# Table of Contents

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

Respite Home Evaluation, SFN 659 525-05-60-85

Compliance Checklist/Adult Day Care Standards, SFN 1703 525-05-60-90

Request for Attendant Care Services, SFN 944 525-05-60-95

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

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

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

Rural Differential, Unit Rate Authorization/Closure SFN 212 - 525-05-60-110

# Home and Community Based Services Policies and Procedures 525-05

## Definitions 525-05-05

**(Revised 5/1/19 ML #3551)**

View Archives

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 Service (ARS)

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

Aging Services Division

A Division within the Department of Human Services (DHS) 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. The service is provided under the direction of a licensed nurse who is enrolled with the Department of Human Services 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 (LSW) 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. These services are only provided in cases where neither the recipient, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payer is capable of or responsible for their provision. 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 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.

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 persons 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".

County Social Service Board

The specific county social service board serving the county in which the applicant/client physically lives.

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), and Medicaid State Plan Targeted Case Management (MSP-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 Human Services (DHS).

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.

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, in the home of the client or the home of the qualified service provider who meets the definition of a family member as defined in N.D.C.C 50-06.2-02(4).

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 of a recipient for the provision of personal care or similar services.

Fee Setting Authority

The North Dakota Department of 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 the Department of Human Services' Aging Services Division. 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 denied in the comprehensive human service plan and the other services 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 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 that describes the tasks or training that will be done for a client receiving 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 of Human Services as a Qualified Service Provider, which allows that individual to bill the Department of Human Services 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. 50-24.5-01(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.

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 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 client other than their primary residence.

Living Alone

An applicant or client 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 be anticipated to exceed 30 days.

Medical Services Division

A Division within the Department of Human Services 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 client's progress, condition, and the quality and quantity of services provided.

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".

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)

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 Consolidated Laboratories to provide residential nursing and medical 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

Personal Care Service is to help the individual with activities of daily living on an ongoing basis up to 24 hours per day, if necessary. Assistance with instrumental activities of daily living may also be provided in conjunction with the tasks for activities of daily living.

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 of Human Services 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 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.

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 refers 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.

Willfully

Intentionally, knowingly, or recklessly.

# Legal Reference/Authority 525-05-10

**(Revised 2/1/17 ML #3490)**

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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 Family 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 NDCC 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 Family 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. 50-24.5, Aid to Vulnerable Aged, Blind and Disabled Persons. An eligible beneficiary is defined at N.D.C.C. 50-24.5-01(9) 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.50-24.5-02(4). See also N.D.A.C. 75-02-10. 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.

# 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 5/1/19 ML #3551)**

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 county social service board in the county in which the applicant resides 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 for SPED/Ex-SPED (SFN 1699) or Authorization to Provide Medicaid Waiver Services (SFN 410) is required as a standard form for care plan implementation. The SFN 1699 or SFN 410 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 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 7/1/19 ML #3553)**

View Archives

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

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

2. 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;

3. Eligible to receive care in a skilled nursing facility;

4. Participate to the best of their ability in a comprehensive assessment to determine what services are needed and the feasibility of receiving home and community-based services as an alternative to institutional care.

5. Have Person Centered Plan of Care SFN 404, developed and approved by the applicant/client or legal representative and HCBS case manager that adequately meets the health, safety, and personal care needs of the recipient;

6. Voluntarily choose to participate in the home and community-based program after discussion of available options. This is documented by completion of Explanation of Client Choice, SFN 1597;

7. 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 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.

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.

8. Must receive services on a monthly basis.

9. Not eligible for and/or receiving services through other Medicaid Waivers or private funding sources.

10. The applicant/client(s) impairment is not the result of a mental illness, intellectual disability or a closely related condition.

Financial Information for Medicaid Waiver HCBS:

1. 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.)

2. Charging for Services

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

3. Handling of Collections

   County social service boards shall follow the established policies and procedures for the handling of collections in keeping with the acceptable financial management practices and policies of the Department. (See Accounts Receivable Manual, Service Chapter 115-40)

   All fees collected by county social service boards shall be reported on Form 119 according to the instructions for completing the form.

4. 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)

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

6. 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.

# Technology Dependent Medicaid Waiver 525-05-25-12

**(Revised 2/1/17 ML #3490)**

View Archives

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

1. Recipient of Medicaid Program under the State Plan for Medical Assistance as set forth in Service Chapter 510-05, Medical Assistance Eligibility Factors;
2. Age 18 or older and physically disabled as determined by the Social Security Administration, or be at least 65 years of age;
3. Eligible to receive care in a skilled nursing facility;
4. Ventilator dependent minimum of 20 hours per day;
5. Medically stable - documented by primary physician at a minimum on annual basis;
6. Has an informal caregiver system for contingency planning;
7. Is competent to participate in development of care plan as documented by physician annually;
8. Have Person Centered Plan of Care SFN 404, developed and approved by the applicant/client or legal representative and HCBS case manager that adequately meets the health, safety, and personal care needs of the recipient
9. Voluntarily choose to participate in the Technology Dependent Waiver after discussion of available options. This is documented by the completion of Explanation of Client Choice, SFN 1597;
10. Receive services on a monthly basis (does not include Case Management); and
11. Not eligible or receiving services through other waivers.

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.
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.**

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;
- A hospital;
- Any other locations that have qualities of an institutional setting as determined by the Secretary or:
- Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS

Prohibited Activities effective 12/31/2016

The provision of services funder under the technology dependent waiver must ensure an individual's right of privacy, dignity, and respect. Coercion, and or seclusion, of waiver recipients is expressly prohibited in all settings where technology dependent waiver services are provided.

Critical Incident Reporting

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

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

**(Revised 7/1/19 ML #3553)**

View Archives

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

The county social service board where the person physically resides 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 transfer the information from the form SFN 820 into the Income and Asset assessment in SAMS on each person for whom funding is being sought under the SPED Program. 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 weekly SPED Pool.

The HCBS Income and Asset assessment must be completed in SAMS within 10 working days of the individual's SPED eligibility date.

1. Functional Eligibility for the SPED Program

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

        - The individual is either functionally impaired in at least four (4) ADLs, OR in at least five (5) IADLs totaling eight (8) or more points (if living alone - totaling six (6) points).

- 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/client must have functional impairments 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.
- Capable of directing their own care or have a legal representative to act in their behalf.
- The individual would receive one or more covered services, in addition to Case Management, in accordance with Department policies and procedures for the specific service.

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

- The applicant has a functional impairment to indicate eligibility.
- The applicant's functional impairment has lasted, or can be expected to last, three months or longer.
- The applicant's functional impairment is not the result of a mental illness, intellectual disability, or a closely related condition.
- The applicant is living in North Dakota is a housing arrangement commonly considered a private family dwelling and not in an institution.
- The applicant is not eligible for services under the Medicaid waiver program or the Medicaid state plan of personal care services.
- The applicant would receive one or more of the covered services under department policies and procedures for the specific service.

- The applicant's parent or legal guardian agrees to the plan of care developed for the provision of home and community based services.
- The applicant's parent(s) is not responsible for one hundred percent of the cost of the covered service provided, under the SPED sliding fee scales.
- The applicant's parent(s) have not made a disqualifying transfer of assets.
- The applicant is unable to regularly attend school or is severely limited in the amount of time the applicant is able to attend school.

- The individual must be screened in need of nursing facility level of care. When completing the LOC screening tool, the "HCBS/Other" check box must be completed.
- For an infant under 3 months of age and requiring apnea monitoring, see the Respite Care section.
- If applying for Family Home Care or Respite Care, see the sections for additional requirements that must be met.
- SPED Personal Care Service is not available for those under age 18.
- Parents are not eligible to be the paid service provider unless prior approval is granted by the HCBS Program Administrator.

2. Financial Eligibility for the SPED Program

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

  Real property (e.g. land or farm) is NOT included in the asset resource determination. However, the income produced by the real property is considered when establishing the applicant's/client's share of the cost of services. If the client has real property from which income is NOT being received AT THEIR DISCRETION and the applicant/client 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 client pay for services in accordance with a fee scale based on family size and income. The county social service board must use SFN 820, SPED Income and Asset form, to obtain the information needed to establish the client'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/client make application for Medical Assistance. 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 (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 $1038), or if the individual is receiving a service that is not available under Medicaid or the Medicaid waiver for example family home care.

| SPED Fee Schedule | Less the Medically Needy Amt | Less $20 Disregard | Max Service Amt |
|---|---|---|---|
| $1,131.00 | ($864.00) | ($20.00) | $247.00 |

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 a client'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 $247 or less they are not required to apply for Medicaid. If at any time a client's service needs increase and the cost exceeds $247 per month they will be required to apply for MA.

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

If the applicant/client was closed due to not meeting recipient liability (after summing the medical expenses, plus the case management, plus Medicaid State Plan Personal Care Services) then the individual may receive SPED Personal Care Services if found eligible through the SPED program.

Institutional Spouse and Community Spouse

Income and Medical Deductions:

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

- All income is counted for the community spouse which would include the deemed income;
- Medical deductions/prescription drugs 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/clients SPED services, which includes the deemed assets

If institutional spouse resides in the personal home and the applicant client will receive 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 a client has a recipient liability or SPED service fee, it is the responsibility of the provider to collect the client's share of the cost directly from the client or their identified legal payee.

Handling of Collections

County social service boards shall follow the established policies and procedures for the handling of collections in keeping with the acceptable financial management practices and policies of the Department. (See Accounts Receivable Manual, Service Chapter 115-40).

All fees collected by county social service boards shall be reported on Form 119 according to the instructions for completing the form.

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

Service Fee, SPED Program

With the completion of the SPED Income and Asset form, SFN 820, and by using the sliding fee schedules, the HCBS Case Manager will determine if a client participation fee percentage will be assessed to the service costs. The participation fee is applied to not only the direct services but can also apply to HCBS Case Management.

Refer to Policy SFN 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/client 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/client 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 client 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 client's income. If a client 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/client 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 client'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 NH and is receiving MA 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 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 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/client must provide full financial information upon initial assessment or redetermination, every twelve months thereafter, and at such time that the client s family income or size changes significantly. Clients not providing full financial information will be billed the full service fee.

An applicant/client 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 when a change in the client's income results in changes in the client's service fee. **The change in fee is effective the first of the month following the month in which the change occurred.**

3. Ineligibility for the SPED Program

   a. 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; (However, the individual may receive Family Home Care from SPED plus a Medicaid Waiver service if the applicant/client is Skilled Nursing Facility level of care and there is an identified need for additional 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 (excluding the cost of case management) will exceed $247.

Overpayment

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

person that benefitted from or was responsible for the overpayment. A statute of limitations or similar statute does not apply.

b. Disqualifying Transfer

Per NDCC 50-06.2-07, a disqualifying transfer has occurred if at any time before or after making application, the individual or the individual's spouse has made any assignment or transfer of any asset for the purpose of making that individual eligible for benefits. 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 client before the goods and/or services were received or provided. Payment for such goods and/or services must be reasonable.

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

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

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

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

    - There is a presumption that a transfer was made for the purpose of making an individual eligible for SPED if:
        - An inquiry about SPED benefits or benefits under this chapter was made by or on behalf of the individual to any other individual before the date of transfer;

- The individual or the individual's spouse was an applicant for or recipient of SPED benefits before the date of transfer;
- A transfer is made by or on behalf of the individual's spouse, if the value of the transferred asset, when added to the value of the individual's other assets would exceed SPED limits; or
- The transfer was made, on behalf of the individual or the individual's spouse, by a guardian, conservator, or attorney-in-fact, to the guardian, conservator, or attorney-in-fact or to any spouse, child, grandchild, brother, sister, niece, nephew, parent, or grandparent, by birth, adoption, or marriage, of the guardian, conservator, or attorney-in-fact.

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

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

4. SPED Pool

Upon completion of the comprehensive assessment and the SPED Income and Asset form, AND if it is determined the applicant meets the functional and financial eligibility criteria for the SPED Program, the 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 SAMS on each person for whom funding is being sought under the SPED Program.

The documents above must be received no later than 5:00 on Tuesdays to be considered for entrance into the Wednesday SPED Pool. Services must not be authorized until the County Social Service Board is notified the applicant was successfully removed from the SPED Pool. HCBS Program Administration will notify the County 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 either returned to the County Social Service Board or will be reviewed with the County Social Service Board.

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

At the time the person 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.

The Department's notification of the SPED applicant by the HCBS Program Administration is valid for **30 calendar days**. If services have not started within that time, the approval is voided and an SFN 474 is completed and forwarded to Aging Services/HCBS. The process for approval must start over.

SPED Pool Exceptions

A recipient of Medicaid State Plan Personal Care, HCBS Medicaid Waiver, Technology Dependent Waiver, or Expanded SPED who becomes ineligible for services under these programs does not have to go through the SPED program pool to receive SPED services provided the recipient meets all other SPED eligibility criteria.

An individual who is discharged from an inpatient hospital stay, skilled nursing facility, swing bed facility, long term care facility, or

basic care facility or who has been off the SPED program for fewer than 60 days, does not have to go through the SPED pool to receive SPED services provided the recipient meets all other eligibility criteria.

The HCBS Case Manager must include the reason for the exception and the date that SPED services should start on the SFN 676, Add New Record to MMIS Eligibility File.

The HCBS Case Manager should also include a request for an exception to apply for MA on these forms if the applicant will be receiving personal care but the cost of their services (excluding case management) are less than $247.

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

**(Revised 8/1/17 ML #3515)**

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

1. Functional Eligibility, ExSPED Program

    a. 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. 50-24.5-01(9)(a);
    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.
    c. 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.)

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

f. The applicant/client(s) impairment is not the result of a intellectual disability or a closely related condition.
g. Service/care need is within the scope of services available under this chapter;
h. When the person's needs can be met in either a basic care facility OR in their home, the least costly to the Department of meeting the applicant's/client's needs must be used. This is determined and documented by comparing the monthly cost of the basic care facility he/she would enter (or the local or closest basic care facility), minus the applicant's/client's recipient liability determined by the Eligibility Specialist, compared to the estimated monthly costs for the Expanded SPED Program plus the Medicaid State Plan Personal Care Service. If the costs of services to the Department under the Expanded SPED Program would be greater than those of the basic care facility, the person is not eligible for the Expanded SPED Program.

2. Financial Eligibility for ExSPED

a. The first step is to have a determination of Medicaid eligibility by the Economic Assistance Unit of the county by using Service Chapter 400-29 (Basic Care Assistance Program). Provided on the State's e-forms is the form, SFN 21, to be used in transmitting information between the Economic Assistance Unit and Services Unit AND serves as the means of documenting eligibility for the Home and Community-Based Services (HCBS) Case Manager, Transmittal Between Units form (SFN 21). The individual must be approved through the Economic Assistance Unit for Medical Assistance prior to the individual's submission to the Expanded SPED Pool.

   In addition to being eligible for Medical Assistance, the applicants/clients 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)].

b. Estate Recovery

Legislation passed during the 1995 session gives the Department the authority to file a claim against a client'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.

c. 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.

d. Annual Redetermination

At the time of the annual Medicaid redetermination, functional eligibility must be re-established as well. N.D.A.C. 75-02-10-06(2)

In addition, the case file must contain the annual verification of continued Medicaid eligibility with the completion of the Transmittal Between Units.

