able to complete the task as frequently as needed or wanted?

[Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

Who assists with the task?

What service does this task fall under.

Indicate the overall number of units authorized for this service type.

Example: QSP will support me by providing physical assistance with shopping under the overall service of homemaker. Total units authorized for homemaker are **not to exceed** ?? units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

To maintain independent living

To obtain needed items, supplies and groceries

To prevent injury

Other information you should know about supporting me with shopping.

In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

Mobility outside the home

This item refers to the individual's ability to move around outside, to walk or get around by some other means (i.e., wheelchair), and to do so without assistance.

Consider ability to negotiate stairs, streets, porches, sidewalks, and entrances and exits of residence and destination.

Without help: Able to complete the task without the assistance of another person.

With help: Needs some assistance from another person to complete the task.

Cannot do at all: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity.

I need support with this activity because [justify impairment score]

In the narrative box provided, indicate the justification for the impairment in sentence form.

Example: I need support mobility outside the home to access essential services such as shopping, due to overall weakness and needing assistance with my wheelchair.

The note may include:

The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.

Type of equipment used, if any. Any problems with equipment?

I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].

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In the box provided describe the individuals request for when they would like the task completed and the frequency.

Example: I need support with mobility outside the home one time per week.

The note may include:

Is individual able to complete the task as frequently as needed or wanted?

[Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

Who assists with the task?

What service does this task fall under.

Indicate the overall number of units authorized for this service type.

Example: QSP will support me by providing physical assistance to get outside my home to push my wheelchair as part of the overall service of personal care. Total units authorized for personal care services are not to exceed ?? units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

To maintain independent health and living.

To ensure safe arrival and departure
To prevent injury or getting lost.

Other information you should know about supporting
me with mobility outside of my home:

In this box indicate any other information that the
individual may want the provider to know about how
or why they prefer cares a certain way.

Transportation

This item measures an individual's ability to use transportation. For this question only, ability to use transportation includes access to a means of transportation.

Consider ability to negotiate entering and exiting of vehicle. Consider the ability to secure appropriate and available transportation and to know locations of home and essential places. Lack of appropriate and available transportation as needed, will increase the score. Consider cognitive as well as physical ability to use transportation.

Without help: Able to complete the task without the assistance of another person.

With help: Needs some assistance from another person to complete the task.

Cannot do at all: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity. (2)

I need support with this activity because [justify
impairment score]

In the narrative box provided, indicate the justification
for the impairment in sentence form.

Example: I need support accessing transportation
by scheduling transportation for appointments and

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navigating getting in and out of the vehicle due to weakness and confusion with organizing tasks.

The note may include:

The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.

Type of equipment used, if any. Any problems with equipment?

I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].

In the box provided describe the individuals request for when they would like the task completed and the frequency.

Example: I need support with transportation one time per week.

The note may include:

Is individual able to complete the task as frequently as needed or wanted?

[Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

Who assists with the task?

What service does this task fall under.

Indicate the overall number of units authorized for this service type.

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Example: QSP will support me by providing physical assistance scheduling appointments as part of the overall service of personal care. Total units authorized for personal care services are not to exceed ?? units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

To maintain health and independent living
To access community services
To prevent injury

Other information you should know about supporting me transportation:

In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

Housework

This item refers to the individual's ability to do routine housework.

The HCBS case manager might ask the individual "Are you able to do routine housework (such as dusting)?" and "Are you able to do heavy housework (such as washing floors)?" Again, be sure to stress ability, physical and cognitive, rather than actual performance.

Consider minimum hygienic conditions required for individual's health and safety. Do not include laundry. Do not include refusal to do tasks if refusal is unrelated to the impairment.

Without help: Able to complete the task without the assistance of another person.

With help: Needs some assistance from another person to complete the task.

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Cannot do at all: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity. (2)

I need support with this activity because [justify impairment score]

In the narrative box provided, indicate the justification for the impairment in sentence form.

Example: I need support housework due to overall weakness and fatigue.

The note may include:

The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.

Type of equipment used, if any. Any problems with equipment?

I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].

In the box provided describe the individuals request for when they would like the task completed and the frequency.

Example: I need support with housework once a week for 2 hours.

The note may include:

Is individual able to complete the task as frequently as needed or wanted?

[Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are

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not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

Who assists with the task?

What service does this task fall under.

Indicate the overall number of units authorized for this service type.

Example: QSP will support me by providing physical assistance housework as part of the overall service of homemaker. Total units authorized for personal care services are **not to exceed 70 units a month.**

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

To prevent injury

To maintain a safe and healthy environment

Other

[if Other] Describe

Other information you should know about supporting me housework:

In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

Money Management

This item refers to the individual's ability to handle money and pay bills.

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Consider client's ability to plan, budget, write checks or money orders, and exchange currency and coins. Include the ability to count and to open and post mail. Do not increase the score based on insufficient funds.

Some individuals may have a legal representative (guardian, conservator or representative payee).

Without help: Able to complete the task without the assistance of another person.

With help: Needs some assistance from another person to complete the task.

Cannot do at all: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity. (2)

I need support with this activity because [justify impairment score]

In the narrative box provided, indicate the justification for the impairment in sentence form.

Example: I need support with money management and organizing the associated paperwork due to confusion and inability to track tasks that need to be completed.

The note may include:

The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.

Type of equipment used, if any. Any problems with equipment?

I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].

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In the box provided describe the individuals request for when they would like the task completed and the frequency.

Example: I need support money management one time per week.

The note may include:

Is individual able to complete the task as frequently as needed or wanted?

[Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

Who assists with the task?

What service does this task fall under.

Indicate the overall number of units authorized for this service type.

Example: QSP will support me by providing assistance with going through my mail and paperwork as part of the overall service of homemaker. Total units authorized for personal care services are not to exceed 70 units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

To maintain independence

To ensure timely and accurate payment of bills

other

Other information you should know about supporting me money management:

In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

If Support person cannot assist me with these IADLS, (contingency plan).

Individual Specific Needs

Some individual needs require additional training and expertise for a qualified service provider to assist the individual with their individual specific needs. The specific needs are grouped into two categories and may require the QSP to get additional education. The case manager must ensure that the authorized QSP has the correct global endorsements or have been trained in the "Client Specific Needs" and this is listed on their QSP status in order for the QSP to be able to perform the task.

The Global Endorsements are:

Maintenance Exercise
Catheter Care
Medical Gases-Limited to oxygen
Suppository-non-prescription
Cognitive/Supervision (REQUIRED for RESPITE CARE, SUPERVISION & COMPANIONSHIP SERVICES)
Taking Blood Pressure, Pulse, Temperature, Respiration Rate
Ted Stockings (surgical stockings)
Prosthesis/Orthotics/Adaptive Devices
Hoyer Lift/Mechanized Bath Chair

The following Client Specific Endorsements (J-N) require verification of the provider's ability to provide the service for a particular client who requires the endorsement. Note: Send the completed Request for Client Specific

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Endorsement, SFN 830 to Medical/HCBS Services only if the client's case manager has authorized service for that endorsement.

Ostomy Care
Postural Bronchial Drainage
Jobst stockings (compression stockings)
Rik/Specialty Bed Care
Apnea Monitoring (is available only to a provider meeting the standards for Respite Care)

Individual specific needs/other services/global endorsements

Apnea monitor*
Cognitive/supervision*
Community integration
Exercises*
Eye care
Fingernail care (may not be authorized if individual has diabetes, heart or other circulatory conditions)
Hair care/shaving
Hoyer lift*
Indwelling bladder catheter*
Jobst stockings
Ostomy care
Oxygen/medical gases*
Postural/bronchial drainage
Prosthesis/orthotics*
Skin care
Social appropriateness
Specialty bed (Ric)*
Suppository/Bowel Program*
Ted socks*
Teeth, mouth, denture care
Vital signs**
Care Coordination
Emergency Response System
Nurse Education
Extended Personal Care
Extended Personal Care – Nurse

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Chore per Job
Chore Labor
Chore Labor (lawn)
Chore Labor (snow removal)

The tasks with an asterisk require additional information and documentation on file. The additional information is as follows:

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 PreAuth in Therap.

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 (including respiratory) functioning or communication 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.).

When authorizing the task of vital signs, the case manager must have on file: a written, signed recommendation (provided by a nurse or higher credentialed medical provider) outlining the requirements and frequency of monitoring.

Note: When authorizing vitals under [Community Support Services 525-05-30-21](#) or [Residential Habilitation 525-05-30-50](#) refer to specific instructions specified under the corresponding chapter.

"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.

Specialized Support

I need support with these activities because [justify impairment score]

I need support with this task [frequency] times a [day/week/month] in the [morning/night/afternoon/no preference].

[Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

Other information you should know in supporting me with specific needs

Supervision/Structured Environment

Supervised or Structured Environment Scoring

Discuss the need for supervision, and if there is a need for 24-hour supervision. What factors contribute to the individuals need for supervision. How has the individual been managing in periods when there has not been supervision? Describe any health or safety risks associated with the lack of appropriate supervision.

A setting such as adult foster care, adult residential care or basic care does not justify the need for supervision.

Does the individual require supervision or a structured environment on a continuous basis except for brief periods of time.

Yes

No

I need support with this because [justify impairment score]

Describe any additional information that would be helpful to support me during supervision or within the structured environment.

If [support person] cannot assist me, [contingency plan].

Quality Review

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 Quality Review process is used to obtain information from individuals/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.