3. 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 677

The documents above must be received no later than 5:00 on Tuesdays to be considered for entrance into the Wednesday ExSPED Pool. Services must not be authorized until the County Social Service

Board is notified the applicant was successfully removed from the ExSPED Pool. HCBS Program Administration will notify the County of the decision by forwarding a copy of the SFN 677 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 County Social Service Board or will be reviewed with the County Social Service Board.

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

The Department's notification by the HCBS Program Administration is valid for **30 calendar days**. If services have not started within that time, the approval is voided. The process for approval must start over.

# Financial Information for HCBS Programs 525-05-25-30

**(Revised 7/1/19 ML #3553)**

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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)**

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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 7/1/19 ML #3553)**

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## Purpose

Case Management is a service that assist individuals in gaining access to needed services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

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

## Standards for HCBS Case Managers

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

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

in the SPED or Expanded SPED Program Pool is authorized for services under the SPED or Expanded SPED Program.

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

Case file documentation must be maintained:

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

Standards for waiver case management

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). Any violation of a waiver recipient's rights must be reported as complaint to the HCBS Case Manager and/or Vulnerable Adult Protective Services.

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

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

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

- Case Managers employed by a County Social Service Agency who have sufficient knowledge and experience relating to the availability of alternative long term care services for elderly and disabled individuals.
- Developmental Disabilities Program Manager (DDPM) who is a Qualified Mental Retardation Professionals (QMRP) or has one year experience as a DDPM with the Department.
- An Individual Case Manager or Agency Case Manager that has sufficient knowledge and experience relating to the availability of alternative long term care services for elderly and disabled individuals.
- Indian Tribe or Indian Tribal Organization who has met the provider qualifications outlined in the North Dakota State Plan Amendment.

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

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

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

- County HCBS Case Managers, DDPMs, enrolled Individual or Agency Case Managers and enrolled Indian Tribe or Indian Tribal Organizations.
    - If the client requests a contact more than once every six months the Case Manager needs to obtain prior approval from a HCBS Program Administrator.
    - Indian Tribe or Indian Tribal Organizations are limited to providing TCM Services to enrolled tribal members.

Targeted Case Management (TCM)

The individual receiving TCM will meet the following criteria:

1. Medicaid recipient.
2. Not a recipient of HCBS (1915c Waiver) services.
3. Not currently be covered under another case management/targeted case management system or payment does not duplicate payments made under other program's authorities for the same purpose.
4. Lives in the community and desires to remain there; or be ready for discharge from a hospital within 7 days; or resides in a basic care facility; or reside in a nursing facility if it is anticipated that a discharge to alternative care is within six months.
5. Case management services provided to individuals in Medical institutions transitioning to a community setting. Services will be made available for up to 180 consecutive days of the covered stay in the medical institution. The target group does not include individuals between the age of 22-64 who are served in Institutions for Mental Disease or inmates of public institutions.
6. Has long-term care need (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.
7. The applicant or referred individual must agree to a home visit and provide information in order for the assessment to be completed.

Activities of Targeted Case Management

1-Assessment/Reassessment

2-Care Plan Development

3-Referral and Related Activities,

4-Monitoring and Follow-up Activities

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

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

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

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

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

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

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

Limits:

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

Case file documentation must be maintained:

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

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

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

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

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

   During the assessment process, when applicable, the information needed for submission to Dual Diagnosis Management (DDM) is obtained. The case management entity shall use the existing and established procedures for requesting a level-of-care determination from (DDM).

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

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

The following service combinations require approval by the HCBS Program Administrator and re-approved annually:

- Homemaker services when client lives with capable person or provider
- Clients receiving FHC or FPC and do not want formal respite authorized
- If a client lives with a prospective respite care provider

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

All other service combinations or exceptions require one-time approval or when the client's needs change.

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

2. Care Planning

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

a. All needs are identified in the comprehensive assessment and the services authorized to meet those needs are identified on the individual care plan (ICP) SFN 1467 or SFN 404. Additional information regarding needs and consumer choice will be outlined in the narratives in the HCBS comprehensive assessment;
    1. If a client will be receiving services Medicaid State Plan-Personal Cares (MSP-PC), the needs and services authorized will be identified on the Personal Care Services

Plan of Care and Authorization (SFN 662 and 663).

b. For each functional impairment identified for which a service need has been authorized the narrative note must include:
   1. the reason the client is unable to complete the task and/or why the client is impaired,
   2. who is completing the task,
   3. number of units,
   4. time per week allocated for the task, and
   5. the anticipated outcome or goal.

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

d. Refer to the Authorization to Provide Services for SPED/ExSPED, (SFN 1699) or Authorization to Provide Medicaid Waiver Services (SFN 410), to choose and discuss with the client the services and scope of the tasks (limits to the tasks) that can be provided. A written, signed recommendation for the task of vital signs provided by a nurse or higher credentialed medical provider must be on file outlining requirements for monitoring is required, and the frequency. For the task/activity of exercise a written recommendation and an outlined plan by a therapist for exercise must be on file.

e. The HCBS Case Manager shall review with the client or the client's representative the following information about qualified service providers (QSP) available to provide the service and endorsements required by the client:
   - Name, address and telephone number of 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 SFN 1699, or on the SFN 410, document the name of the agency or person who is to be contacted and provided the results of the client's blood pressure, pulse, rate of respiration, or temperature.

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

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

representative and approved.

g. The service, amount of each service to be provided, the costs of providing the selected services, the specific time-period, and the source(s) of payment are recorded on the ICP, SFN 1467 or SFN 404, and Authorization SFN 1699 or SFN 410. Clients must be made aware of funding caps and documentation must verify that the client has been informed of the service limits when developing the care plan at a minimum of every 6 months. If an individual's needs exceed the service limit, they would be issued a denial notice and would have the right to appeal (see Closures, Denials, Terminations, and Reductions in Services 525-05-40).

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

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

j. For Medicaid Waiver Only: Complete SFN 1597, Explanation of Client Choice and submit to Aging Services/HCBS.

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

l. When services are reduced, you must provide the client or their legal representative with a completed SFN 1647 (see Closures, Denials, Terminations, and Reductions in Services 525-05-40).

Interim Care Plans

Interim care plans are limited to clients who receive services though the HCBS Medicaid Waiver and require services immediately, or who are affected by a natural disaster or other emergency. An interim care plan may be developed for a client, who is on Medicaid, has an approved 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: A client who is currently in a Nursing Home, has a LOC in place, and is on Medicaid, plans to return home and the Case manager is unable to see the client on the day of transfer home. An interim care plan could be written, and services could begin however a face-to-face visit would need to be completed within 10 days.
- Example 2: A current client has a LOC in place, is on Medicaid but because of flooding their residence is not accessible, an interim care plan could be written so services could continue for up to 60 days before a face-to-face visit is required.

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

3. Implementing the Individual Care Plan or Person Centered Plan of Care - The Case Manager assures that services are implemented and existing services continued, as identified in the Individual Care Plan or the Person Centered Plan of Care. This activity includes contacting the QSP and issuance of an Authorization to Provide Services for

SPED/ExSPED SFN 1699 or Authorization to Provide Medicaid Waiver Services SFN 410 to be delivered. For instructions on how to complete these forms, see Authorization to Provide Services for SPED/ExSPED, SFN 1699 (525-05-60-70) and Authorization to Provide Medicaid Waiver Services, SFN 410 (525-05-60-107).

4. Monitoring - Service monitoring is an important aspect of case management and involves the case manager's periodic review of the quality and the quantity of services provided to service recipients. The Case Manager monitors the client's progress/condition and the services provided to the client. As monitoring reveals new information to the Case Manager, regarding formal and informal supports, the care plan may need to be reassessed and appropriate changes implemented. The case management entity is responsible to monitor the service plan and participant health and welfare. If the client's care needs cannot be met by the care plan and health, welfare, and safety requirements cannot be assured, case management must initiate applicable changes or request a team staff meeting through the HCBS Program Administrator to discuss possible terminate termination of services. If the case is closed, the client 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 client's case file.

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

        - For Medicaid Waiver Only: The HCBS Case Manager must contact the client after the first 30 days from the initial care plan implementation. This may be via phone or face-to-face. Face-to-face contacts are required at least quarterly thereafter.

    b. Monitoring for Targeted Case Management (TCM) - The same case management monitoring schedule followed for SPED and Expanded SPED recipients applies even when TCM covers the cost of case management.
    c. Residents of basic care facilities under Basic Care Assistance Program must have two face-to-face visits per year (annual and 6-month review), no other contacts are required.

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

In all situations:

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

    - To file a VAPS report, visit: https://fw2.harmonyis.net/NDLiveIntake/ or
    - Complete the SFN 1607 (Report of Vulnerable Adult, Abuse, Neglect, or Exploitation). The SFN 1607 fillable form may be found at: https://www.nd.gov/eforms/Doc/sfn01607.pdf

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

Documentation must include:

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

Process:

- Immediately report suspected physical abuse or criminal activity to law enforcement.
- If you have reasonable grounds to believe the recipient's health or safety is at immediate risk of harm, make a home visit to further assess the situation and take whatever action is appropriate to protect the recipient.

- If you can document that no immediate risk exists, but a problem requires further action, work with the recipient and other interested parties to resolve the matter as soon as possible.
- If the HCBS Case Manager and Nurse Manager/Trainer determine that an incident is indicative of abuse, neglect, or exploitation, the HCBS Case Manager must immediately report the incident to the Department.
- Comply with North Dakota State law Chapter 50-25.1, CHILD ABUSE AND NEGLECT.
- When the service is provided on Reservation Lands, the Tribal Laws that govern abuse and neglect on that reservation must be followed.

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

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

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

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

  Notify the Ombudsman Program Administrator, Aging Services Division

  And

  The North Dakota Department of Health Facilities.

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

  Notify the Ombudsman Program Administrator, Aging Services Division

  And

The DHS Program Administrator responsible for Assisted Living Licensing.

- If the complaint involves the provision of home delivered meals, contact the HCBS Program Administrator.
- Client lives in his or her own home and is being abused, exploited, or neglected by an individual other than the QSP:

  File a report with law enforcement and/or Adult Protective Services as indicated by the seriousness of the allegation.
- If the client is living in a AFC Home:

  Contact the CSSB responsible for AFC licensing,

  And

  Contact the 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 a client who is receiving DD Services, contact the client's DD Program Manager or the Regional Program Administrator.

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

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

or continuation of the goal must be noted in the narrative of the comprehensive assessment.

6. Termination of Service - When documenting that service(s) on the Individual Care Plan or the Person Centered Plan of Care were terminated, and indicating the reason(s) for termination, refer to Closures, Denials, Terminations, and Reductions in Services (525-05-40).

Contacts with Clients

For SPED and EXSPED -

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

Waiver:

- HCBS and TD Wavier Services: An Initial Assessment is required to establish eligibility for services and following implementation of the service a contact shall be made with a NEW client within the first 30 days of implementation of services. Quarterly contacts with the client are required including an annual assessment, 6 month reassessment and two quarter contacts. **All four contacts must be face to face and take place in the client residence.** During the first quarterly visit, the Medicaid Waiver Quality review, (SFN 1154) must be completed (this visit should **not** occur during the annual or 6-month contact). Submit a copy of this review to Aging Services/HCBS.

- Services under the HCBS Waiver that are specific to Adult Residential and Transitional Care Services provided to clients as a result of the need for independent living skills training, support and training provided to promote and develop relationships, participate in the social life of the community, or develop workplace task skills including behavioral skill

building requires all four contacts to be face to face. The annual and six month contact need to occur in the client's residence. The other contacts must be face to face but can occur at other locations. Case Management coordinates an annual interdisciplinary team conference and invites the legal representative and others as requested by the client.

All required contacts must include responses to the following questions:

- Date
- Reason for contact. (initial, annual, six month, quarterly, collateral, returned call, received call, etc)
- Location of visit (home visit, care conference, hospital visit, office visit, telephone contact, letter sent, etc)
- A description of the exchange between yourself and the client or the collateral contact. If this is a face to face visit- describe the environment, clients appearance, and communication style.
- A listing of identified needs, which includes the services the client is currently receiving.
- Service delivery options which includes, discussion about service caps, and potential service available, needed, or requested.
- Summary of care plan, which includes the outcome of the discussion of the agreed upon services requested, including other agencies or individuals providing care.
- Identify client stated goals, progress, change in goals, etc at the initial, annual and six month contact in this narrative note or in question #1.H.1. Describe the client's stated goals and results or progress
- Review the Individual Service Plan developed by the Adult Residential Provider (who provides services primarily to individual with TBI) or the Transitional Care Provider at the annual and semi-annual interdisciplinary team meeting and document the results of the Individual Program Plan
- Client satisfaction
    - Do the amount, duration and frequency of services meet the client's needs?
    - Does the provider, provide the services outlined on the care plan and authorization in the amount, duration and frequency expected.
- Follow-up plan,
- Case Managers initials

Reimbursement/Payment for Service

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

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

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

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

Administrative Tasks (Non-billable)

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

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

Level of Care Determination (LOC)

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

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

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

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

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

Upon completion of LOC determination, DDM will submit to the 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 County for filing in the client's record.

When a HCBS client 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. DDM needs to be informed of the reason for the screening and intended outcome to "other." If DDM concurs the recipient no longer needs NF care, an ending date of services needs to be given to 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 client a ten-day (calendar days) notice of service termination under the Medicaid Waiver funding source. DDM 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 Client Is Not Receiving Waiver Services

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

Case File Contents

1. For all programs, all case files should have (at a minimum):

    a. Application for Service SFN 1047
    b. A signed copy of Your Rights and Responsibilities brochure (DN 46).
    c. Completed/Signed SPED/ExSPED Individual Care Plan SFN 1467 (updated every six months) or a completed/signed Medicaid Waiver Person Plan of Care SFN 404.
    d. Authorization to Provide Services for SPED/Ex-SPED SFN 1699 (updated every six months) Or an Authorization to Provide Waiver Services SFN 410.

e. Monthly Rate Worksheet (if daily rate client) (SFN 1012 updated annually)
f. HCBS Notice of Denial or Termination SFN 1647 (if applicable)
g. HCBS Case Closure/Transfer Notice SFN 474 (if applicable)
h. A cancelled SFN 1699 or SFN 410 (if applicable)

2. The case file for each Medicaid Waiver client must contain:

a. Verification the person is a Medicaid recipient
b. Medical information (if applicable)
c. Record of current level-of-care determination(s) (updated annually)
d. Completed/Signed Explanation of Client Choice SFN 1597
e. HCBS Case Closure/ Transfer Notice/Provider Termination SFN 474 (if applicable)
f. Medicaid Waiver Quality Review SFN 1154

3. The case file for each Expanded SPED client must contain:

a. Expanded SPED Program Pool Data SFN 56
b. Add New Record to MMIS Eligibility File, SPED and ExSPED, SFN 676

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

a. SPED Program Pool Data SFN 1820
b. Add New Record to MMIS Eligibility, SPED and ExSPED, SFN 676
c. SPED Income and Asset SFN 820, HCBS Income and Asset Assessment (updated annually)

# Adult Day Care 525-05-30-10

**(Revised 5/1/19 ML #3551)**

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 client is able to function in an ambulatory care setting.
3. The client is able to participate in group activities.
4. The client requires assistance in Activities of Daily Living and Instrumental Activities of Daily Living as determined by the Comprehensive Assessment.
5. When the client 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 to Provide Services for SPED/Ex-SPED SFN 1699 or Authorization to provide Medicaid Waiver services (SFN 410).

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.

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 county social service board 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 county social service board.

By completing and submitting the Adult Day Care Standards Compliance Checklist, SFN 1703, the adult day care provider is notifying the county social service board that they are ready to have the county social service board review their compliance with adult day care standards.

The county social service board 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 5/1/19 ML #3551)**

View Archives

Purpose

The purpose of Adult Foster Care 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 a person'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 recipients 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 recipient's file.

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;
4. Have needs or a disability that makes a family home environment an appropriate care setting;
5. A licensed Adult Foster Care facility is available;
6. Not be related by blood or marriage to the licensed provider;
7. The care required by the recipient 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 recipient for board and room costs.

        - The first source for the board and room cost is from the recipient'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 recipient and is not included in the provider's daily rate.

    b. The service payment for Adult Foster Care is determined using the Monthly Rate Worksheet, SFN 1012, and is in addition to the amount for board and room.
    c. The maximum service payment that may be allowed to a recipient of adult foster care is listed in the funding source manuals, Section 05-35.
    d. 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 recipient or their representative, and the licensed Adult Foster Care provider.
    b. Case Management is not a required service.

Service Tasks

The service tasks/activities within the scope of this service chapter are identified on the Authorization to Provide Services for SPED/Ex-SPED SFN 1699 or Authorized to Provide Medicaid Waiver Services SFN 410, and the

Monthly Rate Worksheet, SFN 1012. Only tasks indicated as needed on the SFN 1012 can be authorized on the SFN 1699 or SFN 410.

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 recipients is expressly prohibited in all adult foster care settings.

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.**

A client 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.

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

Client Out of Facility with Foster Care Provider

A provider may claim payment for care of the client when the client vacations with the foster care provider if the client has continuously lived with the foster family for a substantial period of time and the client made an independent choice to vacation with the family. The provider must report the following to the county social service agency prior to departure:

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

Employment Outside of the Facility

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.

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

Employing individuals other than those who meet the definition of a respite provider or substitute caregiver is not permitted. Employing respite care providers or substitute caregivers to assist in the daily operation of the adult foster care facility is also prohibited. Respite care and substitute caregivers may provide care only in the absence of the provider.

The HCBS Case Manager must be informed of outside employment to evaluate whether client care would be negatively impacted.

# Adult Residential Care 525-05-30-16

**(Revised 5/1/19 ML #3551)**

View Archives

Purpose

To provide an array of services to an individual in a 24-hr setting. Adult residential 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 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.

Adult Residential 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 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.

6. Approval from a HCBS Program Administrator is required.

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. Assistance with ADLs and IADLs within the guidelines of the Basic Care licensure standards;
4. Allowable service tasks as identified on the Authorization to Provide Medicaid Waiver Services SFN 410.

Limits

Limited to the tasks as in agreement between the Department of Human Services and the Residential Care facility provider and as authorized by the County Social Service Board Case Manager.

To avoid duplication homemaker, chore, emergency response system, adult day care, adult foster care, respite, transitional care, attendant care, environmental modification, and non-medical transportation are not allowable service combinations for individuals receiving adult residential services. Non-medical transportation is not allowed because it is included in the rate for adult residential services.

Residential Services is an all-inclusive service with the exception of 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.

Prohibited Activities effective 12/31/16

The provision of adult residential 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 service settings is allowable but only as described in NDCC 50-10.2-02 (1).

Adult Residential Service facilities must be licensed as Basic Care facilities in accordance with ND Admin Code 33-03-24.1-03. Adult Residential 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.

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 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 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 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 Department of Health (licensing entity) will be initiated. VAPS and/or ND Department of Health will be responsible for independent review and follow up.

The Aging Services Team consists of the Aging Services Director, HCBS Program Administrator, 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.

# Attendant Care Service 525-05-30-18

**(Revised 2/1/17 ML #3490)**

View Archives

Purpose

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.

Service Eligibility, Criteria for

The individual receiving ACS must be:

1. Eligible for the Technology Dependent Medicaid Waiver
2. Dependent upon a ventilator for a minimum of 20 hours per day
3. Medically stable, as documented by their primary care physician on an annual basis (at a minimum) or as requested by the Case Manager
4. Competent, as documented by the primary care physician on an annual basis (at a minimum) or as requested by the Case Manager

The individual receiving ACS must:

5. Have an informal caregiver support system to provide contingency (back-up) care in case of absence of ACS providers
6. Actively participate in the development and monitoring of their individual care plan

Authorization for Service

1. The initial Request for Attendant Care Services, SFN 944,Person Centered Plan of Care SFN 404, and NPOC (including documentation of education provided for tasks, monitoring plan and instructions for incident reporting) must be pre-approved by the Technology

Dependent Medicaid Waiver Program Administrator, Aging Services Division. The case manager is responsible to send the completed documents to Medical Services/HCBS.

2. The Person Centered Plan of Care SFN 404 and NPOC must be updated and reviewed at the six-month level by the Technology Dependent Medicaid Waiver Program Administrator, Aging Services Division. The case manager is responsible to send the completed documents to Medical Services/HCBS.
3. The Person Centered Plan of Care SFN 404, instructions for incident reporting, and NPOC must be completed and reviewed on an annual basis by the Technology Dependent Medicaid Waiver Program Administrator, Aging Services Division. The case manager is responsible to send the completed documents to Medical Services/HCBS.

Service Delivery

ACS and Nurse Management are provided in accordance with the nursing plan of care (NPOC), developed by the client, the HCBS Case Manager and the Nurse Manager, to meet the identified needs of the client. The Case Manager is responsible to complete a Person Centered Plan of Care SFN 404 taking into consideration the needs identified in the NPOC.

The ACS client is required to identify and oversee their ACS providers. The client with the assistance of the Case Manager must develop a contingency plan to assure health, welfare, and safety in the event clients care needs change or providers are not available.

Incidents

The Nurse Manager provides written documentation to the Department that shows he or she has provided instructions to the ACS Provider that outlines the types of situations that are considered reportable incidents. ACS providers must report incidents that result in client injury or require medical care to the Nurse Manager and the Home and Community Based Services (HCBS) Case Manager. If the HCBS Case Manager and Nurse Manager 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.

Limits

1. Payment to ACS providers can be made for time performing authorized services even if performed outside of the client's home, and as approved by the Case Manager and delegated by the Nurse Manager. The authorized hours remain the same regardless of where the services are delivered.

   Note: When care will be delivered outside the client's home for a period in excess of 7 calendar days, the client must provide the Case Manager and the Nurse Manager with contact information and an itinerary. The comprehensive assessment must identify and the POC must outline the care required during the absence from the client's home.

2. When there is an appearance of potential ineligibility (change in medical or mental status), the Case Manager, Nurse Manager or HCBS Program Administrators can request a re-evaluation of eligibility determination.
3. For consumers receiving Attendant Care Service, the cost is limited to the highest monthly rate allowed to a nursing facility within the rate setting structure of the Department of Human Services. This cap may be increased as determined by legislative action. If the client's needs cannot be met within the allowed rate, case management would explore other service options with the participant including nursing home placement. The case manager should make participants aware of the service cap.
4. Due to the complexity of the care provided to individuals receiving attendant care services, contingency plans are required as a prerequisite to receive this service to assure that health welfare and safety are maintained in the event that a provider is unavailable to provide the service.

Service Activities, Authorized and Limits

1. The service tasks/activities within the scope of this service chapter are identified on the Authorization to Provide Waiver Service, SFN 404.
2. Community Integration, Social Appropriateness, shopping & Transportation, are tasks which cannot be authorized.

3. Documentation outlining the tasks the nurse has trained/delegated to the Attendant Care Service Provider are maintained by the Nurse and a copy sent to the Case Manager. The Case Manager notes on the SFN 404 within Authorization of Waiver Services in Section VIII "Other," that the nurse has trained/delegated tasks to the ACS Provider.
4. Nursing Plan of Care (NPOC) assessments must be done face to face to assure that the health, welfare, and safety needs of the client are met.

# Chore Service 525-05-30-20

**(Revised 1/1/19 ML #3543)**

View Archives

Purpose

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

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

Service Eligibility, Criteria for

The individual receiving Chore Service will meet the following criteria:

1. Must be eligible for Medicaid Waiver for Home and Community Based Services, SPED, or ExSPED.
2. For Emergency Response Service, is limited to installation and monthly rental fee. ERS Service is restricted to individuals living alone.

    a. Exception: If an individual resides in a multiple person household and there are occasions when the client may be at risk due to the absence of the other household member(s), contact the HCBS Program Administrator for one-time prior approval to allow a client to receive Emergency Response Service.

3. The individual is not able to complete tasks to maintain his/her residence, or walkway.
4. The chore activity is a one-time or intermittent task.
5. If the individual is a renter, chore services shall not replace the responsibilities of the landlord to complete tasks to maintain the residence, or walkway.
6. No family, friends, or neighbors (informal network) are available/willing/capable of completing the chore tasks to maintain the individual's residence, or walkway.

7. There are no alternative community resources such as local community action agency, housing rehabilitation, church groups, or service groups to complete chore tasks.
8. Pre-approval from the Department of Human Services is required if the cost of the service is expected to exceed $200 per month. See Service Tasks listed below for specific tasks that require additional prior approval.
9. Emergency Response Service is limited to persons cognitively and physically capable of activating the emergency call.

Service Tasks

| | |
|---|---|
| Professional extermination or sanitation<br>Need prior approval<br>Authorized per job, not units | Snow/Ice removal (when measurable snowfall or drifts present a safety hazard to the client)<br>Authorized per job, not units |
| Floor care/cleaning of unusual nature, tacking down loose rugs or tiles<br>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<br>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) |

# Community Transition Services 525-05-30-22

**(Revised 7/1/19 ML #3553)**

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 Person Centered Plan of Care (SFN 404) and Authorization to Provide Medicaid Waiver Services (SFN 410), must be completed and noted

"preliminary care plan" at the top. The HCBS Case Manager is responsible to send the completed documents to the HCBS line.

Services Activities, Authorized and Limits

1. Community Transition Services do not include expenses that constitute room and board; monthly rental or mortgage expense; escrow; specials; insurance; food; regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.
2. Community Transition Services may 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 and a Person Centered Plan of Care (SFN 404) and Authorization to Provide Medicaid Waiver Services (SFN 410) have been signed.

<u>Standards for Providers</u>

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

Agency QSP staff: Completion of an associate or bachelor's degree in sociology, social services, social work, nursing, or a field related to

programmatic needs from an accredited university. Staff with an associate degree must also have at least one year of progressively responsible experience in programs related to the task.

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

# Environmental Modification 525-05-30-25

**(Revised 1/1/19 ML #3543)**

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) to enhance the recipient's ability to function as independently as possible in the home or family member's home.

## Service Eligibility, Criteria for

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

1. Must be eligible for the programs of SPED, ExSPED, or Medicaid Waiver for Home and Community Based Services.
2. The recipient or family member must own the home prior to application.
3. The individual has a need for a safer and/or adapted environment in which to live, such as the installation of grab bars in the individual's bathroom.
4. The home modification must directly facilitate the applicant's/recipient's ability to complete his/her own cares independently or to receive care. It must be evident that without the home modifications, adequate care or the ability to perform self or environmental care is not possible.
5. The benefit outcome of the home modifications must be proportionate to the cost. Factors to consider are: the age of applicant/recipient, life expectancy, the value of the house, the applicant's/recipient's commitment to remain in the home including the family's commitment to assist.
6. Documentation must be on file that alternative community programs or funding sources available to pay for the home modification costs were explored. Examples are: Office of Vocational Rehabilitation, Community Action (e.g. weatherization, rehab.), Community Development Grant (Housing) Funds, FmHA Loan and Grant Program.

7. The informal network (family members, friends, or neighbors) are not available/willing/capable of completing or paying for the home modifications(s).
8. Physical adaptations to the home required which are necessary and without which, the recipient would require institutionalization.

Limits

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

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

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

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

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

member. This home must be owned by the recipient or the recipient's family member.

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

Pre-Approval Service Eligibility Determination

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

1. The individual must make application for services to the HCBS Case Management Agency in their county of physical residence using "Application for Services" (SFN 1047).
2. The HCBS Case Management Agency will determine whether or not the need for home modification is related to the care needs of the applicant. The comprehensive assessment is used to identify functional impairments.
3. A visual inspection of the home is completed by the HCBS Case Manager and, whenever possible, a professional of another discipline with experience in evaluating home care needs of the elderly and disabled. They will determine if the applicant's/recipient's request for Environmental Modification Service will be of direct benefit to the applicant's self- care needs. If it is found the requested/proposed modifications will not be of direct benefit to the applicant/recipient, the County Social Service Board must deny the service request following the service denial policy procedures.
4. If the home is in poor condition and not structurally sound, Environmental Modification will not be approved.
5. A summary of the applicant's/recipient's service request and the recommendation(s) resulting from the home inspection is documented in the case file records. Included in the documentation must be an explanation of the proposed home modifications and how they will enable self-care or enhance care provided by others.

6. Written construction bids must be obtained for any work funded under this service chapter. When the estimated cost exceeds $500.00, bids must be obtained from at least two licensed general contractors if possible. Exceptions may be made to the two bid requirement if it can be demonstrated that there is a lack of available service providers in the area. All bids must include a breakdown of the labor AND material costs of the modifications. See section 525-05-45 for Contractor Standards.
7. Upon receipt of the written bid(s), the following information is sent to the HCBS program administrator: written bids, narrative explanation of the proposed work and how it will assist the applicant/recipient to complete or receive self-care, a photocopy of the most recent Comprehensive Assessment, and the SPED/ExSPED Individual Care Plan, SFN 1467, or Medicaid Waiver Person Centered Plan of Care SFN 404 that lists Environmental Modification Service. If an exception is being requested to the two bid minimum include a written explanation of the facts supporting the request. HCBS Program Administration's decision will be based on this information.
8. If the proposed Environmental Modification Service is not approved, the Case Management Agency will issue a denial notice following the procedures of denying services.
9. After the HCBS Case Management Agency is notified that the environmental modification project is approved, the Case Manager will assist the contractor (awarded the bid) to complete the forms required for enrollment as a Qualified Service Provider. The Authorization to Provide Services for SPED/ExSPED, SFN 1699, or Authorization to provide Medicaid Waiver Services SFN 410 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, SFN 1699, or Authorization to Provide Waiver Services SFN 404 Section VII is the time span in which the contractor agrees to finish the project.

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

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

Environmental Modification, Scope of

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

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

1. Labor and materials to widen doorways to accommodate wheelchair.
2. Labor and materials to install a wheelchair ramp when structural changes to the house are required.
3. Labor and materials to install or relocate plumbing and/or electrical systems to accommodate specialized equipment.
4. Labor and materials to modify a bathroom, including installation or relocation of fixtures to accommodate the individual's personal care needs.
5. Labor and materials to modify a kitchen to enable accessibility for independent meal preparation.
6. Adaptations may include the installation of ramps, and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies and necessary for the welfare of the recipient.

Materials Authorized for Purchase

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

# Extended Personal Care Service 525-05-30-27

**(Revised 5/1/19 ML #3551)**

View Archives

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 client. Services provided by a licensed nurse include but are not limited to nurse assessments, care planning, training, periodic review of client 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.

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 that 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 ND Century Code chapter 43-12.1.
5. Have an informal caregiver support system to provide contingency (back-up) care in case of 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.