The Quality Review is to be completed for all individuals, regardless of funding source, with the exception of Basic Care. The Quality Review helps to determine an individual's satisfaction with services but is also used to determine compliance with the HCBS settings rule. Any violations of rights must be reported to Program Administration. This section is to be completed during the annual assessment and six-month review. This section is not to be completed during an initial assessment, as services have not yet been implemented.

Financial Assessment

A financial assessment is required in accordance with policy for Service Payments for the Elderly and Disabled (SPED) 525-05-25-20 regarding financial information for SPED and Medicaid Waiver for Home and Community Based Services 525-05-25-10.

For individuals receiving SPED, this section of the Participant Assessment, along with the SFN 820, must be completed. Instructions for completion of the complete SFN 820, SPED Income and Asset form and assessment in can be found at <https://www.nd.gov/dhs/policymanuals/52505/52505.htm>.

Caregiver Assessment

The caregiver assessment must be completed initially and every six months for all formal/paid live-in providers, including FHC and FPC providers.

Discuss options for respite care and other programming that may provide caregiver supports and relief. Options may include support groups, Powerful Tools for Caregiver evidence-based training, socialization opportunities, the Alzheimer's Association, etc. This assessment may be done via telephone if the individual is not able to participate in a face-to-face meeting.

Risk Assessment and Health and Safety Plan

The Risk Assessment and Health and Safety Plan must be completed initially, annually, and every six months. The Risk Assessment and Health and Safety Plan may need to be updated when there is a critical incident, QSP complaint, or VAPS report that identifies a risk or potential risk: including but not limited to risks related to financial concerns, legal issues, fire safety, falls, access to health care, family issues, natural, community or social supports, mental health/behavioral health needs, cognitive decision making, nutrition, medication, employment, education, and housing. The case manager and client will review the assessment results and develop the Risk Assessment and Health and Safety Plan to reduce or help mitigate risk.

A risk assessment must be completed in the following circumstances:

Critical incident report (CIR) has identified a risk to the individual served by HCBS.

The Program Administrator responsible for monitoring and review of all CIR's will contact the case manager in the event there is a CIR that requires a risk assessment.

QSP complaint has identified a risk to the individual served by HCBS.

The Program Administrator responsible for monitoring and review of all QSP complaints will contact the case manager in the event there is a complaint that requires a risk assessment.

VAPS report has identified a risk to the individual served by HCBS.

VAPS and HCBS case manager will work together to ensure a risk assessment is completed and included in the person-centered plan of care.

The risk assessment may include:

How safety needs or risks were assessed based on the individual's abilities and current condition.

Any approach that has been taken to mitigate identified risks.

Any deviation from helping the client to achieve their goals or assure their health and safety.

Interventions and methods that were tried first but were not successful.

Any specific timeline for periodic review if the timeline of the review varies from the required reassessment and monitoring reviews.

Recipients must be fully informed of the plan and any modifications made to their stated preferences or goals to assure safety. The risk assessment must be completed in collaboration with the individual and/or their legal representative and any other formal or natural supports the individual wishes to include in the assessment of risk and risk mitigation planning. Documentation must be included to assure that the intervention will not cause harm to the recipient.

The individual and/or their legal representative must sign the risk assessment and be given a signed copy.

A copy of the signed risk assessment must be retained in the individual's file.

Narrative/Case Note:

All contacts relating to the individual must be documented in the case notes in Therap.

Requirements

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Date

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

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

A description of the exchange between the case manager and the individual or the collateral contact.

Whether the exchange was face to face or by other means.

Client satisfaction and follow-up plan

SPED Program Pool Data, SFN 1820 525-05-60-15
(Revised 1/1/20 ML #3570)

[View Archives](#)

Purpose: To provide evidence an applicant is eligible for the Service Payments for the Elderly and Disabled (SPED) program. This form, SPED Program Pool Data, SFN 1820, is forwarded to the Aging Services Division, along with the Add New Record MMIS Eligibility File, SFN 676, in order to enter the applicant into the SPED 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

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 "yes".

ADLs: Based on the functional assessment, transfer the scores from the assessment document to the applicable score box. 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. IADLs scored in this

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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 SPED program, the following criteria must be met:

Impaired (score is 2 or 3) in at least two (2) Activities of Daily Living (ADLs)

OR

Impaired (score is 1 or 2) in at least four Instrumental Activities of Daily Living (IADLs), totaling at least four (4) points if living alone, or six (6) or more points if living with an able-bodied adult.

Please indicate whether the SPED applicant's total assets are below \$25,000 or above \$25,000 by selecting the appropriate box.

In an effort to measure the goal of preventing or delaying nursing home placement, please indicate whether or not the SPED applicant would reasonably meet the LOC screening for nursing home placement.

For SPED Personal Cares Only: Record the estimated amount of SPED Personal Care Service and provide an explanation why the applicant is not medical assistance eligible and seeking Medicaid State Plan Personal Care Services.

Case Manager: Record the HCBS Case Manager's name.

County and County Number: Record the county in which the client resides and the county number.

Client Participation Fee: Record the applicant's percentage portion of the cost of services as determined by the SPED financial eligibility criteria. This

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percentage will be found by completing the SPED Income and Asset Form (SFN 820). This percentage must match the percentage on the "Add New Record to MMIS Eligibility File" (SFN 676).

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 1820).

SPED Income and Assets, SFN 820 525-05-60-20

(Revised 03/01/2024 ML #3829)

[View Archives](#)

Purpose: In order for individuals to access the SPED program, information regarding assets, income, and deductions must be obtained to determine SPED program financial eligibility.

The [SFN 820](#) must be completed (at a minimum) at the time of application and annually thereafter. If there is a significant change to the individual's financial resources or documented deductions, a new SFN 820 must be completed and signed by the individual if the individual remains eligible for SPED program services.

If a question arises on how to count a particular asset or income that is not covered in this section the HCBS Program Administrator will consult with State Medicaid Eligibility staff for guidance. Medicaid financial eligibility criteria may be used to make decisions involving SPED eligibility not covered in policy.

The information obtained on the SFN 820 must correlate with the web-based data collection system Income and Asset worksheet.

CLIENT INFORMATION – record the individual's name, Client identification number, individual's address, whether or not they are covered members of health insurance, and whether or not they are recipients of Medical Assistance. (If they are QMB or SLMB only – do not record "yes". Only record yes if they are receiving Medicaid State Plan medical and/or personal care services.)

ASSETS

The total amount of funds held in any type of joint account is considered an available asset to the applicant/client unless the applicant/client can verify that the funds are, in fact, the sole possession of only one owner that has the generally recognized authority to direct disbursement. When the applicant/client claims that he/she is NOT in possession of the funds AND

CANNOT direct their disbursement, substantiating documentation must be included in the case file. The applicant's/client's oral statement alone is not sufficient. This statement applies to all types of assets.

Just as the income of the spouse must be considered in completion of SFN 820 SPED Income and Asset form, all liquid assets of the spouse must be considered in determining SPED Program eligibility even if the applicant/spouse's name is not on the statements or accounts. See N.D.C.C. [14-07](#). This applies also to applicants who have pre-nuptial or ante-nuptial agreements. The statutory obligation to support and care for a spouse is not negated by such agreements nor whether the spouse's name is included on financial documents. However, you do not need to count the income or assets of the spouse if the applicant or recipient states that there has been a marital separation, with or without court order, and the spouses are currently living in separate households and have not separated for the purpose of securing HCBS benefits.

- A1 Crop inventory: Non-contract crops held in storage at the discretion of the owner, who is the applicant/client, is considered a liquid asset for purposes of the SPED Program. However, crops being held for feed or for planting would not be included as an available asset. The cash value is based on the market price on the date of application or annual review.

- A2 Cash – includes: Coins, currency, checking, savings accounts, money market accounts, and/or Certificates of Deposit. Include all accounts the individual has access. Funds held or prepaid for funeral accounts are also considered assets and cannot be deducted for the purposes of determining SPED eligibility. Any income or dividends received are reported as income, not in the asset section.

- A3 Bonds – savings bonds, treasury bonds, others. Record the face value of the bond. The earnings are reported in the

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income section of this form.

- A3 Mutual Funds - A type of mutual fund that allows investors to write checks against their account in established increments. The earnings are reported in the income section.
- A3 Stocks – the current value of the stock is reported in the asset section, the dividends are reported in the income section.
- A3 Trusts - All trusts must be submitted to Medical Services HCBS Program Administrator to coordinate review with the Legal Advisory Unit to determine how the trust will affect financial eligibility.
- A4 Retirement programs: Earnings on retirement programs are tax deferred until taking payouts. At that time the income is reflected on their federal income tax form. If the individual will realize a penalty for an early withdrawal from the retirement account, the retirement account would be exempt.
- A5 Residence other than Primary residence – individuals owning more than one residence, must report residence other than the primary residence as a liquid asset. If the individual owns more than one residence, the value of the other property, less the secured debt owed for the property, that is not the primary residence is counted in determining the financial eligibility. In order to obtain the value, you may use a recently completed appraisal, or verify documentation from the county assessor showing the assessed value. If this documentation cannot be obtained, the fair market value can be obtained by contacting real estate or lending institution personnel.

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Individuals residing outside of their home: If an individual is residing outside of their residence, that residence must be considered as an asset if not otherwise occupied. A residence is considered occupied when occupied by self, spouse, or minor dependent OR when the individual is temporarily absent but possesses the ability to return within a certain length of time which is reasonable. A reasonable length of time is six months.