Authorization for Service

1. The initial Request for Extended Personal Care Services (written request by Case Manager), SPED/Ex-SPED Individual Care Plan (SFN 1467) and Authorization to Provide Services for SPED/Ex-SPED, (SFN 1699),or Medicaid Waiver Person Centered Plan of Care (SFN 404) and Authorization to Provide Medicaid Waiver Services (SFN 410) 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)Program Administrator, Aging Services Division. The case manager is responsible to send the completed documents to Aging Services/HCBS.

2. The SFN 1467 and SFN 1699 or SFN 404 SFN 410 and NPOC must be updated and reviewed at the six month level by the Extended Personal Care Service (EPCS)Program Administrator, Aging Services Division. The HCBS case manager is responsible to send the completed documents to Medical Services/HCBS.

3. The SFN 1467 and SFN 1699 or SFN 404 SFN 410 and NPOC must be completed and reviewed every six months by the Extended Personal Care Service (EPCS)Program Administrator, Aging Services Division. The HCBS case manager is responsible to send the completed documents to Aging Services/HCBS.

Service Delivery

EPCS and Nurse Education are provided in accordance with the nursing plan of care (NPOC), developed by the client and the Nurse Educator, to meet the identified needs of the client. The Case Manager is responsible to

complete a SFN 1467 and SFN 1699, or SFN 404 and SFN 410 taking into consideration the needs identified in the NPOC.

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

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 client'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 client, incident reporting Assistance with activities of daily living (ADLs) and instrumental activities 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 in the event that 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 client are met.

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 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 on the SFN 1699 or on the SFN 410 the units authorized.
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 client. Services provided by a licensed nurse include but are not limited to nurse assessments, care planning, training, periodic review of client 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.
3. The nurse educator will provide at a minimum, a review of the client's needs every six months to determine if additional training and or tasks are required.

# Family Home Care 525-05-30-30

**(Revised 1/1/19 ML #3543)**

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:

1. Must be eligible for the SPED or ExSPED program.
2. The client and the qualified family member shall reside in the same residence.
3. The client and the qualified family member shall mutually agree to the arrangement.
4. The qualified family member must be one of the relatives as defined in this chapter and must be the provider performing the care to the client.
5. The need for services must fall within the scope of tasks identified on the SFN 1012, Monthly Rate Worksheet - Live-In Care, and SFN 1699, Authorization to Provider Services.

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

Service Tasks/Activities - Family Home Care

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

Family Home Care Limitation, Under 18 Years of Age

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

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

Out of Home Care

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

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

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

This provision within the Family Home Care service is appropriate for clients who can be left alone for routine temporary periods of time (e.g. part-time employment of the qualified family member) without adverse

impact to the client's welfare and safety. The client must agree to be left alone.

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

Service Combinations

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

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

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

   - Respite care must be authorized because FHC providers cannot delegate their care to another individual if a client cannot be safely left alone.
   - If informal respite is in place and of benefit to the client, an exception must be obtained from the HCBS Program Administrator.

3. Emergency response is acceptable if a safety risk (i.e. potential fall risk or sudden illness) has been identified during the FHC provider's short term absence. ERS is not acceptable for clients who require supervision for cognitive or heath related reasons. Contact the HCBS

Program Administrator in writing to obtain approval for the combination of FHC and ERS service.

4. Under unusual or unique circumstances other HCBS service combinations may be appropriate. In such cases, contact the HCBS Program Administrator in writing to obtain approval.

# Family Personal Care 525-05-30-32

**(Revised 1/1/19 ML #3543)**

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. It provides for the provision of extraordinary care payments to the legal spouse of a recipient for the provision of personal care or similar services.

## Service Eligibility, Criteria for

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

1. Must be eligible for the HCBS Medicaid Waiver program.
2. The client and qualified provider (who is the legal spouse and is enrolled as a personal care provider) shall reside in the same residence.
3. Before a legally responsible individual who has decision making authority over a client can be enrolled as a qualified service provider for Family Personal Care, the Case manager must approve the choice of provider. The case manager is responsible to forward a copy of the narrative that explains why the legally responsible person acting as the family personal care provider is in the best interest of the client to the State office. The narrative must be attached to the clients care plan.
4. The client and qualified provider shall mutually agree to the arrangement.
5. The need for services must fall within the scope of tasks identified on the SFN 1012, Monthly Rate Worksheet - Live-In Care (MRW), and Authorization to Provider Waivered Services.

## Service Tasks/Activities

The service tasks/activities within the scope of this service chapter are identified on the Authorization to Provide Medicaid Waiver Services form,

SFN 410 and only those listed on the SFN 1012, Monthly Rate Worksheet, can be approved and authorized.

Out-of-Home Care

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

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

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

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

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

Limitations

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

Service Combinations

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

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

basis, and the client can be left alone safely for brief periods of time, respite care is appropriate only when the qualified family member will be gone for an extended period of time, for example, to attend a wedding.

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

- Respite care must be authorized because FPC providers cannot delegate their care to another individual if a client cannot be safely left alone.
- If informal respite is in place and of benefit to the client, an exception must be obtained from the HCBS Program Administrator.

2. Emergency response is acceptable if a safety risk (i.e. potential fall risk or sudden illness) has been identified during the FPC provider's short term absence. ERS is not acceptable for clients who require supervision for cognitive or health related reasons. Contact the HCBS Program Administrator in writing to obtain approval for the combination of FPC and ERS service.

# Home Delivered Meals 525-05-30-33

**(Revised 1/1/19 ML #3543)**

View Archives

## Purpose

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

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

## Service Eligibility, Criteria for

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

1. Must be eligible for one of the following Medicaid Waiver for Home and Community Based Services, Service Payments to the Elderly & Disabled, or Expanded Service Payments to the Elderly & Disabled.
2. Service Payments to the Elderly and Disabled or Expanded Service Payments to the Elderly and Disabled recipients who are eligible for home delivered meals under the Older Americans Act (OAA) can access one additional home delivered meal per day, as long as at least one of their meals is provided and paid for under the OAA. Individuals requesting home delivered meals under the HCBS waiver are not required to use Older American Act meals first.
3. Lives alone and is unable to prepare an adequate meal or lives with someone who is unable or unavailable to prepare an adequate meal.

## Limits

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

Standards for Home Delivered Meal Providers

See Standards for Qualified Service Providers 525-05-45

# Homemaker Service 525-05-30-35

**(Revised 5/1/19 ML #3551)**

View Archives

Purpose

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

Service Eligibility Criteria for

The individual receiving homemaker service will meet the following criteria:

1. Must be eligible for the Medicaid Waiver for Home and Community Based Services, SPED, or ExSPED.
2. Needs assistance with environmental tasks that are within the scope of this service.
3. Has no informal network or other agency available/capable/willing to complete environmental task(s)/activities. The client must live-alone or the person(s) living with the client is/are not capable or obligated to complete the task(s). Homemaking services cannot be approved when they are completed for the benefit of both the client and the provider.

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

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

5. The need for environmental tasks/activities is intermittent or occasional.
6. Occasionally the provision of Homemaker Service tasks/activities may impact other family members. When this occurs it must be considered insignificant or must be inseparable from tasks/activities provided to the client (e.g. cooking, cleaning).
7. The department may provide essential homemaking tasks such as meal preparation if the adult not receiving care who resides in the home is unavailable due to employment. Prior approval for these tasks must be obtained from the HCBS Program Administrator.
8. The funding cap applies to a household and may not be exceeded regardless of the number of clients reside in the home.

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

Service Tasks/Activities

1. Housework
2. Meal Preparation
3. Laundry
4. Shopping

    a. Transportation or escorting of the client are unallowable.

5. Communication
6. Managing Money

Services Activities, Authorized and Limits

1. The service tasks/activities within the scope of this service chapter are defined on page 2 of the Authorization to Provide Services for SPED/ExSPED, SFN 1699 and page 2 of the Authorization to Provide Medicaid Waiver Services, SNF 410.
2. When a client receives assistance with laundry, shopping, housekeeping, under Medicaid State Plan Personal Care (MSP-PC) in

excess of the funding cap allowed for homemaker services under SPED, EXSPED, or HCBS Wavier, additional tasks of Meal Prep, Communication or Managing Money may not be authorized under Homemaker Services.

3. If a client is receiving MSP-Personal Care assistance for meal prep, communication, and money management, these tasks are not allowable homemaker tasks unless approval is obtained from a HCBS Program Administrator.
4. If a client 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:
    1. MSP-PC Level C is authorized; or
    2. The total cost of the maximum number of units that are able to be authorized under MSP-PC is less than $150.
        1. If a rural differential (RD) rate is authorized, the RD rate must be used to calculate the laundry, shopping, housekeeping total cost.
    3. Homemaker is authorized under Medicaid Waiver then all HMK tasks may be authorized under MSP-PC or Medicaid Waiver since both (MSP-PC and Medicaid Waiver) are Medicaid-funded programs.

# Non-Medical Transportation 525-05-30-40

**(Revised 1/1/19 ML #3543)**

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.

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

## Service Activities

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

1. Driver with Vehicle

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

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

2. Authorization of Escort

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

3. Authorization of Driver with Vehicle and Escort

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

Unallowable Service Activities

- HCBS Non-Medical Transportation CANNOT be used to transport a client to and from work/or school or to facilitate socialization or to participate in recreational activities, (i.e. wellness programs, church activities, etc.).
- HCBS Non-Medical Transportation CANNOT be used to transport a client to and from a health care provider or medical facility (doctor, dentist, hospital, physical therapy, etc.).
- If the client is not able to be transported or participate in the activity, this cannot be billed under Non-Medical Transportation. The service may be covered under Homemaker.

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

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

# Nursing Assessment 525-05-30-42

**(New 7/1/18 ML #3543)**

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 (SFN 404) and Authorization to Provide Medicaid Waiver Services (SFN 410), must be completed and noted "preliminary" at the top. The HCBS Case Manager is responsible to send the completed documents to the HCBS line.

Services Activities, Authorized and Limits

1. Nursing Assessment may not duplicate the assessment completed by the HCBS Case Manager.
2. Nursing Assessment may be authorized up to 180 consecutive days prior to admission to the waiver of an institutionalized person.
3. Nursing Assessment is limited to more than 14 units (unit = 15 min) per recipient to complete the assessment tool. Any exceptions to this limit must be prior approved by an HCBS Administrator.
4. Nursing Assessment will require prior approval from the HCBC Program Administrator to prevent any duplication of services.
5. When Nursing Assessment Services are furnished to individuals returning to the community from a Medicaid institutional setting through entrance to the waiver, the costs of such services are considered to be incurred and billable when the assessment is completed
6. The Nursing Assessment may be shared with the HCBS Case Manager if an appropriate release of information has been completed.

Billing

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

Authorization of Services

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

Standards for Providers

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

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

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

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

# Personal Care Service 525-05-30-45

**(Revised 5/1/19 ML #3551)**

View Archives

Purpose

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

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

1. Personal care provided up to 24 hours per day, differs from adult foster care in that personal care is provided in the client's home, and adult foster care is provided in the service provider's home. If a non-relative is caring for the client on a 24-hr live in basis in the provider's home, the service must be Adult Foster Care. It cannot be Personal Care service.
2. Live-in personal cares (daily care) are all inclusive with the exception of Respite Care.
3. Personal care differs from respite care in that respite care is provided to relieve the primary, live-in caregiver, whereas the primary purpose of personal care is to provide the care a client needs and not to relieve the caregiver.

Service Eligibility, Criteria for

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

1. Must be eligible for the SPED program and not eligible to receive Personal Cares under the Medicaid State Plan, or Family Home Care;
2. Be at least age 18;
3. The care needs of the client must fall within the scope of personal care service as described in this service chapter. The care needs may include a combination of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Either the client must have the ADLs and IADLs needs performed for him/her OR a cognitively impaired client may be able to complete the activity ONLY with supervision, guidance, or prompting.

    a. The task of supervision is allowed between other personal care tasks, up to the maximum number of units authorized.

4. Daily Personal Cares live-in must be authorized if the provider and the client live in the same residence.

    a. Daily Personal Care is an all-inclusive service and can only be combined with Respite Care. For unusual or unique circumstances, prior approval from the HCBS Program Administrator must be obtained.

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

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

The provision of Daily Personal Cares live-in is appropriate ONLY for clients who can be left alone for routine temporary periods of time (e.g. part-time employment) without adverse impact to the client's welfare and safety. The client must agree to be left alone.

Cognitively Impaired Clients, Services to

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

how the informal network entity(s) is involved to meet this primary need with the formal service network filling gaps.

Limits:

1. Clients whose providers do NOT meet the definition of Family Home Care may qualify for Personal Care Service. SPED Personal Care Service is not an option for clients when the live-in care provider is a family member. See N.D.C.C. 50-06.2-02(4) for the definition of family member.
2. Under Personal Care Service, payment can be made for time performing authorized personal care tasks even if performed outside the client's home as long as the cares are provided in the local trade area. The hours remain based on the care necessary in the client's home. The care provided outside the home must be within the defined scope (allowable tasks as authorized) of the service.

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

Assisted Living Facility

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

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

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

    a. The provider is a family member as defined in State law for Family Home Care.
    b. The intensity of care needs cannot be met under "assisted living" (e.g. need for continuous on-site care).

c. The assisted living personal care provider is not identified in the tenant's rental agreement.

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

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

Service Activities, Authorized and Limits

1. The service tasks/activities within the scope of this service chapter are identified on the Authorization to Provide Services for SPED/ExSPED, SFN 1699.
2. For Personal Care unit rate, housework, laundry, communication, money management, shopping, and meal preparation are considered homemaker tasks and cannot be authorized as a personal care tasks.
3. For Personal Care unit rate, Community Integration, Social Appropriateness, and Transportation are tasks which cannot be authorized under the SPED personal care service.
4. Live-in personal care services are limited to those tasks identified on the SFN 1012, Monthly Rate Worksheet.
5. For clients who require two-person assist with personal cares, approval is required from a HCBS Program Administrator.

# Respite Care Service 525-05-30-55

**(Revised 1/1/19 ML #3543)**

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 client's home, or outside the client's home in either a Respite Care Providers home or an enrolled Qualified Service Provider of Institutional Respite Care.

## Service Eligibility, Criteria for

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

1. Must be eligible for Medicaid Waiver for Home and Community Services, SPED, or ExSPED.
2. The individual has a full time (live-in) primary caregiver OR the individual is a child under 22 years of age who is attending school AND the primary caregiver is responsible for providing full time care when the individual is not in school.
3. The relief is not for the primary caregiver's employment or enrollment/attendance of an educational program.
4. Children three (3) months of age and under would be eligible only for SPED Respite Care for apnea monitoring. See Limits section for infants over three months of age.
5. Clients enrolled in a Hospice program are not eligible for institutional Respite Care but would be eligible for in-home intermittent Respite Care.

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

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

    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 client, contact the HCBS Program Administrator for prior approval.
10. A client who is a resident of an Adult Foster Care home may choose their respite provider and is not required to use a relative of the Adult Foster Care provider for respite.

Information Provided to the Respite Care QSP:

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

1. The Respite Care QSP shall be informed about the client's daily routine. This may include strengths and weaknesses of the client, what the client enjoys doing, unique instructions for specific activities, or special assistance requirements.
2. The primary caregiver will explain in writing situation(s) which may result in an emergency. The written information should clarify what might happen, the appropriate response, and who the Respite Care QSP should contact for assistance.
3. The primary caregiver shall identify to the Respite Care QSP the location of a first aid kit in the home, the location of the fuse box and spare fuses, the fire exit plan for the home and explain special instructions/restrictions on the operation of household appliances, kitchen equipment, etc.
4. If client specific or global endorsements are required, the Respite Care QSP must meet the competencies for these tasks.

Service Activities, Authorized

The service tasks/activities within the scope of this service chapter are identified on the Authorization to Provide Service, SFN 1699 or Authorization to Provide Waivered Services SFN 404.

Service Activities, Not Allowed

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

Limits

1. Non-institutional Respite Care is capped at the daily swing-bed rate (http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-fee-schedules.html) regardless of whether an overnight stay is included. Respite Care providers must bill using the Procedure Code for a 15-minute unit, not to exceed the daily swing-bed rate. Only providers of Institutional Respite Care can bill using the Procedure Code for a daily rate.
2. Twenty-four hour care shall be allowed in an emergency and cannot exceed the Respite Care cap without prior approval of the HCBS Program Administrator.
3. Respite Care may be provided for up to three (3) months to an infant requiring apnea monitoring if other SPED Program eligibility criteria are met, AND an apnea monitor is recommended by the applicant's physician.
4. An applicant/client requiring apnea monitoring is eligible upon the HCBS Program Administration receiving the SFN 1820, Data for SPED Program Pool Entry/Denial, with the notation the client is on apnea monitoring. The effective date of service will be the date requested by the HCBS Case Manager. Coverage under the SPED program can be extended beyond three (3) months upon written request to the Respite Care Program Administrator documenting the continued need for Respite Care as a result of continued need for apnea monitoring.
5. The total allowable monthly maximum for Respite Care must be prorated for all residents in the Adult Foster Care home (regardless of private or public pay). The number of public and private pay AFC residents in a home should be evaluated quarterly during the quarterly contact. Any changes in the amount of respite should be updated at that time.
6. The total allowable maximum for respite care must be prorated for all clients receiving and living in the same Family Home Care setting.
7. If multiple clients live in the same home and have the same primary caregiver the respite cap must be divided by the number of client's in the home.

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

Institutional Respite Care

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

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

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

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

Adult Foster Home for Respite Care

Adult Foster Homes that are also enrolled as Respite Care Homes and are providing services for clients who are not current Adult Foster Care recipients bill their established Respite Care unit rate; the total cost per day cannot exceed the current swing bed rate.

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

Respite Care in QSP's Home

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

1. A minimum of one (1) home visit to the Respite Care QSP's home shall be made by the County Social Service Board to complete the form Respite Home Evaluation.
2. Upon determining the respite care QSP's home meets the standards as outlined in SFN 659, a copy of the completed SFN 659 approving such compliance shall be issued to the respite care QSP to be effective for no more than two (2) years. The Respite Care Home QSP must sign an agreement to maintain the standards and keep a copy of the standards on the premises of the home. The approval shall apply to only the home at the address evaluated. Should the Respite Care QSP move, another evaluation is required.
3. The County Social Service Board shall maintain records of the evaluation, the decision, and the reason for that decision.

# Specialized Equipment and Supplies 525-05-30-60

**(Revised 1/1/19 ML #3543)**

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 a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
2. Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;
3. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;

4. Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and
5. Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

Service Eligibility, Criteria for

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

1. Must be eligible for the programs of Medicaid Waiver for Home and Community Services.
2. The basis of need for the equipment is established through the assessment process and must include an adaptive assessment completed by a professional with expertise in the equipment requested, (e.g. PT/OT, Speech and Hearing). Prior approval is required for the purchase of specialized equipment or supplies.
3. The equipment purchased is of significant benefit to the applicant/recipient in the performance of personal cares and/or household tasks in the home.
4. The recipient does not already have access to a product that serves essentially the same purpose.
5. The need for the equipment is expected to extend indefinitely.
6. The individual is motivated to use the equipment.
7. A written bid must be obtained for any specialized equipment and/or supplies funded under this service chapter. If the equipment or supplies are considered durable medical equipment (DME), the bid must include healthcare common procedure coding system (HCPCS) codes.
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. The informal network (family members, friends, or neighbors) is not willing or able to purchase the equipment for the individual.

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

Limits

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

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

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

All items shall meet applicable standards of manufacture and design.

Specialized Equipment and Supplies, Scope of

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

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

Specialized Equipment and Supplies, Delivery Of

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

1. The HCBS Case Manager will contact a supplier of the specialized equipment and/or supplies who are enrolled as a Qualified Service Provider or may be willing to enroll as a Qualified Service Provider. The purpose of the contact is to authorize purchase of the approved item and to verify the cost.
2. The supplier will ship/mail the item only upon receipt of the Authorization to Provide Medicaid Waiver Service, SFN 410. The Qualified Service Provider will request payment from the Department of Human Services using the QSP payment system.
3. The supplier is responsible to arrange for or provide any instruction the recipient may need to use the specialized equipment.
4. One month following delivery, the HCBS Case Manager is to contact the recipient to monitor the effectiveness of the specialized equipment. The results of this monitoring contact are documented in the case file. It is at this point that Specialized Equipment and Supplies Service should be deleted from the Medicaid Waiver Person Centered Plan of Care, SFN 404 if no further need exists for the reimbursable items of this service chapter.

# Supervision 525-05-30-63

**(Revised 5/1/19 ML #3551)**

View Archives

Purpose

Supervision may be provided to assist eligible recipients who live alone or with an individual who is not identified as a relative within the definition of family home care under subsection 4 of N.D.C.C. 50-06.2-02.

If the individual who is requesting supervision services lives with their ex-spouse or one of their following relatives, or the current or former spouse of one of their following relatives, they are not eligible for supervision: Parent, grandparent, adult child, adult sibling, adult grandchild, adult niece or adult nephew.

- If a client lives with a relative but the relative is unable to provide supervision because of a physical or cognitive impairment contact a HCBS Program Administrator to discuss potential eligibility.

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. Lives alone or with an individual who does not meet the definition of relative under N.D.C.C. 50-06.2-02(4);
3. Be at least age 18;
4. The care needs of the client must fall within the scope of supervision as described in this service chapter.
5. If a client requires supervision 24 hours per day, the case manager must justify in the client narrative why the client needs the support of awake staff to assure health and safety needs are met at night. Providers, who provide supervision at night while the client is sleeping, must stay awake while providing supervision.
6. Prior approval from a HCBS Program Administrator is required before this service may be authorized.

Service Tasks/Activities

Allowable supervision tasks include: 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 supervising the recipient and is not actively providing personal care or homemaker tasks etc., they may play games, visit, read, and participate in activities with the client. If the client is physically able, they may also participate in activities on or around the recipient'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 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, hoyer 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, ric bed care. Communication, housework, laundry, meal preparation money management, and shopping are not allowable service tasks under this

service. Clients, who live alone, or with a non-relative, are still eligible for home maker services. Medication assistance is not an allowable task under this service.

Supervision outside of the client's home

Payment cannot be made for time performing authorized supervision tasks outside of the client's home/grounds.

1. Exception: When the client is required to seek essential services i.e. medical care etc. outside of North Dakota, contact the HCBS Program Administrator for approval.

    - If a supervision client needs transportation to an essential community service non-medical transportation with escort may be authorized.

Cognitively Impaired Clients, Services to

For cognitively impaired clients who are receiving less than 24 hours of personal care with supervision, 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 personal care with supervision service is not being provided, cooperative and coordinated efforts of meeting the needs of the client by the family, other informal providers, must be identified.

Service Activities, Authorized and Limits

1. Clients who live alone or with someone who does NOT meet the definition of family member as defined in N.D.C.C. 50-06.2-02(4) may qualify for supervision.

    - If a client lives with a relative but the relative is unable to provide supervision because of a physical or cognitive impairment contact a HCBS Program Administrator to discuss potential eligibility.

2. Under Supervision, Community Integration, Social Appropriateness, and Transportation are tasks which cannot be authorized under this chapter. If a client needs these tasks they must be authorized under transitional care.
3. 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, personal care, transitional living, specialized equipment and supported employment.
4. Supervision cannot be combined with, respite care, emergency response system, adult foster care, residential services, and family personal care.
5. 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, SFN 404.
2. The amount of units allocated for supervision of the client is determined by subtracting the amount of time the client is receiving informal supports and authorized services i.e. personal care, homemaker etc. from a 24 hour period.

   **Example:** a client 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.

# 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

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 1/1/19 ML #3543)**

View Archives

Purpose

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

Service Eligibility, Criteria for

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

1. Must be eligible for the Medicaid Waiver for Home and Community Services;
2. Service/care is delivered in the recipient's private family dwelling (house or apartment);
3. Individual must benefit by receiving Transitional Care Living and is cost-effective and necessary to avoid institutionalization;
4. Require supervision, training, or assistance with self-care, communication skills, socialization, sensory/motor development, reduction/elimination of maladaptive behavior, community living and mobility;
5. Disabled as determined by Social Security Disability criteria; and
6. Recipient is capable of directing own care as determined by the interdisciplinary ICP team or have a (legally) responsible party to act in the recipient's behalf.
7. Pre-approval from the Department of Human Services is required before this service can be authorized.

Service Tasks

Tasks that can be authorized are bathing, communication, community integration, dress/undress, eye care, feeding/eating, hair care/shaving, housework, incontinence, laundry, meal preparation, medication assistance, money management, nail (finger) care, shopping, skin care, social appropriateness, teeth/mouth care, toileting, transferring/turning/positioning. Escort to accompany individuals while

they are being transported to/from work or school, to facilitate socialization, or to participate in recreational activities is allowed.

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

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

Service Combinations

1. Non-Medical Transportation Driver w/Vehicle may be combined with Transitional Living Service.
2. Non-Medical Transportation Escort Service is 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.

Individual Program Plans

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

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

The Plan must also identify the goal or goals of the individual and how the goals will be accomplished. This Plan will be subject to review by the HCBS Case Manager during the initial Plan implementation period and every six

months thereafter. At the team meeting, the team will review the goals and progress, and strategies for accomplishing the plan goal or goals.

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

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

**(Revised 7/1/19 ML #3553)**

View Archives

The maximum amount allowable under the Medicaid Waiver for Home and Community Based Services per client 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:

https://www.nd.gov/dhs/services/medicalserv/medicaid/longtermcare.html

The maximum amount allowable under the SPED and ExSPED Programs per client and per month is an aggregate of $3468 for all services excluding Case Management.

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. For example, homemaker units paid at the rural differential rate cannot exceed 50 units using an agency QSP or 70 units using an individual QSP.

Service Maximums Per Client Per Month for Dates of Service

| | |
|---|---|
| Homemaker Service | $328 |
| Respite Care | $1091<br>(Daily amount not to exceed daily swing bed rate).<br>Refer to link:<br>http://www.nd.gov/dhs/services/medicalserv/medicaid/pr |

| | |
|---|---|
| | ovider-fee-schedules.html |
| Respite Care in Homes with Multiple Clients | $1091 split by the total number of public and private pay clients in the home.<br><br>Plus $202.29 per month for each additional (2nd 3rd or 4th) public pay client in the home, the total amount will need to be divided between the public pay clients.<br><br>For Example: An AFC provider has a total of 3 clients, 2 are public pay & 1 is private pay. To calculate respite for the public pay clients you should divide the current respite cap ($1091) by the total number of public & private pay clients living in the home (3) that equals $363.66 for each client or $727.33 for the 2 public pay clients combined. Now add $202.29 for the 2nd public pay client that equals $929.62. Now divide that amount between the 2 public pay clients 2/$929.62 = $464.81.<br><br>The final step is to allocate $464.81 on each of the public pay client's care plan. |
| Adult Foster Care | $91.77 per day for Medicaid |

| | Waiver for Aged & Disabled |
|---|---|
| Family Home Care | $45.91 per day |
| Family Personal Care | $74.80 per day |
| Daily Rate for SPED AFFC and Personal Care | $78.92 per day |
| Unit Rate for SPED Personal Care | $3537 |

Extraordinary Costs/Exceed Monthly Aggregate or Service Maximum

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

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

- Name and ID number of the client.
- Reason for the request: the client's circumstances that necessitate the short duration extraordinary costs AND what options were explored as alternatives to meeting client's need.
- The additional dollar amount request, for what 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 5-1-2019

The current maximum monthly room and board rate that providers may charge Adult Foster Care, Adult Residential and Family Home Care

recipients is $739.00. 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 5/1/19 ML #3551)**

View Archives

## Purpose

The purpose of the rural differential rate (RD) is to create greater access to home and community-based services for clients 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 client'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 (does not include snow shoveling), or Transitional Living services.

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

If the QSP or agency employee resides in another State, the Department will accept another form of address verification i.e. current utility bill etc. If out of state residents submit other forms of identification the decision to accept it for purposes of being eligible to receive the RD rate will be made on a case by case basis.

**Service Activities, Authorized**

A Rural Differential Unit Rate Authorization/Closure (SFN 212) must be completed by the case manager for each provider eligible to bill a rural differential rate. The SFN 212 must be submitted with a Map Quest to Aging Services/HCBS.

The RD rate must be identified on the SPED/Ex-SPED Individual Care Plan (ICP) (SFN 1467) and the Authorization to Provide Service for SPED/Ex-SPED (SFN 1699) and/or Medicaid Waiver Person Centered Plan of Care (SFN 404) and Authorization to Provide Medicaid Waiver services (SFN 410).

**Service Eligibility, Criteria for**

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

1. Client must be eligible for one of the following services: Medicaid Waiver, Service Payments to the Elderly & Physically Disable (SPED), Expanded Service Payments to the Elderly & Disabled (EX-SPED), Medicaid State Plan personal Care (MSP-PC). For MSP-PC please see Personal Care Services 535-05-40.
2. Client 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.

3. Client needs any of the following services: respite care, homemaker, personal care, nurse education, extended personal care, chore labor (does not include snow shoveling), transitional living 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 client's home, the RD rate may be used. If the employee lives less than 21 miles (round trip) from the client's home, the RD may not be used.
- Rural differential rates are based on the distance it takes to travel to each individual client'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 client'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 client'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 SFN 212 under QSP physical address. If a QSP states the physical address on the QSP list is incorrect, they must

contact the HCBS office to change it before an authorization can be provided that includes a rural differential rate. It is not sufficient to notify the case 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 SFN 212 noting the change of address and an updated Map Quest with the current address.

If the QSP's new address changes the tier the provider is eligible to bill, the case manager must update the tier and rate on the SFN 212 and develop a new authorization with the correct rate and provide it to the client and QSP.

If the QSP no longer qualifies for an RD rate, the Case Manager must complete and submit a SFN 212 to Aging Services/HCBS.

**Determining Distance:**

Case managers are required to verify distance between the HCBS client's home and the QSP's home base by using the following website- www.mapquest.com. The Case Manager is responsible to choose the most reasonable route and print a copy of the MapQuest results that must be kept in the clients file and submit to Aging Services/HCBS along with the SFB 212.

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

# Closures, Denials, Terminations, Reductions, and Transfer of Services 525-05-40

**(Revised 5/1/19 ML #3551)**

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1. Closures

   If a client (both, new or current client) does not utilize the services authorized in the care plan within a 30-day period of time or an exception has not been approved, the case should close and an HCBS Case Closure/Transfer Notice/Provider Termination (SFN 474), SFN 474, should be completed and forwarded to Aging Services/HCBS.