- A6 Other Liquid Assets - The face value of loans that the applicant/client has made to others (money owed to the applicant/client) is also a liquid asset. Common loans are notes, and mortgages. Contracts for Deed and Limited Partnerships are excluded due to the difficulty of establishing a current market value for such instruments on the open market.
- A7 Total Assets – if using the electronic (e-forms) SFN 820, the amounts entered for assets will automatically sum and be recorded on this line. If using the paper copy of the SFN 820, add the amounts from the asset types and record the sum on this line.
- A8 Disqualifying transfers – If a current SPED client has transferred or assigned assets for the purpose of continuing to make themselves eligible for SPED services, or to reduce the amount of their service payment or if an applicant has transferred or assigned assets within five years of the date they initially applied for SPED to make themselves eligible for services check yes, this is considered a disqualifying transfer. If you check yes, please describe the nature of the disqualifying transfer.
- A9 Money and assets in a North Dakota Achieving a Better Life Experience (ABLE) Plan are not considered for the purpose of determining eligibility in order to receive SPED services.

Total annual contributions into an ABLE account may not exceed the federal gift tax limit of \$15,000. ABLE accounts up to \$100,000 do not affect asset limits for SPED financial eligibility.

Verifying Assets

The individual must provide their most recent federal income tax form 1040 AND the most recent monthly, quarterly or annual statement from the company(s) holding such liquid assets. If the individual does not make the documents available, eligibility cannot be established. Therefore, eligibility is denied or terminated. If the individual did not file a tax return for the previous year, other documentation must be obtained. Such documentation may include, but may not be limited to:

1. Bank statements
2. Monthly/Quarterly/Annual financial statements from the investment/financial institution(s)
3. Employer reporting statements
4. Contracts or other legal documentation

By reviewing these documents, the HCBS case manager can confirm the value of the liquid assets as well as the income derived from accounts or arrangements.

Exempt (Liquid) Resources

Excluded when calculating the value of the applicant's/client's resources are:

1. Cash surrender of life insurance policy(s).
2. Annuities or other pension plans IF a penalty would be imposed for withdrawal at the time of application or redetermination of eligibility. (e.g. There would be a penalty for withdrawal of funds from an IRA if the applicant/client is under 59 years.)
3. Any amount necessary for the fulfillment of a Plan for Achieving Self-Support (PASS) under Title XVI of the Social Security Act (SSI) will NOT be counted as an asset.

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4. Contracts for deed or limited partnerships. Contracts for deed and limited partnerships are excluded due to the difficulty of establishing a current market value for such instruments on the open market.
5. Limited Partnerships.

Funds held or prepaid for funeral accounts cannot be deducted for the purposes of determining SPED eligibility.

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Asset Detail – record the Asset Type, Institution/Organization, Invoice/Statement Date, and Statement Amt or Balance. Examples:

Individual has \$342 in checking, \$200 in savings, \$23 in cash, and \$12,475 in a retirement account.

Asset Type	Instit/Organ	Invoice/St. Date	St. Amt or Balance
Cash	Smith Credit Union	July 8, 2005	\$342
Cash	On-hand		\$23
Retirement Prog.	NP Railroad	July 1, 2005	\$12,475

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Section 1, HOUSEHOLD INCOME SECTION

If the primary income comes from self-employment, or a combination of salaries and self-employment, add the monthly amounts from the income sources.

If a client has self employment income but does not have a tax return reflecting this income, disregard the first \$65 of the monthly self

employment income and one-half of the remaining self-employment income.

Some farmers report not having enough income to file federal income tax. Federal farm program payments are reported to IRS (Internal Revenue Service) on a 1099. Therefore, an IRS representative advises that farmers would file an IRS 1040 so that IRS knows why no tax was due for the year. The farmer or rancher may have a negative taxable income after personal exemptions and other deductions are made. The figure required on the [SFN 820](#) is the "Adjusted Gross Income," the last line on the first page of the IRS 1040; not the taxable income shown on the back. The farmer or rancher, as operator or as renter, must have federal tax forms.

For an applicant/client having rental farm property, the net income on IRS form 4835 is entered on the front page of the 1040. That is the amount reported on the [SFN 820](#) divided by 12 months.

For the applicant/recipient reporting income or loss as operators of their farm or ranch, the amount is determined by use of IRS Schedule F. That is the amount entered on SFN 820 after dividing by 12 months.

If a family member is paying room and board for the recipient who resides in an Adult Foster Care home you do not need to count the amount of room and board paid as income if the payment is made directly to the provider. If the money is paid or deposited directly to the recipient it must be counted as income.

Payment from reverse mortgages is not counted if it is a type of reverse mortgage that needs to be repaid unless, the amount of the reverse mortgage results in a profit for the recipient and or the recipient's spouse. If they receive a payment in excess of the value of the home it would be counted as income.

Income received by the recipient or the recipient's spouse as the result of a community benefit, go fund me account etc. will be considered countable income unless the money is deposited in to an account that is managed by

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a 3rd party. Countable income may be calculated by dividing the total amount received /12 months to get a monthly average.

In addition to completed IRS tax forms, include the following:

B Wages, Salaries – record the wages and salaries found from income tax documentation, federal tax form 1099, and/or federal tax form W2. If the individual does not file taxes or has limited wages or salaries and tax documentation is not required, copies of checks or receipts may be used.

B3 Veterans Benefits – include all benefits including Aid & Attendance unless counting Aid and Attendance as income will have a negative effect on an individual's eligibility for SPED. In that case, you can deduct the amount of Aid and Attendance the individual receives from the amount of SPED services being authorized.

If a veteran is unsure of the amount of Aid and Attendance payment included in their veteran's pension, contact the county veteran's office to obtain the information.

B4 Social Security, SSI, Disability Income

B5 Dividends, Interest – found from financial accounts from financial institutions or could include interest paid to the applicant/client from a loan or sale of property/goods.

B6 Estates, Trusts, Net Rentals, Royalties

B7 Pensions, Annuities

B8 Temporary Aid for Needy Families

B9 County General Assistance

B12/B1 Self-Employment Income
3

B2/B10 Combine alimony/child support/unemployment
/B11/B compensation/Workers Compensation/ and other

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Disregards to Income

1. Compensation or stipends received by volunteers participating in Senior Community Service Employment Program (formerly known as the Green Thumb project or Experience Works) or Senior Companion;
2. Income earned or unearned by dependent children;
3. Income earned of adult children caring for parent(s);
4. The family home care payment if the spouse is the family home care provider;
5. The conversion of one asset form to another form may not be considered income.

Example 1: A house is sold for cash. The cash would not be considered income but would be considered additional liquid assets.

Example 2: Cash is converted to a CD. The CD is considered as a liquid asset, but now the interest generated from the CD would be income. If a client has made the choice to reinvest the interest by having the interest increase the value of the CD or saving account, the interest is to be considered as income in the month in which the client could have accessed the dividend or interest.

6. Any amount of funds held in a restricted or unrestricted IIM account.
7. Recovery Rebates authorized by section 2201 of the Coronavirus Aid, Relief, and Economic Security Act of 2020 [Pub. L. 116-136].

Section 2: DEDUCTIONS TO INCOME

Deduct the following monthly expenses to determine the family adjusted gross monthly income:

- | | |
|----|---|
| C1 | Child Support Payment For Child(ren) Not Claimed As Dependent(s) |
| C2 | Medical Deductions, a medical deduction of up to \$850 for a family or \$500 for an individual is allowable for any |

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medical/accident insurance paid by the individual AND any regular payment (out of pocket) for medical expenses. Medical expenses do not include prescription drugs. If the individual is a recipient of Medicaid or Economic Assistance programs, the information has already been verified and is on file with the Eligibility Specialist. In these cases, the case manager can cross reference those files.

Medical expenses include, but are not limited to, the following items, which must be paid for either in part or full by the client:

- Health/accident insurance: insurance premium, Medicare Part B payment, coinsurance, and deductibles on health plans.
- Medical services by a licensed medical facility or professional
- Supplies for incontinence (e.g. Depends, Chux, et cetera)
- Adaptive Devices such as wheelchairs, crutches, eyewear
- Medical Transportation costs: bus, taxi, train, or plane fares; actual care expenses such as gas and oil or 65 cents a mile; and parking fees and tolls.
- Long term care premiums
- Over the counter medications (non-prescription) that a medical professional has directed the client to take for a specific medical condition. The client will need to obtain a written recommendation from a medical professional for the over the counter medication, and it must relate to a specific health condition.
- Private pay personal care services (would not include SPED service fee).

- C3 Child Care Expenses paid Because Of Employment
- C4 Alimony (Paid)
- C5 Prescription Drugs -- For out of pocket prescription drugs deductions, the drugs must

be verified and the information recorded in the Deduction Detail section (unless can cross reference with eligibility specialist). Medical marijuana is considered a prescription drug for which out of pocket payments can be deducted if the individual provides verification of a valid registry identification card, and items purchased can be verified via receipts from a North Dakota registered compassion center dispensary.

Upon completion of the document, the client will sign signifying they have provided the county with all information required to meet SPED financial eligibility. The individual should not sign the document until the verification process has been completed.

The "For Office Use Only" section is for case managers to assess the client service fees based on the sliding fee schedules, sign, date, and designate documentation is on file.

Also in this section, the case manager will record the "Number of Individuals" in the household. This number should only contain those persons counted in the official household count.

The form, SFN 820, is not available from the Department. HCBS Case Managers are required to make sufficient copies for their use. The form is available electronically through the state e-forms system.

Overpayment

If there are credible allegations that an individual or their legal representative concealed or misrepresented financial or functional information with the purpose of obtaining eligibility for HCBS, the Department may recoup the overpayment.