   - If services were to be implemented within a few days after the 30th day, contact the HCBS Program Administrator for written approval.

   HCBS Case Managers must notify HCBS Program Administration of HCBS closures using the SFN 474, this includes all HCBS programs. The Notification is to be submitted to HCBS/Aging Services within 3 days of closing the case.

   10-day Notice Not Required

   Either because the client has taken action that results in the termination of services (i.e. a client indicating, in writing, his/her 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 Reduction, Denial, or Termination (SFN 1647) is not required. The HCBS Case Manager is required to inform the client 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 client's death, a letter is not required to be forwarded to the client'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:

1. HCBS Case Manager has factual information confirming the death of the client.
2. The HCBS Case Manager has received in writing the client's decision to terminate services
3. Client has been admitted to a basic care facility or nursing facility.
4. Client's whereabouts are unknown.
5. Special allowance granted for a specific period is terminated.
6. State or federal government initiates a mass change which uniformly and similarly affects all similarly situated applicants, recipients, and households.
7. Determined the client has moved from the area.

2. Reduction/Denial/Termination Notice

The applicant/client must be informed in writing of the reason(s) for the denial/termination/reduction. Complete SFN 1647 or if allowable send a letter with all applicable information to the client or applicant or their legal decision maker. The citation used to complete the SFN 1647 must be obtained from a HCBS Program Administrator.

- Reduction in services may include reducing the number of units or reducing the tasks in a specific category. A written reduction note SFN 1647 is required (the client agreeing with the reduction is not sufficient).
- Termination of a service is discontinuing the service. The client must be informed in writing of the termination by providing the client with a completed SFN 1647 or the client may provide a written statement indicating they no longer want the service.
- Denial of a service may include denying the service to a new applicant or denying the number of units a current client requests.
    - When denying units the client has requested, the client must be informed in writing of the denial by providing the client a completed SFN 1647.

- When a home visit is completed to assess an applicant about services, an application for service is implied by the client and a completed SFN 1647 must be provided informing the client of the denial or the client can provide a written statement indicating they do not want the service. If a home visit is completed but an assessment wasn't completed but information was shared, an SFN 1647 is not required.
- When a client contacts the HCBS Case Manager for general information about the service, the 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 client must be offered the option to complete an Application for Services (SFN 1047). Upon receipt of the completed SFN 1047 a home visit would be scheduled to determine eligibility.
    - After the SFN 1047 is received and a formal assessment is completed, the client must be informed in writing of the denial by providing the client with a completed SFN 1647 or the client may provide a written statement indicating they do not want the service.

The Notice of Denial/Termination/Reduction 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 the client 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 client must be informed in writing of the reasons s/he is no longer eligible under this Service Chapter.

<u>The client must be notified in writing by completing a SFN 1647 at least 10 days (it may be more) prior to the date of terminating</u>

services **UNLESS** 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 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/client's needs.

3. Former SPED or ExSPED Clients

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 two calendar months from the month of closure. However, the HCBS Case Manager must determine that the former client is still eligible and what the current service needs are.

- If a client 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. 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."

2. Transfer to Another County

The Closure/Denial Section of the SFN 474 is to be completed to indicate the funding source and the last day a client will receive services in the county. The closure code "T" (transferring to another county) is to be used.

The Transfer Case to Another County section of SFN 474 is to be used when an open case is transferred to another county. This section of the form is used when the client remains eligible for services but will not continue to reside in this county. HCBS Case Managers must contact the receiving Case manager and case information should be forwarded to the new county of physical residence.

3. Medicaid Waiver Clients

   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.

# Critical Incident Reporting 525-05-42

**(New 7/1/18 ML #3543)**

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Critical Incident

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

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

Reportable incidents

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

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

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

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

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

Incident reporting requirements

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

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

1. Reported to the HCBS Case Manager and
2. Complete an incident report (SFN 53601 – Risk Management Medical Services Incident Report).

    a. SFN 53601 is found here: https://www.nd.gov/eforms/Doc/sfn53601.pdf
    b. The completed SFN 53601 is to be forwarded to the HCBS Case Manager within 24 hours of the incident.
    c. The HCBS Case Manager will forward to Aging Services.

Examples

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

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

Example 3: If a QSP comes to a client's home and the client is found on the floor and the QSP calls 911 so the client may receive medical attention, a

critical incident report is required because the client required medical attention AND the QSP responded to the event (fall).

# Standards for Qualified Service Provider(s) 525-05-45

**(Revised 5/1/16 ML #3471)**

View Archives

## Provider Enrollment

### Purpose

The purpose of Provider Enrollment is to ensure that Qualified Service Providers meet the standards and qualifications set by the Department of Human Services 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 renew or they may be closed for inactivity.
5. No outstanding debts can be owed to the Department of Human Service.
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 client 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.

For additional information about provider standards refer to the current QUALIFIED SERVICE PROVIDER (QSP) HANDBOOKS. For a copy of one or both QSP Handbooks, contact the HCBS Program Administration.

<u>Standards for Qualified Service Providers for Environmental Modification</u>

- Environmental Modification Service may only be provided by a contractor approved by the Department of Human Services as a Qualified Service Provider. Standards for Qualified Service Providers 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 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).

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

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 enrollment effective date cannot be prior to the required verification screening date.
3. Effective enrollment date for services of Family Home Care or Family Personal Care may not be prior to client/member's signature on care plan.
4. A Monthly Rate Worksheet SFN 1012 must be sent to the QSP provider enrollment Program Administrator before final approval of QSP for Family Home Care or Family Personal Care will be granted.

5. If enrollment is not complete by the end of the 30 day notice period, the QSP status will be stopped and a new start date will be given if/when a complete application is received and approved.
6. Any break in licensure or documentation of competency dates will result in a stop and new start date.
7. A break in renewal status greater than 30 days from the QSP closed date will result in a stop and a new start date and a complete application will be required. (This is due to the monthly renewal verification checks not being completed as required)

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.

Enrollment Process for New Applicants

1. All forms must be completed correctly and the required verification checks by the HCBS Program Administrator must be complete before an enrollment start and end date will be given (dates cannot be retroactive).
2. The following provider verifications must be completed by the HCBS Program Administrator 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) Previously (EPLS)
    - National Sex Offender Site
    - ND Sex Offender Site
    - Child Abuse and Neglect Background Inquiry
    - 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 Plana and Provider Enumeration System (NPPES) or NPI (National Provider Identifier) Registry
- DEA (Drug Enforcement Administration)
- Addresses

3. QSP will be issued an "enrollment end date" no longer than 24 months from the date of enrollment.
4. Enrollment end date may be up to 23 months from original competency date to allow sufficient time for renewal.

<u>Enrollment Process for Family Home Care and Family Personal Care</u>

1. All forms must be completed correctly and the required verification checks by the HCBS Program Administrator must be complete before an enrollment start and end date will be given.
2. The following provider verifications must be completed by the HCBS Program Administrator 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) Previously (EPLS)
   - National Sex Offender Site
   - ND Sex Offender Site
   - Child Abuse and Neglect Background Inquiry
   - 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 Plana and Provider Enumeration System (NPPES) or NPI (National Provider Identifier) Registry
     - DEA (Drug Enforcement Administration)
     - Addresses
3. Family Home Care does not require documentation of competency.

4. Family Personal Care requires that a valid proof of competency be sent with the application.
5. Effective enrollment date of QSP enrollment for the services of Family Home Care or Family Personal Care may not be prior to the date of the client/member's signature on the care plan.
6. A monthly rate worksheet must be sent to the QSP provider enrollment Program Administrator before final approval of QSP for Family Home Care or Family Personal Care will be granted.
7. A start date will be determined by reviewing:
    - The completed application;
    - Provider screening verification date;
    - Client approval date for service;
    - Client/member signature on care plan and;
    - Monthly Rate Worksheet.
8. QSP will be issued an "enrollment end date" no longer than 24 months from enrollment.
9. Enrollment end date may be up to 23 months from original competency date for family personal care or the date of signature on the Medicaid Agreement for family home care, to allow sufficient time for renewal.

<u>Enrollment Process for Renewals</u>

1. All forms must be completed correctly, and the required verification checks by the HCBS Program Administrator must be complete before renewal of QSP status can be approved.
2. The following provider verifications must be completed by the HCBS Program Administrator 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) Previously (EPLS)
    - National Sex Offender Site
    - ND Sex Offender Site
    - Child Abuse and Neglect Background Inquiry
    - 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 Plana and Provider Enumeration System (NPPES) or NPI (National Provider Identifier) Registry
- DEA (Drug Enforcement Administration)
- Addresses

3. QSP is given an "enrollment end date" no longer than 24 months from enrollment.
4. Enrollment end date may be up to 23 months from original competency date to allow sufficient time for renewal.
5. Six to eight weeks prior to the end date, the QSP will be sent a renewal application.
6. If renewal is not received by the renewal end date, the QSP and the 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 renew.
7. If renewal 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. *(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 HCBS Program Administrator.

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.

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.

30 Day Stop Notice

A 30 day stop notice is the period of time when a written notification is sent to the QSP and case manager, allowing the QSP time to renew enrollment status, without losing eligibility for reimbursement from the state. During this period a valid Documentation of Competency SFN 750, licensure, or certification and all completed renewal forms must be received by the Department and all required provider verifications must be completed.

**NOTE: The QSP must meet all requirements and is still competent during the 30 day stop notice period. The notice is sent to assure QSPs understand that they have 30 days to complete the application or they will no longer be eligible for reimbursement.**

**If the application is not complete after the 30 day stop notice period has ended, the case manager must remove the QSP from the care plan.**

Stop and Start dates

If the 30 day stop notice date has passed, and the QSP has not submitted an application, or their submitted application is not complete, QSP status will be closed. If the QSP submits a complete application or finalizes a previously submitted application they will receive a new QSP enrollment start date. The QSP will not be eligible for reimbursement between the stop and new start date.

Closure for Inactivity

QSPs with no billing activity within the last 12-15 months will receive a 30 day stop notice. The notice will allow the QSP time to notify the Department of the reason for inactivity.

If a valid reason for inactivity is not received within the 30 day stop notice, 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
3 units: at least 38 minutes
4 units: at least 53 minutes
5 units: at least 68 minutes
6 units: at least 83 minutes
7 units: at least 98 minutes
8 units: at least 113 minutes

The pattern remains the same for allowable tasks performed in excess of 8 units (2 hours).

# Appendix 525-05-60

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

**(Revised 9/1/18 ML #3543)**

View Archives

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

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

- Applicant's Name – print the name of the applicant (one SFN 1047 per applicant);
- Date – date of application;
- Agency – County Social Service Board of applicant's physical county or HCBS Case Management agency;
- County of Residence - applicant's physical county of residents;
- 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 7/1/15 ML #3460)**

View Archives

An application for services must include a complete functional assessment that was conducted with the individual in the home where the individual resides by an HCBS Case Manager. THIS ASSESSMENT IS FOR PERSONS 18 YEARS OF AGE OR OVER. The HCBS Comprehensive Assessment enables the HCBS case manager to record the applicant's/client's functional impairment level and correlate that to the need for in-home and community-based services. The HCBS Comprehensive Assessment is a web-based product of Synergy Technologies.

The HCBS Comprehensive Assessment Form is intended to collect information based on the client's response(s), information reported by significant other (such as family or friends), and the HCBS case manager's observation. In most cases, the applicant/client is the respondent of choice, and the HCBS case manager should make every attempt to conduct the interview with the applicant/client.

Individuals must actively participate in the functional assessment to the best of their ability. Case Managers must document in the client narrative if there is a medical reason why the client cannot participate in the assessment or answer questions directly. If a third party (including family) reports that the client cannot participate in the assessment but the case manager questions if this information is accurate you may request medical documentation to confirm that the client is not capable of participating before you can establish eligibility.

It is the responsibility of the client 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 from PT, OT, Speech, neuro-psych evaluation etc. that would assist the case manager in completing a determination for HCBS services.

KEY FACTORS:

1. Cover Sheet

    a. Assessment Information
    b. Client Identification
    c. Demographic
    d. Informal Supports
    e. Legal Representatives
    f. Emergency Contacts
    g. Medical Contact Information

2. Physical Health Information

    a. Nutrition
    b. Impairments
    c. Current Health Status
    d. Medication Use

3. Cognitive /Emotional Status

    a. Cognition/Behavior
    b. Emotional Well Being/Mental Health

4. Functional Assessment

    a. Activities of Daily Living (ADL)
    b. Instrumental Activities of Daily Living (IADL)
    c. Supervision/Structured Environment
    d. Special Needs

5. Home Environment Physical Environment

    a. Physical Environment

6. Services/Economic Assistance Information

    a. Services/Funding Sources

Narratives and Signatures/Dates

The HCBS case manager shall note the following information in the corresponding or relevant narratives and or notes which are available throughout the HCBS Comprehensive Assessment:

1. Record related comments which the applicant/client or family member offers. Document if comments are self reported, family reports, collateral contacts, or observation.
2. Does client have any difficulty preparing meals? Dental limitations? Cost? Are home delivered meals available? Special diet requirements?
3. Is applicant/client currently being treated for medical problems? If not, is the client refusing treatment?
4. Any medical condition not being treated may necessitate HCBS case management intervention in arranging for care.
5. Foot problems should be described in comments relating to client's medical conditions/diagnosis
6. Vision, hearing and speech problems should describe and how they affect the applicant's functioning.
7. Does the applicant/client experience difficulty in using adaptive devices? Note which devices are used inside and outside the home.
8. Details relating to history of falls, hospital, and emergency room visits.
9. Does client take dosage as prescribed?
10. Who administers the treatments and any problems the client is experiencing with medical treatments, particularly those which are self or family-administered?
11. Also, note any difficulty in remembering to take medication as well as side effects. If more than one doctor has prescribed the medications, ask if client's primary physician is aware of all the medications client is taking.
12. Does client have any difficulty getting medicine refilled? Cost? Does pharmacy deliver? Is client still taking medications?
13. Other details may be recorded at the HCBS case manager's discretion.

HCBS case managers are not expected or qualified to make medical diagnoses. Through observation and interviews, the HCBS case manager shall obtain pertinent medical information and any necessary medical documentation regarding the applicant's/client's physical health status.

All questions on the HCBS Comprehensive Assessment should be answered if they apply to the client in any way.

The HCBS Comprehensive Assessment Form and completion instructions are as follows:

**Section 1. Cover Sheet.** A HCBS case manager may have frequent need to refer to basic demographic information. HCBS case managers should be sure to confirm the accuracy of emergency and medical information.

a. Assessment Information
b. Client Identification
c. Demographic
d. Informal Supports
e. Legal Representatives
f. Emergency Contacts
g. Medical Contact Information

**Section 2. Physical Health Information.** An applicant's/client's physical health is an important indicator of overall well-being. The purpose of this section is three-fold:

- It should enable the HCBS case manager to identify areas which require the attention of skilled medical personnel.
- It will assist the HCBS case manager in assessing the client's rehabilitative potential and in establishing the goals of the service plan.
- It will provide information that will be useful in indicating a need for personal care assistance.

a. Nutrition
b. Impairments
c. Current Health Status
d. Medication Use

**Section 3. Cognitive/Emotional Status.** This section collects basic information related to the applicant's/client'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 client's ability to remain at home.

## Section 4. Functional Assessment

4-A. Activities of Daily Living

HCBS case managers require specific information regarding the activities a client 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 applicant/client is experiencing, based on specific medical, emotional and cognitive status. It is based on standard scales which have been tested and validated in programs serving the elderly.

The questions measure the degree to which an applicant/client 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 client, 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 applicant's/client's impairment level. The following general definitions shall determine the ratings.

Information on each of the ADLs can be collected by observation, by direct questioning of the applicant/client, or by interview with a significant other.

HCBS case managers will want to know how the applicant/client usually performs a task, i.e., most of the time. Applicants/clients who have 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)

| | |
|---|---|
| 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 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 a client is compared with the assessment criteria: The client is considered as a "whole entity." The Case Manager does not measure physical capacity or 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 him/her from doing so, that person cannot complete it. The Case Manager also measures the client's level of functioning in the present. What the client could or could not do in the past is not an issue nor is what the client, 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 of the parts of a task in order to complete the task.

A Rating 2 OR 3 ON THE ASSESSMENT OF AN ADL INDICATES AN IMPAIRMENT

Since the ADL scale which follows will be used in determining an applicant's/client's functional impairment level, standard definitions for each ADL item are:

A-1. BATHE

This item measures the 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 circumstances. Consider minimum hygiene standards, medical prescription, or health related considerations such as incontinence, skin ulcer, lesions, frequent nose bleeds, and balance problems. Consider ability to turn faucets, regulate water temperature, wash and dry completely.

0. Able to prepare and take a bath or shower independently within a reasonable time.

   NOTE: If the only help an applicant/client requires is help with shampooing, score this item "0." Many elderly or disabled persons require help with shampooing, but this scale does not include shampooing. The need for help with shampooing shall be recorded in the narrative.

1. Requires the use of equipment (i.e., tub stool, grab bars, or handle bars) to bathe or shower him/herself. Small items such as mitten wash cloths, long-handled brushes or non-slip soap dishes are not considered special equipment.

2. Needs another human to assist him/her through this activity. This may include supervision for safety or cuing. Able with Helper will be circled if the client performs at least half the effort him/herself.

3. Unable to assist or assists minimally (less than half the effort) or is totally dependent on another human to complete the activity.

A-2 Comments/Notes on client's ability to bathe self: The HCBS case manager shall record the following information in the narrative:

- Reason client is not able to bathe self.
- Does the applicant/client take showers, baths, or sponge baths? Indicate the reasons why this is or is not appropriate for the applicant/client's circumstances. Indicate if client refuses assistance
- Type of equipment used, if any. Any problems with equipment?
- Who helps with bathing? How often? Type of Assistance?
- Is applicant/client able to bathe as frequently as needed?
- Service needed/approved, frequency, outcome desired.

A-3 Comments/Notes on client's ability to groom and complete oral hygiene tasks: The HCBS case manager shall record the following information in the narrative:

- Reason client is not able to groom or complete hygiene tasks per self.
- Does the applicant/client groom and complete oral hygiene tasks? Indicate the reasons why this is or is not appropriate for the applicant/client's circumstances. Indicate if client refuses assistance
- Type of equipment used, if any. Any problems with equipment?
- Who helps with grooming-hygiene? How often? Type of assistance?
- Is applicant/client able to groom and complete hygiene as frequently as needed?
- Service needed/approved, frequency, outcome desired.

A-4. DRESS/UNDRESS

This item measures the applicant's/client's ability to dress or undress. Consider applicant/client'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.

0: Able to dress independently within a reasonable amount of time.

1: Uses aids such as zipper pulls and specially designed clothing (e.g., velcro fasteners) or requires an inordinate amount of time to do so.

2: Needs another human to assist with dressing and performs at least half the effort OR needs human assistance as a reminder to get dressed or for the laying out of clothes.

3: Totally dependent due to physical or cognitive impairment or provides less than half the effort in dressing.

A-5 Comments/Notes: Comment on client's ability to dress/undress in these fields

- Reason client is not able to dress/undress self.
- Type of help an applicant/client is getting, who assists?
- Type of equipment?
- Are arrangements satisfactory?
- Inappropriateness of clients dress due to weather or street attire.
- Service needed/approved, frequency, outcome desired.

A-6 EAT

This item refers to the applicant's/client's ability to feed him/herself including cutting meat and buttering bread. Consider client'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)

0: Able to eat independently within a reasonable amount of time.

1: Uses special grip utensils or plates or client takes an inordinate amount of time to eat.

2: Performs at least half the effort required to eat, but receives some assistance from another human.

3: Performs less than half the effort.

A-7 Comments/Notes: Comment on the client's ability to eat

- Reason client is not able to feed self.
- Note aids applicant/client uses.
- Who helps, which tasks?
- Need for equipment or assistance?
- Type of human assistance, if any.
- Service needed/approved, frequency, outcome desired.

A-8. TOILET

This item deals with the applicant's/client'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.

0: Able to complete this activity independently or the client uses a urinal, bedpan or commode at night only and manages without assistance (including emptying the device).

1: Uses grab bars, raised toilet seat or transfer board or client takes an inordinate amount of time.

2: Requires human assistance in completing the activity but performs half the effort.

3: Performs less than half the effort.

A-9 Comments/Notes: Comment on the client's ability to complete toileting tasks.

- Reason client is not able to toilet.
- Note who the helper is and the extent of assistance.
- Type of equipment.
- Service needed/approved, frequency, outcome desired.

A-10 CONTINENCE
BLADDER/BOWEL

0: Complete Control. Complete voluntary control of the bladder; never incontinent. Complete voluntary control of bowels; never incontinent.

1: Self-care Devices, No Accidents. Applicant/client has a catheter or other urinary drainage device including absorbent pads. Applicant/client is able to empty, clean, and manage the use of the device without human assistance. Applicant/client has no accidents. Requires stool softeners, suppositories, laxatives, or enema, but does not require human assistance, or has colostomy, but can manage device without human assistance. No accidents.

2: Helper. Occasional accidents. Applicant/client needs human assistance with a device, or has occasional accidents (with or without a device). Requires human assistance with devices, medications, enemas, etc., or has occasional accidents.

3: Incontinent. Cannot control urinary flow, despite aids or assistance. Applicant/client cannot control bowels despite aids or assistance.

A-11 Comments/Notes: Comment on the client's ability to manage incontinence needs/activities.

- Reason for bladder or bowel continence problem.
- Type of device. How long has it been used? Any problems?
- Who helps?
- Tasks performed by helper.
- Any problems?

- Service needed/approved, frequency, outcome desired.

A-12. TRANSFER IN AND OUT OF BED OR CHAIR

This item measures the level of assistance the client 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.

0: Able to transfer independently within a reasonable amount of time.

1: Special equipment is used in transfers such as lifts, hospital beds, sliding boards, "trapezes" or pulleys or client takes an inordinate amount of time to transfer in and out of the bed or chair.

2: Is supported by human help in getting in/out of bed/chair or performs half the effort.

3: Must be lifted in/out of bed/chair.

A-13 Comments/Notes: Comment on the client's ability to complete transfer in and out of bed/chair.

- Reason client is not able to transfer self.
- Types of aids.
- Who helps-tasks performed by helper.
- Service needed/approved, frequency, outcome desired.

A-14. GET AROUND INSIDE

This item measures an applicant's/client'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.

0: Able to get around inside independently within a reasonable amount of time.

1: An aid such as walker, wheelchair, cane, crutches, or furniture is used to get around.

2: Needs human assistance to get around.

3: Bedbound client.

A-15 Comments/Notes: Comment on the client's ability to get around inside.

- Reason client is not able to get around inside.
- Types of aids.
- Who is helping? Tasks performed by helper.
- Service needed/approved, frequency, outcome desired.

4-B INSTRUMENTAL ACTIVITIES OF DAILY LIVING

This section deals with an applicant's/client's ability to carry out tasks which may not need to be done every day (like ADLs), but which nevertheless are important for living independently. Intervention may be required to help an applicant/client 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 telephone use. 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 applicants/clients have the opportunity to perform IADL tasks. For example, an applicant/client who lives with a relative or spouse might not prepare meals simply because another person routinely does this task. Similarly, some applicants/clients do not manage their own money because a spouse does it. However, the IADL scale is designed to measure an applicant's/client's ability both physical and cognitive to perform these tasks, regardless of the individual's opportunity to perform them. Thus, in asking applicant's/client's 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.?"

As with ADL ratings, the HCBS Case Manager will want to know how the applicant/client usually performs a task, i.e., most of the time. Applicants/clients who have occasional difficulty should be scored based on their usual performance, noting occasional difficulties in the narrative/note.

Like ADL scores, the HCBS case manager can obtain 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 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:

B-1. MEAL PREPARATION

The HCBS case manager may ask the applicant/client, "Can you prepare your own meals?" Regardless of whether the applicant/client actually does prepare meals, ask whether he/she can.

Consider the applicant's/client's ability to prepare hot and/or cold meals that are nutritionally able to sustain the client or therapeutic, as necessary. Consider applicant's/client's cognitive ability, such as ability to remember to prepare meals, applicant's/client's ability to prepare foodstuffs, to open containers, to properly store and maintain foodstuffs, 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.

0: Able to prepare and cook meals or client does not usually cook but is able to.

1: Needs assistance from another person, i.e., client is unable to prepare a meal but is able to reheat a prepared meal.

2: Unable to prepare or cook meals.

B-2 Comments/Notes: Comment on the client's ability to prepare meals.

- Who helps with preparation?
- Frequency and type of assistance.
- Reason for inability to cook.

- If applicable, inadequacy of present diet to extent that it would not sustain applicant/client nutritionally, or does not meet therapeutic needs.
- Service needed/approved, frequency, outcome desired.

B-3. HOUSEWORK

This item refers to the applicant's/client's ability to do routine housework.

The HCBS case manager might ask the applicant/client "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 applicant's/client's health and safety. Do not include laundry. Do not include refusal to do tasks if refusal is unrelated to the impairment.

0: Completely able.

1: Can do some housework, but not all housework.

2: Cannot do any housework.

B-4 Comments/Notes: Comment on the client's ability to do ordinary housework.

- Reason client is unable to complete housework
- Who helps with housework?
- Frequency and type of assistance (i.e., family does spring cleaning)
- Why is the client unable to do housework? (i.e., severe arthritis or cognitive problem.)
- What types of routine housework client is unable to do.
- Service needed/approved, frequency, outcome desired.

B-5. LAUNDRY

This item measures the applicant's/client's ability to do his/her laundry.

Can the applicant/client sort, carry, load and unload, fold and put away clothes? Consider the need to use coins for pay machines. 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 applicant's/client's cognitive ability to complete these tasks. Consider applicant's/client's physical and cognitive ability to complete these tasks even if applicant/client lives with others who do them for the applicant/client.

0: Completely able to do laundry.

1: Requires human assistance (i.e., facility is in the basement and a family member carries the laundry up the basement stairs).

2: Cannot do laundry at all.

B-6 Comments/Notes: Comment on the client's ability do laundry.

- Reason client is not able to do laundry.
- Who helps with laundry?
- Frequency of assistance.
- Note where laundry facilities are located (i.e., in home or laundromat.
- Service needed/approved, frequency, outcome desired.

B-7. SHOPPING

This item measures the client's 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. Applicant/clients ability to access

transportation is measured under Transportation and ability to manage money is measured under Management of Money.

0: Able to shop but needs help with transportation (note this under Transportation).

1: Needs human assistance (i.e., carrying bundles).

2: Unable to shop.

B-8 Comments/Notes: Comment on the client's ability to do shopping.

- Reason client is not able to complete shopping.
- Who helps with shopping?
- Frequency of assistance.
- Also note proximity of shopping facilities.
- Service needed/approved, frequency, outcome desired.

B-9. TAKING MEDICINE

This item measures the ability of the applicant/client 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; actually swallowing the pill; applying the ointment; or giving oneself injections (including the filling of syringe).

Score 0 for applicant/client 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.

0: Completely able including giving injections.

1: Needs human assistance (i.e., reminder or RN to give

injection).

2: Unable (either physically or cognitively unable).

B-10 Comments/Notes: In these fields if an applicant/client cannot take his/her own medicine.

It is important to ask the reason and record this in the narrative. For service planning purposes, an applicant/client who forgets to take medications may require different types of services and supports than an applicant/client who is physically unable to take medication.

- Who helps with medicine?
- Reason client is not able to take his/her medication independently.
- Frequency of assistance.
- Service needed/approved, frequency, outcome desired.

B-11 GET AROUND OUTSIDE

This item refers to the applicant's/client'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.

0: Completely able to get around outside (even if he/she uses a wheelchair/walker).

1: Requires an escort to push a wheelchair, hold his/her arm for stability or to assist in event of disorientation.

2: Completely unable to go outdoors due to physical or mental disability.

B-12 Comments/Notes: Comment on the client's ability to be mobile outside.

- Reason client is not able to move around outside
- Who helps?
- How often does client get outside.
- Service needed/approved, frequency, outcome desired.

B-13 TRANSPORTATION

This item measures an applicant's/client'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.

0: Completely able to travel in a car, bus, or senior van without assistance and has access to at least one of these methods on a regular basis.

1: Needs assistance arranging for or using transportation either due to mental/physical impairment or has limited access.

2: Completely unable to travel. This type of client is usually severely impaired and requires occasional specialized or medical transportation to doctor's appointments.

B-14 Comments/Notes: Comment on the client's ability to use transportation

- Reason client is not able to use/access transportation.
- Who helps with transportation?
- Frequency.
- Service needed/approved, frequency, outcome desired.

B-15 MANAGEMENT OF MONEY

This item refers to the applicant's/client's ability to handle money and pay bills.

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 applicants/clients may have a legal representative (guardian, conservator or representative payee).

0: Able to manage his/her money independently.

1: Cannot write checks and pay bills without help, but makes day to day purchases and handles cash.

2: Has a legal guardian or conservator or client is unable to manage money.

B-16 Comments/Notes: Comment on the client's ability to manage money.

- Reason why client is not able to manage money.
- Explain why applicant/client has legal representative or representative payee (for social security payments).
- How long has this arrangement been in effect.
- Service needed/approved, frequency, outcome desired.

B-17 USE TELEPHONE (Communication)

This item refers to the applicant's/client's ability to use the telephone. Include getting telephone numbers and placing calls by him/herself. The applicant/client must be able to reach and use the telephone, answer the telephone, dial, articulate and comprehend. If the client uses special adaptive telephone equipment, score the client based on the ability to perform this activity with that equipment.

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 head sets 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 telephone. If the applicant/client 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 telephone.

If an applicant/client has no telephone, ask about his/her ability to use a telephone elsewhere (i.e., at a neighbor's home).

0 : Completely able.

1 : Requires human assistance (i.e., someone else must dial).

2 : Cannot answer the telephone or dial the operator.

B-18 Comments/Notes: Comment on the client's ability to use the telephone.

- Reason why the client is not able to use the telephone
- Types of equipment.
- Who provides help?
- Service needed/approved, frequency, outcome desired.

4-C SUPERVISED STRUCTURED ENVIRONMENT

A rating of yes in assessment indicates an impairment

C-1 Does the client/applicant require supervision or a structured environment on a continuous basis with the exception of brief periods of time?

This item measures the client's need for supervision or a structured environment on a continuous basis except for brief periods of time.