SPED Sliding Fee Schedules 525-05-60-25

(Revised 07/01/24 ML #3847)

[View Archives](#)

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

Click to view and/or print these schedules.

[Schedule 1](#)

[Schedule 2](#)

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

(Revised 03/01/2024 ML #3829)

[View Archives](#)

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.

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) file.

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.

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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 and cannot be retroactive.

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?

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

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For a rate change, address change, correction (which includes a legal name change requests), or to re-open within 60 days from the date of closure, this completed form is to be emailed or faxed to Aging Services/HCBS.

If an individual has a legal name change, a copy of the individual's social security card is required for the name to be updated in MMIS. The case manager is to include this copy along with the SFN 676 when requesting a name change.

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
(Revised 1/1/20 ML #3570)**

[View Archives](#)

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

Does the Person Live Alone: If the person lives alone, or lives with minor children, or any adult that is not considered able-bodied, check "yes".

ADLs: Based on the functional assessment, transfer the scores from the assessment document to the applicable score box. 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. 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:

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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.

Indicate whether the applicant is receiving Supplemental Security Income (SSI).

If the applicant is not receiving SSI, record his/her monthly income. The monthly income must be at or below the maximum monthly SSI amount.

In order to be eligible for Ex-SPED, the applicant must be on Medicaid. Please indicate if this has been verified.

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

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](#)).

Level of Care Determination 525-05-60-45

(Revised 5/1/19 ML #3551)

[View Archives](#)

Purpose: The purpose of this form is to determine/redetermine functional eligibility for the Waiver programs or for minor children applying for the SPED program.

It is the responsibility of the County to trigger the screening either by telephoning DDM or by submitting information to Dual Diagnosis Management Ascend Management Innovations (DDM). The information is verified and documented in the completion of the materials identified in items 1 and 2 below. Item number 2 below is the ONLY form that needs to be submitted to DDM.

1. A copy of a completed HCBS Comprehensive Assessment Form, OR if the screening is for a person under age 18 the Social History completed for HCBS Case Management.
2. Level of Care (LOC) Determination Form.

If you mail the screening information to DDM, the Level of Care Determination Form is the only form that needs to be submitted.

Forms are to be mailed to:

Dual Diagnosis Management (DDM)
North Dakota Review Staff
220 Venture Circle
Nashville, Tennessee 37228
Phone: 877-431-1388
Fax: 877-431-9568

Before conducting the telephone screening with DDM you must have completed the Level of Care Determination form. This includes having the client's Medicaid ID number. When conducting telephone screenings, you

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must have the written materials on file in the client's case records for verification of the information transmitted in the telephone screening.

When the telephone screening has been completed, send a copy of the completed LOC Determination form to DDM.

If you are unable to resolve screening issues with DDM, contact Medical Services at 701-328-4864.

To access the DDM website, visit <https://www.ascendami.com/ami/>.

To complete a LOC screening online or to review LOC form instructions or other educational materials, visit the DDM website and select "North Dakota PASRR/LOC" or visit <http://www.pasrr.com/NorthDakotaDefault.aspx>.

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

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

[View Archives](#)

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

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

Section 1:

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

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

Section 2:

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

1. Nurse Educator will review Virtual Support Option requirements
2. Nurse Educator will acknowledge completion by checking each box listed below the requirements to confirm understanding
3. Nurse Educator will fill out which HIPPA compliant service delivery provider was utilized

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4. Nurse Educator will fill out where the Nurse Educator was located during the time the Virtual Supports Option was utilized
5. Nurse Educator will fill out where the client was located during the time the Virtual Supports Option was utilized
6. Nurse Educator will complete the number of Nurse Education units requested per month if additional units are needed and the frequency needed
7. Nurse Educator will total the units for a six-month period
8. Nurse Educator will write detailed plan on how the Nurse Educator will address any health, safety, or behavioral needs while the Virtual Supports Option is being provided
9. Nurse Educator will review HIPPA laws and print Nurse Educator name, sign, and date the form
10. Nurse Educator will submit document to HCBS Case Manager for State RN Program Administrator review

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

(NEW 07/01/2024 ML #3847)

[View Archives](#)

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

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

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

(Revised 07/01/2024 ML #3847)

[View Archives](#)

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

SECTION I: IDENTIFYING INFORMATION

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

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

SECTION II: ASSIGNMENT OF POINT VALUE(S)

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

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

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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).

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 SFY24 Rate. The rate that calculates in this column is the daily rate.

If the calculated rate exceeds the funding source maximum (see maximum amounts at the bottom of the MRW), record the maximum rate in the column marked SFY24 Rate.

SECTION IV: PROVIDER INFORMATION

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

DISTRIBUTION

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

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

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

(Revised 05/01/23 ML #3730)

[View Archives](#)

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 an individual, 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 individual's name, county of residence, funding source (i.e. SPED, Ex-SPED, HCBS Medicaid Waiver) specific service or task (if applicable) and the reason services are denied, closing, or terminating.

The 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 individual's needs.

When the individual is no longer eligible for a specific HCBS Program or service, the HCBS case manager must terminate services under the funding source and end or delete any current authorizations (Preauths), issued to the individual's provider(s). Even if services continue under another funding source, the individual 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:

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

Date: Record the date of completion;

Individual Name, Individual ID: Record the individual's first and last name and the identification number (if applicable) The identification number is the individual's "ND Number";

HCBS Case Manager Name, County Name (Individual's county of residence), Title of Employee;

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

Reason: Record the reason why the individual is being terminated for the service or program, or the reason for denial.

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

Date this Denial or Termination is Effective: The individual must be notified in writing at least 10 days prior to the date of termination or denial 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.

Appeal Rights are outlined on the SFN 1647.

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.

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If a SPED or ExSPED 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.

During an open appeal:

The case manager may share with the provider that the individual is currently terminated from HCBS, but that the case is in the appeals process. While a determination is being made, the department is able to authorize services under HCBS Medicaid waiver, but cannot specify how long services will continue.

The case manager shall not share with the provider any information that is within the appeal or why the individual was terminated.

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

**HCBS Case Closure/Provider Termination, SFN 474
525-05-60-80**

(Revised 2/1/22 ML #3663)

[View Archives](#)

Purpose: To notify Aging Services/HCBS that an HCBS case and/or FHC/FPC provider has closed to take action on a level of care screening for a Medicaid waiver case that would temporarily or permanently end a screening, or to reopen a current screening.

When Prepared:

This form is to be completed for:

- Case Closures related to individuals receiving services under SPED, Ex-SPED, and Medicaid waiver;
- Medicaid waiver LOC closures and reopenings;
- Termination of a QSP if a QSP is closing his/her status when the individual's case is closed (including Family Home Care or Family Personal Care providers even if they remain an individual QSP and/or serve other individuals).

Steps of Completion:

In the first section, complete the individual's name, identification number, county name where the individual resides, and name of the case manager.

Waiver LOC Screening Reopen/Closure Section:

Mark appropriate action being taken: Reopen current screening or termination/closure of a screening.

Waiver reopen-close section:

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Reopen Current Screening effective date: Record the date the Medicaid waiver services are to begin. This line is used when an individual's Medicaid waiver LOC screening was previously closed and now must re-open.

- Example: an individual receiving Medicaid waiver services entered a skilled nursing facility, swingbed, or other facility in which Medicaid waiver services cannot be received, and the current screening was closed. This individual then transitions back to Medicaid waiver services and therefore needs the screening to re-open.

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 to communicate when and why the Medicaid waiver LOC screening is to be terminated/closed. Enter the date of the LOC closure, and the closure code. The closure codes are identified in the "Waiver LOC Screening Reopen/Closure Section" Even if the individual's overall Medicaid waiver case will remain open during a short stay skilled nursing facility or swingbed admission, this section must be completed to close out the LOC screening. **This section is not completed if the overall Medicaid waiver case is to close. Instead, the Case Closure/Denial Section is completed, as described below.**

Case Closure/Denial Section:

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

Enter date of closure, and the closure code. The closure codes are identified in the "Case Closure Codes" section of the form.

If an individual is closed due to death, a critical incident report must be completed (see Critical Incident Reporting 525-05-42). The date of closure should match the date of death.

Provider Termination:

Complete this section if the case closure results in the closure of the provider's FHC/FPC status for the individual (even if they remain an individual QSP and/or serve other individuals) or if a provider's QSP status is to terminate completely (no longer working as a QSP). Include the provider's full name and provider number.

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Aging Services/HCBS will process the documentation in order to close the QSP provider file as appropriate.

The HCBS Case Closure/Provider Termination (SFN 474) is due to Aging Services/HCBS within 3 working days of the date of closure.

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

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

Respite Home Evaluation, SFN 659 525-05-60-85
(Revised 1/1/20 ML #3570)

[View Archives](#)

Purpose: The form is completed to provide evidence that the respite care QSP's home meets the following minimum standards.

When Prepared:

Upon the request of a provider who is enrolled and eligible to provide respite care.

By Whom Prepared:

A minimum of one (1) home visit to the respite care QSP's home shall be made by the HCBS case manager to complete the "Respite Home Evaluation". The HCBS case manager shall maintain records of the evaluation, the decision, and the reason for that decision.

SPECIFIC INSTRUCTIONS:

Check standards 1-16 either yes or no. This section does not need to be completed if the home is a licensed Adult Foster Care Home.

All responses must be yes prior to consideration of approval for a Respite Care QSPs Home.