Supervised or Structured Environment Scoring

1. Determine the individual's need for supervision or a structured environment to prevent or reduce health and safety risks. Information can be collected by observation, by direct questioning of the individual, or by interview with a significant other. Documentation must specifically include the reason(s) for the need of a supervised or structured environment.

| | |
|---|---|
| No: | The client does not require supervision or a structured environment. |
| Yes: | The client does require supervision or a structured environment. |

C-2. Summary of the client/applicants need for structured environment/supervision.

What impairment or need qualifies client/applicant to be determined eligible?

- Reason why this impairment presents a health/welfare/ or safety risk
- Explain why the health/welfare/or safety risk will be met by residing in a basic care facility or adult family foster care residence.
- Explain why an alternative setting which is not a structured environment will not meet the individual's needs
- Service needed/approved, frequency, outcome desired.

4-D SPECIAL NEEDS

D-1 Include in this section special needs and services required to maintain clients independency and safety.

D-2 Enter any additional comments regarding special needs.

- Reason client is not able to complete task.
- Who helps with the identified tasks?
- Frequency.
- Service needed/approved, frequency, outcome desired.

**Section 5. Home Environment.** Physical environment may impact positively or negatively on an applicant's/client'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 should elicit information useful in determining whether specialized housing, relocation, or home repair are necessary.

**Section 6. Services/Economic Assistance Information.** The HCBS case manager records information about benefits and Services the applicant/client currently receives as well as those for which the client may be eligible.

**Narratives:** Include all information relevant to the client obtained during the assessment process that was not entered in a comment or note field.

All contacts relating to a client must be noted in the narrative section of the comprehensive assessment. Notes maintained in any other format are not considered valid.

- Date
- Reason for contact. (initial, annual, six month, quarterly, collateral, returned call, received call, etc.)
- Location of visit (home visit, care conference, hospital visit, office visit, telephone contact, letter sent, etc.)
- A description of the exchange between yourself and the client or the collateral contact.
- A listing of identified needs
- Service delivery options
- Summary of care plan
- Identify client stated goals, progress, change in goals, etc at the initial, annual and six month contact in this narrative note or in question #1.H.1. Describe the client's stated goals and results or progress
- Review the Individual Service Plan developed by the Adult Residential Provider (who provides services primarily to individual with TBI) or the Transitional Care Provider at the annual and semi-annual interdisciplinary team meeting and document the results of the Individual Program Plan
- Client satisfaction and follow-up plan
- Case Managers initials

**Signature:** A signed and dated hard copy of the assessment including the narrative must be kept in the client file.

# Rights and Responsibilities, SFN 1047 525-05-60-12

**(NEW 5/1/19 ML #3551)**

View Archives

Purpose: All individuals receiving Home and Community Based Services (HCBS) must be made aware and provided a copy of his/her rights and responsibilities (DHS brochure number DN 46).

The HCBS Case Manager must inform all clients of his/her rights and responsibilities by providing and reviewing all rights and responsibilities:

- Clients' rights;
- Clients' and/or legal decision makers responsibilities;
- HCBS Case Manager's responsibilities; and
- What to do if there is suspected fraud or abuse

After the client has reviewed, he/she or his/her legal representative must complete the following on the DN 46:

- Client's Name;
- Client's/Legal Representative's Signature;
- Case Manager's Name;
- Case Manager's Phone Number; and
- Date.

A copy is to be given to the client and/or his/her legal representative and a copy is filed in client's case record.

The Rights and Responsibilities brochure (DN 46) may be found by visiting: https://www.nd.gov/dhs/info/pubs/aging.html.

# SPED Program Pool Data, SFN 1820 525-05-60-15

**(Revised 5/1/19 ML #3515)**

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

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 four ADLs

OR

Impaired (score is 1 or 2) in at least five IADLs totaling eight or more points or if living alone, totaling six points.

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 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 7/1/19 ML #3553)**

View Archives

Purpose: In order for individuals to access the SPED program, information regarding assets, income, and deductions must be obtained in order 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 SAMS 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. 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

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.

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.

<u>Verifying Assets</u>

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.
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.

Front Page

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 |

Back Page

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 recipients 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 recipients 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 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.<br><br>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/B13 | Self-Employment Income |
| B2/B10/B11/B14 | Combine alimony/child support/unemployment compensation/Workers Compensation/ and other |

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.

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 $500for an individual is allowable for any 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 50 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). |

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 in the County office.

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. County social service boards are required to make sufficient copies for their use. The form is available electronically through the state e-forms system and is available through SAMS financial assessment.

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 7/1/19 ML #3553)**

View Archives

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 9/1/18 ML #3543)**

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.

Funding Type: Select SPED or Ex-SPED.

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

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

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

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

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

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).

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

The 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 9/1/18 ML #3543)**

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 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 section include meal preparation, communication, laundry, taking medication, shopping, mobility outside, transportation, housework, and management of money.

The scoring criteria for IADLs is as follows:

0 = without help

1 = with help

2 = unable to do at all

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

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

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

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.

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

**(Revised 9/1/18 ML #3543)**

View Archives

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

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

The SFN 1597 is to be completed prior to the services beginning and not required to be completed on an annual basis. If the individual discontinues as a Medicaid Waiver recipient and re-applies for services, the form must be completed again prior to services being authorized.

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

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

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

The original is to be filed in the applicant's case file, a copy must be given to the applicant or legal representative and a copy must be scanned to Aging Services/HCBS.

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

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

**(Revised 9/1/18 ML #3543)**

View Archives

Purpose:

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

This form is only completed for SPED and EXSPED clients.

When Prepared:

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

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

By Whom Prepared:

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

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

Section I Client Identification:

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

Section II Approved Services:

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

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

Column Headings:

1. SERVICE: Enter the services that has/have been identified for which the client is eligible, a provider is available, and the client has accepted.
2. SERVICE PROVIDER: Identify the qualified service provider (agency or individual) who will provide the service (including the service of Case Management).
3. PROVIDER NUMBER: Enter the qualified service provider's number (including the service of Case Management).
4. UNIT RATE: Refer to the Qualified Service Provider (QSP) listing for rate. Enter the QSP unit rate (including the service of Case Management).

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

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

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

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

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

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

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

Section III: Other Agencies/individuals Providing Services.

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

Column Headings:

1. SERVICE: Name of the service being arranged or received.
2. PROVIDER: Name of the agency, or if an independent contractor, name of the person.

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

Column Headings:

1. GOAL: Enter the client's stated goal.
2. START DATE: Enter the date the goal was established.
3. END DATE: Enter the date the goal was completed, do not complete when the goal is determined to no longer be applicable.
4. CONTINUED: Check if the goal was continued from the last care plan and enter the date the goal was established.

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

Section V: ADLs and IADLs Scores (scores from functional assessment): ADLs & IADLs Scores must be added from the Functional Assessment scoring.

Section VI: Signatures:

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

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

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

Number of Copies and Distribution:

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

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

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

**(Revised 9/1/18 ML #3543)**

View Archives

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

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 Manger's name, the effective date of the rate as determined on the rate worksheet, and the client's date of birth. Check the appropriate funding source and if the client is served under developmental disabilities (DD) services.

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

SECTION II: ASSIGNMENT OF POINT VALUE(S)

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

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

Exception (only applies to SPED personal care): If a provider is caring for more than one client in the home, some of the point tasks could be shared by the clients. For example, if there are two SPED personal care clients in the provider's home, the housekeeping point value of 10 would be shared by the two clients (or each client would receive only 5 points each).

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

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

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

SECTION III: RATE CALCULATION

When using the electronic MRW, a portion of the first area of Section III will automatically fill in the figures through the Unit Rate.

If the calculated rate exceeds the funding source maximum (see maximum amounts at the bottom of the MRW), record the maximum rate in the column marked unit rate.

SECTION IV: PROVIDER INFORMATION

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

DISTRIBUTION

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

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

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

**(Revised 9/1/18 ML #3543)**

View Archives

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

When Prepared:

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

By Whom Prepared:

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

SPECIFIC INSTRUCTIONS:

Section I is identifying information.

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

If services are to be provided by multiple providers and all providers are authorized /endorsed to complete the same tasks, multiple

provider names can be listed on the SFN 1699 but each provider must receive a copy.

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

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

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

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

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

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

Column Headings

a. Service: Write in the name of the Service being authorized.
b. Procedure Code: Enter the correct billing procedure code for the service authorized.

c. Unit/Daily Rate: Enter the correct unit/daily rate for the service authorized.
d. Units: Enter the total number of units authorized.
e. Amount: Enter the total dollar amount for the service.

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

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

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

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

Example:

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

Task: X Meal Prep: 31 units

X Housekeeping: 10 units

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

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

generally should be an aspect of a wellness program for any individual (i.e., walking for weight control, general wellness, etc.).

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

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

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

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

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

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

Number of Copies and Distribution

When a service is provided by multiple providers only one SFN 1699 is completed listing all providers, noting the units are shared. If one of the providers does not have a required /needed endorsement a separate SFN

1699 must be provided and reflect limits in the units authorized to assure that all providers do not provide units over the total authorized amount.

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

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

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

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

**(Revised 5/1/19 ML #3551)**

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

The email from the HCBS case manager must include the client's name, funding source (i.e. SPED, Ex-SPED, Medicaid Waivers) and the reason services are reducing, 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 applicant's needs.

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

Steps of Completion:

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

Date: Record the date of completion;

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

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

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

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

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

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

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

If a SPED or 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.

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

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

**(Revised 1/1/19 ML #3543)**

View Archives

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

When Prepared:

This form is to be completed

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

Steps of Completion:

In the first section, complete the client's name and identification number and **always** complete the County name and Case Manager section even if submitting the form to transfer a case.

Waiver reopen-close section:

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

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

Closure/Denial Section:

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

Enter date of closure, and the closure code. The closure codes are identified in the "Closure Codes" section of the form.

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

Transfer Case to Another County Section:

Print the client's name; the receiving county name, receiving case manager's name, and the client's new address (if known). Enter the date client is leaving current county and date client is entering new county.

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

Provider Termination:

If the client's case is closing/transferring and the provider of that client is **no longer continuing as a Qualified Service Provider (QSP)**, complete this section and Aging Services/HCBS will process the documentation in order to close the QSP provider file. If, however, the **QSP is continuing and providing care** to others or moves with the client, do not complete this section.

The HCBS Case Closure/Transfer Notice is due to Aging Services/HCBS within 3 working days of the date of closure. If the case is to be transferred, the form is due to Aging Services/HCBS within 3 working days

from the date the County is made aware that the case is transferring to another County.

The original is to be filed in the applicant'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 2/1/17 ML #3490)**

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 county social service board to complete the "Respite Home Evaluation". The county social service board 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.

CM 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.

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.

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.

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).

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

**(Revised 9/1/18 ML #3543)**

View Archives

Purpose:

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

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

When Prepared:

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

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

Section I Client Identification:

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

Section II Services:

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

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

When adding or removing RD, a SFN 212 is required to be sent to Aging Services/HCBS.

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

Column Headings:

1. SERVICE: Enter the service that has been identified for which the client is eligible and the client has accepted.
2. PROVIDER: Identify the qualified service provider (agency or individual) who will provide the service.
3. PROVIDER NUMBER: Enter the provider's number.
4. UNIT RATE: Refer to the Qualified Service Provider (QSP) listing for rate. Enter the QSP unit rate.
    a. If RD box was marked – rate should match rates determined within Rural Differential policy. (Total rate cost may be over cap however units should match cap. For example: Homemaker service cap is 70 units for individual QSPs or 51 units for agency QSPs.
    b. If removal of Rural Differential is required: mark the box "RD removed" and write the end date by QSP name being removed from RD, cross off RD rate and write correct rate. Complete SFN 212.
5. UNITS PER MONTH: Enter the total number of units of service to be provided per month.
6. COST/MONTH: The cost per month is calculated based on the amounts in the columns headed "Unit Rate," and "Units per Month" (based on a 31-day month).

Case Management has been pre-entered on the form. The Provider and Provider Number must be entered by the Case Manager.

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

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

Section III: ADL's & IADL's

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

Section IV: Signatures

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

The signature of the client/legal representative and HCBS Case Manager is required.

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

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

Section V: Restrictions

Purpose:

Any restriction on the client's living experience needs to be documented in the Medicaid Waiver Person Centered Plan of Care. A restriction is any control over a client that has been identified specifically towards one client and not required for all clients within that environment.

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

SPECIFIC INSTRUCTIONS for Section V:

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

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

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

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

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

Plans Tried in the Past: what plan(s) has/have been tried in the past?

What has been tried to before getting to this restriction?

Client/Legal Representative Signature:

Of client or legally responsible person and of the case manager is required.

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

Mark this box if team is in agreement.

Six- month review:

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

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

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

Section VI: Waiver Risk Assessment

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

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

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

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

Six-month review:

Indicate the date of the six-month assessment.

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

Three- and Nine-month contacts:

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

Number of Copies and Distribution:

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

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

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

**(New 9/1/18 ML #3543)**

View Archives

Purpose:

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

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

When Prepared:

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

By Whom Prepared:

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

Specific Instructions:

Identifying information

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

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

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

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

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

Services Authorized

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

Column Headings

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

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

Tasks Authorized

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

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

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

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

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

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

Authorization to Provide Medicaid Waiver Services must be sent to the identified provider for a returned signature – agreeing to provide the waiver service. Plan is not completed unless this signature is obtained.

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

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

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

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

Number of Copies and Distribution

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

Number of Copies and Distribution:

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

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

# Rural Differential, Unit Rate Authorization/Closure SFN 212 - 525-05-60-110

**(Revised 5/1/19 ML #3551)**

View Archives

Purpose:

The Rural Differential Unit Rate Authorization/Closure (SFN 212) is used by the HCBS Case Manager to add and/or end a Rural Differential (RD) rate for a QSP. The SFN 212 is to be completed and forwarded to Aging Services /HCBS when a rural differential rate is being added, removed, or if the client or the QSP has a change in address.

A rural differential rate can be authorized for any client 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 (does not include snow removal)
- Extended Personal Care
- Homemaker
- Nurse Education
- Personal Care
- Respite Care
- Transitional Living services

An SFN 212 must be developed for each provider that is authorized a RD rate for a client.

**All** appropriate **boxes must be completed in order to be accepted by the HCBS Administrator.**

Determining Distance

Case managers are required to verify distance between the HCBS client's home and the QSP's home base by using the following website: www.mapquest.com. The Case Manager is responsible to choose the most

reasonable route and print a copy of the MapQuest results that must be kept in the clients file and submit to Aging Services/HCBS along with the SFN 212.

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

Client Information:

Enter the client's name, ND number, 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 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.

Check the appropriate funding source(s). More than one funding category may be selected.

Enter the service(s) that will be billed at the RD rate. More than one service may be entered.

Document the rate that will be billed by the provider and the date that the provider is eligible to start billing the RD rate. When the RD rate is terminated for this provider and client, enter the date of the last day the provider is eligible to bill the RD rate.

Address Change:

Complete this section if there is a change in address for the provider or the client. Update the RD tier and rate if necessary. When an address change occurs, a new Map Quest must be submitted to Aging Services/HCBS with the SFN 212.

Signature:

The HCBS Case Manager is to sign and date the SFN 212 when adding a RD rate and when cancelling the provider's RD rate.

Number of Copies and Distribution:

The original is maintained in the client's case file, a copy of this form must be sent to Aging Services/HCBS within three working days of adding, changing, or cancelling a rural differential rate.

**A MapQuest is required with this form showing the distance between the client and provider's addresses when adding or changing a RD rate.**

This form is available electronically through the state e-forms (SFN 212).