If the home is approved, complete valid through, not to exceed two years, check they meet the standard, sign and date the form. The Respite Home Provider must agree to maintain the standard by signing and dating the form.

If the home does not meet the standard check the box that indicates "does not meet the standard", and sign the form. Make the provider aware they do have the opportunity to reapply to be a Respite Care QSP Home when they have made any needed corrections to meet the standard.

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The HCBS case manager must ensure the chosen QSP has the ability to provide the requested service by checking the web-searchable database.

Approval of Respite Care QSP's Home

Upon determining the respite care QSP's home meets the standards, a copy of the completed SFN 659 approving the respite care home is provided to the provider. Should the respite care QSP move, another evaluation is required. Send a copy of the completed SFN 659 to Aging Services/HCBS.

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

**Compliance Checklist/Adult Day Care Standards, SFN
1703 525-05-60-90**

(Revised 2/1/17 ML #3490)

[View Archives](#)

Purpose: The form is completed to provide evidence that a freestanding Adult Day Care facility or home meets minimum standards.

When Prepared:

Upon the request of a potential free standing Adult Day Care facility or home. (A free standing Adult Day Care facility is an Adult Day Care that will not co-mingle residents, share staff and be located within a licensed nursing home or basic care facility. Adult Day Care facilities that are located with a licensed nursing home or basic care facility, share staff and co-mingle the residents should contact Health Facilities as they may be designated as an Adult Day Care based on their current license. These facilities do not need to complete a check list.)

By Whom Prepared:

The county social service board shall make a visit to the free standing Adult Day Facility or home to complete the checklist, maintain a record of the evaluation, the decision, and the reason for that decision.

SPECIFIC INSTRUCTIONS:

Check all standards in sections I-III either yes or no.

All responses must be yes prior to consideration of approval for an Adult Day Care freestanding facility or home.

If the Adult Day Care facility or home is approved complete the valid through section, not to exceed two years, check that they meet the standard, sign and date the form. The Adult Day Care Provider must also agree to maintain the standard by signing and dating the form.

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If the facility or home does not meet the standards, check, does not meet the standard, and sign the form. Make the provider aware they have the opportunity to reapply to be an Adult Day Care QSP when they have made any needed corrections to meet the standards.

Approval of Adult Day Care Facility or Home

Upon determining the free standing Adult Day Care QSP facility or home meets the standards, a copy of the completed SFN 1703, Compliance Checklist/Adult Day Standards, should be given to the provider and another copy should be mailed to Aging Services/HCBS. The County should maintain the original.

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

**Request for Attendant Care Services, SFN 944
525-05-60-95**

(Revised 2/1/17 ML #3490)

[View Archives](#)

Purpose:

This form is completed to obtain verification that an individual is eligible for Attendant Care Services and has identified eligible providers and a contingency plan.

When Prepared:

The Request for Attendant Care Services is completed when an individual request to receive Attendant Care Services and completed on an annual basis or as changes are identified.

By Whom Prepared:

The clients HCBS Case Manager along with the applicant will complete the form.

Demographic Information:

The HCBS Case Manager completes the applicants name, address, telephone number, email, Medicaid number and date of birth.

Applicant Certifications:

The applicant checks the appropriate boxes and signs and dates the verifications.

Primary Care Physician Certifications:

The form is sent to the individual's primary care physician who checks the appropriate boxes and signs and dates the verifications.

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A letter from the primary care physician can replace this section if it includes all the components of this section and is also signed and dated by the physician.

Providers, Attendant Care Service Providers, and Contingency Care Providers:

These sections are completed by the applicant and HCBS Case Manager.

Number of Copies and Distribution:

The original is filed in the applicant's/client's case record. One copy is provided to the applicant/client when completed. One copy included in the application packet provided to the HCBS Program Administrator and is used in determining approval or continued approval for the service.

This form is available through the state e-forms.

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

(Revised 9/1/18 ML #3543)

[View Archives](#)

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 the first quarterly contact (this visit should **not** occur during the annual or 6-month assessment).

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.

Ask each question and score by circling or marking an X by the boxes scored: Yes-No-N/A-Other.

- a. If the response is: no, n/a or other, please explain.

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- 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.

Sign your name and enter the name of the County the client lives in.

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

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

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

(Revised 05/01/23 ML #3730)

[View Archives](#)

Purpose:

The Preliminary Authorization to Provide Medicaid waiver Services is used to preliminary authorize a qualified service provider (QSP) to provide services to an eligible Medicaid waiver individual. It serves as a "good faith" agreement that the individual is eligible, and that the services will be covered.

This form is only completed for individuals who have applied and have been determined to be functionally and financially eligible for Medicaid waiver service(s).

When Prepared:

The Preliminary 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 individual must have an identified need for the services in order to be authorized to receive the services. While all final authorizations are to be completed in Therap, a Preliminary Authorization (SFN 410) is completed for those services that cannot yet be billed, but are being provided and incurring costs to be billed at a later time. These services include the following:

- Transition Coordination T2038
- Community Transition Services Set up Expenses T5999

The SFN 410 can also be used as an agreement to provide the following services prior to exact dates and amounts being finalized:

- Environmental Modification S5165 and
- Specialized Equipment T2028

Example 1. An individual is currently residing in a skilled nursing facility, but is working with HCBS to transition back into the community. The individual qualifies for Transition Coordination under Medicaid waiver and will open for Medicaid waiver upon discharge from the facility. In order for the provider to start these transition services while the individual is still in the nursing facility, the HCBS Case Manager will complete the SFN 410 to authorize both Transition Coordination and the Community Transition Service Set up Expenses. This will be signed by the provider, and will serve as a Preliminary Authorization for those services. Once the individual is discharged from the facility and is able to receive Medicaid waiver in the community, the HCBS case manager will create a final authorization in Therap, which will reflect the final and correct units, dollar amounts, and dates of services. This will be the authorization the provider utilizes to bill exact amounts for service rendered and costs incurred. As outlined in the SFN 410: If, for any unseen reason, the individual does not enroll in the waiver (e.g., due to death or significant change in condition), Community Transition Services may be billed to Medicaid as an administrative cost.

Example 2. An individual is on Medicaid waiver has been approved for Environmental Modification. Bids were received and a provider has been approved as a QSP to complete the modification job. However, it is not yet certain if the job will be completed in June or July and there may be minor cost changes from the bid and the final cost after work is completed. The provider only feels comfortable starting the work if they have an HCBS authorization in hand. The HCBS case manager will complete the SFN 410 to authorize Environmental Modification at the current approved bid. This will be signed by the provider, and will serve as a Preliminary Authorization for Environmental Modification. Once the job is finalized, the HCBS case manager will create a final authorization in Therap, which will reflect the final and correct dollar amount and dates of services. This will be the authorization the provider utilizes to bill exact amounts for the service rendered.

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

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Specific Instructions:

Identifying information

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

Enter the individual'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 an individual within rural areas, mark the correct RD tier.

"Authorization Period" - Identify the period of time the preliminary authorization is in effect. The preliminary authorization period MAY NOT exceed six 90 days.

"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. Should the transition take longer than 90 days, the HCBS case manager is required to inform the MFP program administrator and the HCBS program administrator. The MFP program administrator will facilitate a team meeting to staff the situation and provide more intensive attention to the situation to remediate identified barriers preventing timely transition.

Services Authorized

Select all authorized services and complete the preliminary 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: Procedure codes have been pre-populated.

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- c. Unit/Daily Rate: Enter the correct preliminary unit rate for the service authorized.
- d. Units: Enter the total number of preliminary units authorized.
- e. Not to Exceed Total: Enter the total preliminary dollar amount for the service.

If RD is authorized, put in determined RD rate for service. Once the services are finalized and you are ready to create the final authorization in Therap, you must also submit an SFN 212 to Aging Services/HCBS State office.

Signatures

The case manager and identified provider must sign and date the form to preliminarily authorize services. The SFN 410 must be canceled and submitted to the provider in the event that the individual is no longer going to transition to the community and no administrative costs will be paid out to the provider.

Number of Copies and Distribution

File a copy in the individual's case record and give a copy to the individual and/or their legal representative. Forward the original to the service provider(s) and scan a copy to Aging Services/HCBS with the first two pages of the Medicaid Waiver Person Centered Plan of Care ([SFN 410](#)).

An electronic copy is available through the state e-forms (SFN 410).

Rural Differential, Unit Rate Authorization/Closure - 525-05-60-110

(Revised 02/01/25 ML #3899)

[View Archives](#)

Purpose:

The Rural Differential Unit Rate Authorization/Closure in the web-based case management system is used by the HCBS Case Manager to add and/or end a Rural Differential (RD) rate for a QSP. The form is to be completed in the web-based case management system when a rural differential rate is being added, removed, or if the individual or the QSP has a change in address.

The RD Case Note Template is completed when the RD rate is added, removed or when the individual or QSP has a change in address.

A rural differential rate can be authorized for any individual receiving the following services under Medicaid Waiver (MW), Service Payments to the Elderly & Physically Disabled (SPED), Expanded Service Payments to the Elderly & Disabled (EX-SPED), and/or Medicaid State Plan Personal Care (MSP-PC):

- Chore Labor
- Extended Personal Care
- Homemaker
- Nurse Education
- Personal Care
- Respite Care
- Transitional Living services
- Supervision
- Companionship
- Transition Coordination Services

The Rural Differential Unit Rate Authorization/Closure form is in the Case Note section in the ASD oversight account.

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Case Managers can click on the blue (i) throughout the document for additional information and instructions.

All appropriate boxes must be completed in order to be accepted by the HCBS Administrator.

Enter Service Date

*Enter the date you enter the form into the case note template.
Select "Rural Differential Unit Rate Authorization/Closure"
Select "Next"

Determining Distance

Case managers are required to verify distance between the HCBS individual's home and the QSP's home base by using a reputable internet-based mapping service. The Case Manager is responsible to choose the most reasonable route and print a copy of the mapped verification of distance, a copy must be uploaded and submitted in the web-based form.

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

Individual Information:

Enter physical address, case manager's name, and county of residence.

Qualified Service Provider (QSP) Information:

Enter the QSP's name, provider number, and physical address. Advise the QSP that this address will be checked against the Department of Transportation's database, if the two do not match, the RD rate will be stopped.

When an Agency is providing care, list agency name, the agency's QSP number, and the physical address. If an agency employee is not required to report to their agency each day, they must make their name and

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address available to the HCBS office for verification. Enter the employee's name and physical address in the appropriate box.

Rural Differential (RD) Rate Authorization/Closure:

Mark the correct RD tier level the QSP has been authorized to bill.

Tier 1 - should be selected when the provider is traveling between 21 miles and 50 miles round trip to provide care.

Tier 2 - should be selected when the provider is traveling over 50 miles up to 70 miles round trip to provide care.

Tier 3 - should be selected when the provider is traveling over 70 miles round trip to provide care.

Enter the date the RD was added to the PCP.

When RD closes. Enter the date RD closed for this individual/provider combination.

(NOTE: Do not enter a date for RD closure if the RD is changing due to an address change.)

Upload the Web-based Map Documentation

☐ (Note: this is Required.)

☐ Determining Distance

Case managers are required to verify distance between the HCBS individual's home and the QSP's home base by using a reputable internet-based mapping service. The Case Manager is responsible to choose the most reasonable route and print a copy of the mapped verification of distance, a copy must be uploaded and submitted in the web-based form.

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

Address Change:

Complete this section if there is a change in address for the provider or the individual. Update the RD tier and rate if necessary. When an address change occurs, a new Map Quest must be uploaded and submitted in the form.

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The RD form can be updated to record up to two (2) address changes per individual/staff combination in the address change section of the form. (If there are more than 2 changes a new form will need to be created.)

To make the change,

- Select who had the address change

- Enter the date the change is effective

- Enter the new address and county

- Upload a new map showing the mileage.

- If the RD rate changed, update the RD rate Tier at the top of the page.

Number of Copies and Distribution:

The original is maintained in the web-based case management file. This form must be submitted within ten (1) working days of adding, changing, or canceling a rural differential rate.

Home and Community Based Services (HCBS) Person-Centered Plan of Care 525-05-60-115

(Revised 05/01/23 ML #3730)

[View Archives](#)

Purpose

The Person-Centered Plan of Care - HCBS web-based version is a summary of the needs and service options identified in the assessment process and is an outline of the plan developed by the individual, case manager and the person-centered planning team.

When Prepared:

The Person-Centered Plan of Care is completed for all individuals served under home and community-based services including, Medicaid Waiver (MW), Medicaid State Plan – Personal Care Services, (MSP-PC), Service Payments for the Elderly and Disabled (SPED), Expanded Services Payments for the Elderly and Disabled (EX-SPED).

The Person-Centered Plan of Care is to be revised or updated as client's needs warrant. It is to be reviewed and updated with the individual at the annual and six-month review. A new Person-Centered Plan of Care is to be completed when there are necessary changes in the individual's needs, or service(s) authorized.

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

Instructions for Completing the HCBS Person-Centered Plan of Care

About Me

The following three questions encompass the person-as-a-whole. Discuss and document the individual's responses to the questions.

1. What People Admire about Me (? Help What are my strengths?)

Example: (Individual's) strengths include that she is able to make her own decisions in all aspects of her life. She is proud of her independence and motivated to work with her care team to meet her needs. (Individual) has a positive outlook on life and is also willing to accept assistance were needed.

2. What is Important to Me (?) List the Individuals goal statement in this section. What is important to me to live the life I choose?

Important to a person includes things that make the person satisfied, content, comforted and happy. It includes relationships, things to do, places to go, rituals or routines, pace of life, status and control, things to have.

Example: It is important for (Individual) to have support for his ADL's and IADL's as noted in the assessment. (Individual needs and has a living environment that is handicap accessible. (Individual) is able to access the home and community with the equipment and modifications that have been made to the home. (Individual's) goal is to have the support to meet his daily needs which is met through the authorized services under HCBS.

(Individual's) goal is to remain as independent as possible. It is important to (individual) to make their own decisions. (Individual) values her families input and advice for support, yet wants to make the final decision. It is important to (individual) to be as independent as possible.

3. How to Support Me Best (?) What supports would help me the most to live the life I choose?

Consider issues of health [prevention and treatment of illness, promotion of wellness, services needed] and issues of safety [environment, physical and emotional wellbeing].) Supports include someone to stay with me for certain portions of the day; toileting, bathing, or transfer assistance; help with medications, housework, or transportation; grab bars in bathrooms; ramps or lifts to avoid stairs.

Example: (Individual) is receiving assistance with personal cares and homemaker services as outline in the comprehensive assessment. (Individual) states she can be best supported by providing having assistance with her care at home by having HCBS and home health care. At this time, she feels the support allows her to interact with her family and friends and continue to do many of the activities she enjoys.

Services and Supports

This section is for Home and Community Based Services authorized. (This section will not be utilized in the Person-Centered Planning of Individuals receiving Long- Term Services and Supports Options Counseling.)

Select "Add Service Support"

Column Headings:

Funding Source

- HCBS- Home and Community Based Waiver
- IID/DD HCBS – Traditional Developmental Disabilities Waiver – (HCBS will not use)
- MSP-PC- Medicaid State Plan Personal Care
- SPED – Service Payments for the Aged and Disabled
- TCM - Targeted Case Management (HCBS will not use)
- TECH – Technology Dependent Medicaid Waiver
- XSPED – Expanded Service Payments to the Elderly and Disabled

Services(s): Enter the service that has been identified for which the client is eligible, and the client has accepted.

Service Provider: Identify the qualified service provider (agency or individual) who will provide the service. (Note: this can be left blank if a provider has not been selected. A "Change Form" can be completed to update the PCP appropriate once a provider is selected.)

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Service Provider Other: Identify a provider they are an approved QSP but not showing up in Therap yet. You may also place a provider's name in this place if the individual has chosen a provider and the provider is pending approval, such as with Family Home Care or Family Personal Care. The pending providers name with pending after would be placed in this box.

Example: Sally QSP- Pending

Service Date From: Enter the start date for service of the QSP.

Service Date To: Enter the end date for service of the QSP.

Total Units: Enter the total units per month for the QSP

RATE: Refer to the Qualified Service Provider (QSP) listing for rate. Enter the QSP unit rate.

- a. If Rural Differential (RD) the 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 per month.)

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

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).

Cost: Select the "Calculate" and the cost will auto populate according to the units and rate.

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Notes: note that you may put units shared in this box or some other directions. If the total units are shared between two or more providers, DO NOT calculate the second and proceeding providers cost and it will populate the total for the funding source authorized.

Cost by Funding Source

Total Cost: The total per month costs of services is the total to be reimbursed under the service program (SPED, XSPED, Medicaid Waiver and MSP-PC). 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.

Questionnaire

Service Plan

Is this individual a Target Population Member (TPM)?

This question is required. Indicate whether the individual is considered a TPM during the time span of the care plan. A TPM is an individual who is age 21 or older, would reasonably meet nursing facility level of care, and is either on Medicaid or has assets at or below \$25,000.

- ☐ Yes
- ☐ No

Is this an initial care plan?

Hints ×

Is this the first- time services are being authorized? (Complete even if services were previously authorized and formally closed, but now open again.)

- ☐ Yes

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- No

Please check below if any of the following funding sources are being authorized for the first time.

Hints ×

Complete even if the funding source was previously authorized and formally closed but is now open again.

- SPED
- Ex-SPED
- HCBS MW
- MSP Level A
- MSP Level B
- MSP Level C

If this is the first-time funding source(s) are being authorized, indicate the effective date.

SPED

Hints: Indicate the date SPED was approved

Ex-SPED

Hints: Indicate the date Ex-SPED was approved

HCBS MW

Hints: Indicate start date of care plan

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MSP Level A

Hints: Indicate start date of care plan

MSP Level B

Hints: Indicate start date of care plan

MSP Level C

Hints: Indicate start date of care plan

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Does plan overlap previous plan?

- ☐ Yes
- ☐ No

Mark the correct tier for rate

Hints: When adding or removing a Rural Differential (RD), SFN 212 is req

- RD1
- RD2
- RD3

RD Removed

SPED Fee Percentage

Hints: Percentage or N/A

Check any services below that have pending final service amounts.

- Transition Coordination
- One-Time Transition Cost
- Specialized Equipment
- Environmental Modification

Demographics

NF LoC Effective Date (This is a free text box and allows you to specify the effective dates of the NF LoC for both MSP-PC and HCBS Waiver. For LTSS-OC indicate the LOC screening date last completed on the SNF resident)

Integrated Settings

Integrated settings are settings where individuals live in a private home alone, with family, significant other, or roommates of their choosing. Non-integrated settings include skilled Nursing Facility, Assisted Living, Basic Care.

In the first section document from the case managers perspective what you believe to be the individuals most integrated setting. Integrated settings must meet the HCBS Settings rule. Adult Residential Service meets the HCBS Settings rule and is classified as an integrated setting.

Identify the Individual's Most Integrated Setting

- A private home in the community, rented or owned, where the individual lives alone or with others
- Other Integrated Settings
- Non-Integrated Settings

Provide answer if "Other Integrated Settings" is selected in "Identify the Individual's Most Integrated Setting"

- Adult Foster Care

Provide answer if "Adult Foster Care" is selected in "Other Integrated Settings"

- Family
- Agency

Or if you believe the individual would be best served in a non-integrated setting mark one of the following non-integrated settings.

- Skilled Nursing Facility
- Assisted Living
- Basic Care

Integrated Setting Comments (Comment on the rationale for the selection of the setting chosen based on the HCBS Comprehensive Assessment.)

In the second section document from the individuals preferred setting. (Answer the following three questions according to the wishes of the individual.)

Identify the Individual's Preferred Setting (select one of the following)

- A private home in the community, rented or owned, where the individual lives alone or with others
- Other Integrated Settings
- Non-Integrated Settings

Provide answer if "Other Integrated Settings" is selected in "Identify the Individual's Preferred Setting" (Select if Applicable)

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- Adult Foster Care

Provide answer if "Adult Foster Care" is selected in "Other Integrated Settings" (Select if Applicable)

- Family
- Agency

Provide answer if "Non-Integrated Settings" is selected in "Identify the Individual's Preferred Setting" (Select if Applicable)

- Basic Care
- Assisted Living
- Skilled Nursing Facility
- Answer the following questions relating to where the individual prefers to live.
- Name of Person Individual Would Like to Live With
- Address Where the Individual Would Like to Live
- Preferred Setting Comments

Hospital/Nursing Home Stay

Answer the following questions relevant to any Hospital/Nursing Facility admission or discharge.

Hint: Is this individual currently residing in a nursing home or are they in a hospital for a long stay? If yes, complete the following. HCBS Case Manager: Once the individual is discharged back home and on services, please complete the section: Date Home and Community Based Services (HCBS) resumed.

- Facility Name
- Date of Admission (MM/DD/YYYY)
- Expected Length of the Nursing Home or Hospital Stay
- List reasons for the expected duration of the stay

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- Date Home and Community Based Services (HCBS) Resumed (MM/DD/YYYY)
- Hospital/Nursing Home Comments

Please write N/A at the top of this section if not applicable as some individuals have not had a hospital or nursing facility stay.

Housing Supports

Identify Housing Services, if any, necessary for the individual to successfully live in the most integrated setting (check all that apply)

- Assistance with housing search
- Assistance with the completion of applications for housing assistance. (Housing Assistance/Rental Assistance Vouchers of any kind)
- Assistance with locating needed documents for apartment and rental assistance applications
- Assistance with securing housing modifications
- Education about the rights and responsibilities of being a good tenant
- Assistance securing any rental modifications and/or accommodations needed.
- Rental Assistance
- Other (specify):
- Date of Housing Facilitator Assignment (MM/DD/YYYY)

Reduction Notice

Complete the following pertaining to a reduction notice:

Are services being reduced from the previous care plan?

- ☐ Yes
- ☐ No
- ☐ N/A

Please complete for reduction of MSP-PC services only:

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- Services are reduced in accordance with 42 CFR 440.230 and NDAC 75-02-02-09.5 for the following reason(s).
 - Enter reason in comment box.
- Reduction Acknowledgement
 - I am aware of the reduction in service, that the Reduction will be effective on date given below and I have been given a copy of my appeal rights (printed on the back of this form). The effective date of the reduction must be no sooner than 11 days after client signs the Person-Centered Plan of Care.
- Signed Statement
 - If the individual requested the citation, a signed statement is saved on file.

Please complete for reduction of services for SPED, ExSPED or/or Medicaid Waiver only:

- Select the services funding source for which the services are being reduced. (Multi-select)
 - SPED
 - ExSPED
 - HCBS-MW

Please complete for reduction of SPED, ExSPED and HCBS-MW services only

- Services are reduced for the following reason(s): (request the closure code from HCBS Program Administrator) Enter reason for citation in the text box.
- In Accordance With (write the citation from program administration in the box)
- Reduction Acknowledgement
 - I am aware of the reduction in service, that the Reduction will be effective on date given below and I have been given a copy of my appeal rights (printed on the back of this form). The effective date of the reduction must be no sooner than 11 days after client signs the Person-Centered Plan of Care.

- Reduction will be effective on (MM/DD/YY)
- Signed Statement
 - Check box if the individual requested the citation, a signed statement is saved on file.

Long-Term Services and Supports

Answer the following questions.

(If the question is not applicable, please state why).

- List other community-based services (other than HCBS) examples include MFP, hospice, public health services, or other services provided by partners in the community. If transition coordination is also involved indicate the goals and action plan for the transition are addressed in the transition plan.
- List and describe services requested but not authorized: (include date of request and date of denial).

Example: "Not applicable, [NAME] has not requested other services that were not authorized."

- Describe why requested services were not authorized

Example: If Not Applicable explanation maybe "All requested services have been authorized."

- Services eligible for but not accepted.

Hint: It would be easier for non-clinicians to understand if the acronyms were spelled out, e.g., HDMs – Home Delivered Meals, ERS – emergency response system

Example: "[NAME] is receiving all eligible services."

- Reasons eligible services not accepted
- Services needed but not available

Example "Not applicable. All services needed to achieve goals are available."

- Describe why services needed are not available

Contingency/Health and Safety Plan

The Contingency Plan must be completed. Name of person assisting, and their contact information must be listed in the contingency plan so the resource can be reached if needed.

Explain the alternative plan in the event that one/all of the providers listed are unable to provide care: (Describe in free text the contingency plan).

Barriers

List Barriers to Receiving Community-Based Services (select all that apply).

- Lack of available Qualified Service Providers for the types of service needed
- Services Needed
- Lack of available Qualified Service Providers in the location where the individual will live
- Location
- Lack of available Qualified Service Providers for the types of service needed
- Services Needed
- Lack of housing that meets the individual's needs
- Family not supportive of community living or return to community
- Lack of Home Health/Hospice services
- Lack of medical service to meet needs in the community of choice. (Example: No dialysis services)
- Ineligibility for a necessary service
- Individual does not want services to address identified need
- Lack of transportation services in the location where the individual will live
- Transportation Needed
- Location
- Other (specify): (enter free text in "If Other, specify")
- None

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Identify strategies to address barriers checked above. (Describe what steps have been taken thus far, when, by whom, and what result):

- Lack of available Qualified Service Providers for the types of service needed

Hints: If lack of available Qualified Service Providers is selected above, list services needed

- Lack of available Qualified Service Providers in the location where the individual will live

Hints: If "Lack of available Qualified Service Providers in the location where the individual will live" is selected above, list location.

- Lack of transportation services in the location where the individual will live

Hints: Provide answer for "Transportation Needed" and "Location" if "Lack of transportation services in the location where the individual will live" is selected in "List Barriers to Receiving Community-Based Services"

Transportation Needed (describe the transportation needed)

Location (state the location that the transportation is needed)

Identify strategies to address barriers.

Hints: Describe what steps have been taken thus far, when, by whom and what the result.

Restrictions

Answer the following questions. Enter NA if not applicable

Date

Reviewed - No restrictions required

Identified Restriction

Plans Tried in the Past

Current Restrictive Plan

Assurances

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

- I wish to receive the services described in this person-centered plan of care rather than receiving care in a nursing home.
- I am aware that I may have a recipient liability.
- I am aware that the services and estimated cost is subject to change based on legislative action.
- I have been made aware of services, funding caps, and limits.
- I selected the services listed above.
- I selected the providers listed above.
- I am aware that if my Medicaid eligibility terminates, I will no longer be eligible for services funded by ExSPED, MSP-PC, or Medicaid waiver.
- I am aware that Case Management, as well as personal care services, will be billed to Medicaid and may be subject to a recipient liability if Medicaid is active, even if it has been determined that I have a 0% SPED fee.
- I am aware of my right to appeal by writing to:

Appeals Supervisor
600 E Boulevard Ave - Dept. 325
Bismarck, ND 58505-0250

Authorization Span and Signatures

The effective date of plan and the signature of the client/legal representative and HCBS Case Manager is required on all PCPs.

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

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Family Home Care and Family Personal Care providers may sign the person-centered plan of care in leu of signing the preauth.

*Provider signature is included on the Service Authorization

The HCBS Signature Sheet may be used to obtain the signature for changes in the care plan that have been initiated by the individual. Additionally, the HCBS signature sheet may be used to sign for the electronic version of the Person-Centered Plan of Care (PCP) and/or the Risk Assessment and Health and Safety Plan and the Referral for Long-Term Services and Supports Option Counseling. Guidance for utilization of the HCBS Signature Sheet is provided in this policy.

Plan Addendum

Check all that apply

- Caregiver Assessment (If Applicable)
- Individual Program Plan (If Applicable)
- Service Authorization (Required)
- Transition Plan (If Applicable)
- Risk Assessment/Health and Safety Plan (Required)
- Vision Tool (Required)

Type of Case Management

Select one of the following types of case management

- Targeted Case Management
- Higher Level Case Management

Please complete if Targeted Case Management is selected.

T2023-TG Case Management Assessment

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T2023-TG Case Management Assessment is billed (amount given below) when service is provided. May have cost share based on Medicaid recipient liability or SPED fee.

Bill amount for T2023-TG Case Management Assessment

Hints: \$

T2023 Case Management

T2023 Case Management is billed (amount given below) when service is provided. May have cost share based on Medicaid recipient liability or SPED fee.

Bill amount for T2023 Case Management

Hints: \$

Please complete if Higher Level Case Management is selected

T2024 Higher Level Case Management Assessment

T2024 Higher Level Case Management Assessment is billed (amount given below) when service is provided. May have cost share based on Medicaid recipient liability.

Bill amount for T2024 Higher Level Case Management Assessment

Hints: \$

T2024 Higher Level Case Management

T2024 Higher Level Case Management is billed (amount given below) when service is provided. May have cost share based on Medicaid recipient liability.

Bill amount for T2024 Higher Level Case Management

Hints: \$

Signature Sheet Utilization Policy

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Introduction

This document provides guidance for utilization of a signature sheet when completing the Person-Centered Plan of Care (PCP) and/or the Risk Assessment and Health and Safety Plan and the Referral for Long-Term Services and Supports Option Counseling. These documents necessitate signatures from entities such as the individual receiving services, legal decision maker, and provider for the delivery of services. Obtaining necessary signatures is the responsibility of the Case Manager or LTSS Options Counselor originating the document. The signature sheet allows for a non-digital option for individuals to sign the plan. It is required that a signature is obtained for initial, 6-month and annual PCP and the Risk Assessment and Health and Safety Plans. Additionally, signatures are required by the service provider which is obtained when acknowledging the Preauth (for FHC and FPC the PCP must be signed by the FHC/FPC provider on the signature sheet or digitally it Therap).

The signature sheet may also be utilized when a change in the Person-Centered Plan of Care (PCP) and/or the Risk Assessment and Health and Safety Plan is initiated by the individual receiving care and a signature is not able to immediately be obtained by an individual or legal decision maker on the Person-Centered Plan of Care (PCP) and/or the Risk Assessment and Health and Safety Plan.

This policy cannot account for every situation; therefore, the case manager must use their professional judgment when applying this policy.

Guidelines

When completing the Person-Centered Plan of Care (PCP) and/or the Risk Assessment and Health and Safety Plan and the Referral for Long-Term Services and Supports Option Counseling the case manager or LTSS Options Counselor work with the individual and team to discuss and develop the plan. The plan is reviewed with the individual and the team and the individual and team members have the option to sign the signature sheet which is attached to the plan in Therap. The plan with the signature sheet is then mailed out to the individual and team members as documented on the plan within 30 days.

When an individual initiates a change in their PCP or the Risk Assessment and Health and Safety Plan, and a case manager is unable to acquire a necessary signature through direct contact with the individual or the legal representative (e.g., guardian attending meeting by phone), a minimum of 3 attempts must be made to obtain the signature of the individual and/or legal decision maker within 30 calendar days. Methods of contact can be made by mail, email, phone contact, or other communications that are available to the person. Services will continue to be provided as long as the person meets the eligibility requirements, and the service is appropriate.

If verbal consent is given, this can be noted on the document along with the signature of the case manager and date. Attempts to obtain the signed signature are still applicable.

Each attempt to acquire signatures should be documented in case notes and should vary from previous unsuccessful attempts. The attempts should inform the individual of the timeline to respond and that if the documents are not signed and returned, it will be assumed that they are in agreement and understand any rights afforded to them.

If the signature is not acquired within the 30 calendar days, it will be acknowledged on the document that the signature was attempted (e.g., unable to obtain signature). Services will continue to be provided as long as the person meets the eligibility requirements and the service is

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appropriate, or the individual/legal decision maker is given advance notice in writing of the intent to terminate the service(s) and includes the person's right to appeal that determination.

If an individual and/or legal guardian refuses to sign the Person-Centered Plan of Care (PCP) and/or the Risk Assessment and Health and Safety Plan because they are not in agreement, the case manager should explain to the person and/or legal decision maker that failure to sign may lead to the discontinuance of services, and that signing the document does not affect their right to appeal. The case manager should then send out a letter documenting the conversation with the individual/legal decision maker and provide information on their right to appeal service level determinations.

**Risk Assessment & Health and Safety Plan 525-05-60-120
(NEW 8/1/22 ML #3692)**[View Archives](#)**Purpose**

The purpose of the Risk Assessment & Health and Safety Plan is to identify potential risk of harm to the individual and develop mechanisms to mitigate risks. The risk assessment should consider all reasonable risks, including but not limited to health, medical and nutritional risk; physical health; cognitive/behavioral health and lifestyle; medication; services/economic assistance; environmental risks and any abuse, neglect, or exploitation concerns. The risk assessment includes an evaluation of severity of outcome, frequency, and description of the identified risk(s). The health and safety plan identifies possible mechanisms to implement controls that mitigate the identified risks. The development of the plan to mitigate risks should be person-centered in its approach to preventing risk and helping the individual live the life they desire while moving towards their goals.

Examples of risks may include but are not limited to unmet needs; a barrier to the health and safety; incidents of health or behavioral health that pose a risk to the individual or their providers. If there is a risk identified that could interrupt services to the individual the health and safety plan should include the steps taken to mitigate these risks and the contingency plan on the person-centered plan of care must reflect the plan in the event the services are interrupted.

When Prepared:

The Risk Assessment & Health and Safety Plan is required for every individual receiving home and community-based services. The Risk Assessment & Health and Safety Plan must be completed initially, annually, at the six-month review or when there is a new risk identified or significant change in the individual's needs.

Participant Information

- Name (Last, First, Middle)
- Date of Birth – Please note that the DOB is not a required field for HCBS Case Management. The individual may not want their DOB displayed on this document as it may be shared with the person-centered planning team or supports upon request of the individual.
- ND Number
- Date of Plan

Section A: Risk Identification

In the following six categories below, check any risk identified throughout the assessment and care planning process.

Health, Medical and Nutrition

- Access to Medical Care
- Aspiration
- Chronic Health Conditions
- Cognitive Decision Making
- Elimination
- ER Visits and/or Hospitalizations
- Malnutrition
- Other
- Mental Health
- Nutrition and/or Special Diets
- Seizures
- Skin Breakdown
- Treatment Compliance

Physical Health

- Ambulation
- Bathing

- Communication
- Dressing and Grooming
- Emergency Response
- Falls
- Home Maintenance
- Other
- Injuries
- Meal Preparation
- Toileting
- Transfers
- Victimization

Cognitive/Behavioral Health and Lifestyle

- Aggression
- Destruction of Property
- Endangering Others
- Endangering Self (or self-neglect)
- Finances
- Homelessness
- Inappropriate Sexual Behavior
- Isolation
- Justice System Involvement
- Substance Abuse
- Victimization or Exploitation
- Other

Medications

- Medication Administration
- Medication Allergies
- Medication Compliance
- Medication Complications
- Multiple Prescriptions
- Psychotropic Medications
- Use of OTC or Herbal Meds

- Other

Services/Economic Assistance

- Home Stability and Situation Housemate Compatibility
- Isolation Limited Support System
- Natural Support
- Service Refusal
- Social Opportunities
- Other

Home Environment (physical environment, adaptive equipment, environmental modifications)

- Accessibility
- Community Access
- Hazardous Dwelling
- Neighborhood
- Sanitation
- Other

Any abuse, neglect or exploitation concerns (past or future?)

- Yes-Explain below: No

Explain Abuse, Neglect, Exploitation Concerns:

Keep in mind this document is shared use concise information/ state the issue in general terms, avoiding specifics and identifying information.

Additional Information

Indicate any additional or relevant information in which may be helpful is risk identification and mitigation.

Section B: Risk Evaluation and Safety Plan

In completing the risk evaluation and safety plan the following questions may be considered. What could happen if they don't have these services or supports? What was the risk that led to the individual needing services or support?

Risk Factor(s) (from Section A)

- Severity of Outcome (choose one)
- Possibly harmful to health/welfare
- Likely harmful to health/welfare
- Immediately harmful to health/welfare
- Debilitating or death

Frequency of Risk (choose one)

- Rarely or Annually
- Seasonally
- Monthly
- Weekly
- Daily
- More than daily

Description Of Circumstances

Could this potentially jeopardize services?

Yes No - Explain below:

What can be done to prevent or mitigate risk?

What strengths or assets does the participant have to reduce the risk?

What additional supports would be helpful in reducing the risk?

Who can help with prevention or mitigation of the risk?

In some cases, the risks, frequency of risks and risk mitigation/reduction may be closely related. In circumstances where the risks are inter-related more than one risk can be identified and documented under the same risk factor. Such as below:

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Section C: Contacts

If staff are unable to reach me for a regularly scheduled contact or other purpose, please contact the following individuals, who will know how I can be reached at all times:

Guardian/Legal Representative

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Name Home Phone Cell Phone Work Phone Relationship.

Personal Contacts

(ex. neighbor, friend or other natural support)

Name

Home Phone

Phone

Work Phone

Relationship

Medical Contacts

(DME ex. oxygen provider, primary doctor, other professionals involved in this plan)

Name Home Phone Cell Phone Work Phone Relationship

AUTHORIZING SIGNATURES

Participant agrees to the Risk Mitigation Plan, Health, and Safety Plan?

- Yes or No – If no, explain below:

Signature of Participant or Legal Representative

- Date of Signature

Signature of Case Manager

- Print Case Manager Name
- Date of Signature

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Signature of Transition Coordinator

- Print Transition Coordinator
- Name Date of Signature

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Plan Continued

If there are no changes needed to the Risk Assessment and Health and Safety Plan, the plan may be continued for the next assessment period utilizing the Plan