Medicaid State Plan
Personal Care Services
Service Chapter 535-05

North Dakota Department of Human Services
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Medicaid State Plan - Personal Care Service 535-05

Authority Reference 535-05-01

(NEW 7/1/07 ML #3088)

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1. Section 50-24.1-18, 50-24.1-18.1 (North Dakota Century Code)
2. Section 75-02-02 (North Dakota Administrative Code)

Purpose 535-05-05

(NEW 7/1/07 ML #3088)

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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. Personal care services are provided so as to assist the eligible individual with as many activities of daily living and instrumental activities of daily living as needed and as permitted in order to maintain independence and self-reliance to the greatest degree possible. Personal care services are appropriate when service activities are essential either on an intermittent or ongoing basis and the need for personal care services is expected to continue for an extended period of time in excess of 30 days.

Personal care services must be the primary need of the individual and are not intended to bring about improvement of an acute medical condition nor are they primarily intended to provide homemaker services to the individual. Personal care services are not appropriate for individuals whose needs fall within normal stages of development.

The individual should direct the care provided, if and when possible, and should be involved in training and monitoring the personal care service provider as much as possible and when appropriate.

Personal care services are generally provided in an individual's residence, however, services may also be delivered in other settings, such as a place of employment, if providing personal care services assists the individual in remaining as independent as possible and avoiding institutionalization. Personal care services may not be provided to an individual who is in a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease.

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 this is necessary for the individual to receive such care.

Definitions 535-05-10

(Revised 10/01/2024 ML #3871)

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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.

Agency - Qualified Service Provider (QSP)

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

Aging Services Section

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

Applicant

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

Basic Care Assistance Provider (BCAP)

An entity that is licensed as a basic care facility; is not owned or administered by state government; does not specifically provide services for individuals with traumatic brain injury or Alzheimer's disease or related dementia; and is enrolled with the Department as such.

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.

Critical Incident Report (CIR)

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

Department

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

Dependent

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

Endorsements

A task that requires special skills and approval.

Developmental Disabilities Section

A Section within the Department of Health and Human Services (DHHS) within the Program and Policy's organizational structure with administrative and programmatic responsibility for Home and Community Based Services (HCBS) for Individuals with Intellectual Disabilities and Developmental Disabilities (IID/DD).

Developmental Disabilities Program Manager (DDPM)

Employee of the Department of Health & Human Services (state Medicaid agency) responsible to provide coordination and monitoring of Medicaid and general fund services provided to individuals with intellectual and/or developmental disabilities. The DDPM is a case manager.

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 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.

Functional Assessment

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

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

Functional Impairment

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

HCBS Program Administration

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

Home and Community-Based Services (HCBS)

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

Individual – Qualified Service Provider (QSP)

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

Institution

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

Instrumental Activities of Daily Living (IADLs)

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

Legally Responsible Person

Legal spouse or parent of a minor child.

Legal Representative

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

Level A Personal Care Services

The level of care for an individual meeting the minimum eligibility criteria for personal care services.

Level B Personal Care Services

The level of care for an individual meeting the nursing facility or ICF/MR level of care criteria in addition to the minimum eligibility criteria for personal care services.

Level C Personal Care Services

The level of care for an individual meeting the nursing facility or ICF/MR level of care criteria in addition to having an impairment in 5 ADLS.

Level-of-Care (LOC) Determination

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

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 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).

Monitoring

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

Most Integrated Setting

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

Natural Supports

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

Neglect

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

Nursing Facility (Long Term Care Facility)

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

Parent

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

Personal Care Service Provider

A qualified service provider or a basic care assistance provider.

Personal Care Services

Services consisting of a range of human assistance, provided to an individual with disabilities or conditions, that will allow the individual to live as independently as possible while delaying or preventing the need for institutionalization. Assistance may be in the form of hands-on assistance or cuing so that the individual can perform a task without direct assistance.

Qualified Service Provider (QSP)

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

Qualified Service Provider (QSP) Handbook

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

Service Payment

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

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.

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.

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.

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.

Unit

Either a 15-minute increment or a day.

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.

Personal Care Eligibility Requirements 535-05-15

(Revised 10/01/2024 ML #3871)

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

1. Application for services in service chapter shall be made to the department utilizing "Application for Services," SFN 1047.
   a. 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.
   b. 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.
   c. The applicant or their legal representative must sign the application and participate in the eligibility process.
   d. 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.
   e. 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.

2. An applicant is eligible for these programs if the Case Management process (comprehensive assessment of needs and care plan development) determines that the applicant meets functional and financial eligibility criteria for MSP PC 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 annually, and reviewed every 6 months, in conjunction with the eligibility redetermination. The functional assessment must include an interview with the individual in the home where the individual resides unless approval is given to interview the individual in an alternative setting.
3. Authorization to Provide Services, otherwise known as the PreAuth, identifies the specific tasks/activities the provider is authorized to perform for the eligible client and sets forth the scope of the service the client has agreed and understands will be provided.
4. The client is eligible for MSP PC once all eligibility criteria have been met. Continued eligibility is monitored under HCBS Case Management/DD Program 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/DDPM is to substantiate eligibility.

To qualify for coverage of personal care services, an individual must currently be open to receive Medicaid benefits under traditional Medicaid or receive Medicaid Expansion and be deemed Medically Frail.

And

1. Eligibility criteria for **Level A (up to 480 units per month), or Daily Rate care, or Basic Care** includes:

    a. Be impaired in at least one of the following ADLS of:

        i. Bathing
        ii. Dressing
        iii. Eating
        iv. Toileting

v. Continence
vi. Transferring
vii. Inside Mobility

Or

b. Be impaired in at least THREE of the following IADLs:

i. Meal Preparation
ii. Housework
iii. Laundry
iv. Taking medications

2. Eligibility for **Level B (up to 960 units per month)** includes:

a. Be impaired in at least one of the following ADLS of:

i. Bathing
ii. Dressing
iii. Eating
iv. Toileting
v. Continence
vi. Transferring
vii. Inside Mobility

Or

b. Be impaired in at least THREE of the following IADLs:

i. Meal Preparation
ii. Housework
iii. Laundry
iv. Taking medications

AND

c. Meet the nursing facility level of care criteria set forth at NDAC 75-02-02-09 or meets ICF/MR level of care criteria.

3. Eligibility for Level C (up to 1200 units per month) includes:

a. Be impaired in at least five of the following ADLS of:

i. Bathing
ii. Dressing
iii. Eating
iv. Toileting
v. Continence
vi. Transferring
vii. Inside Mobility

AND

b. Meet the nursing facility level of care criteria set forth at NDAC 75-02-02-09 or meets ICF/MR level of care criteria.

AND

c. None of the 300 hours (1200 units) approved for personal care services can be allocated to the tasks of laundry, shopping, or housekeeping.

AND

d. Have written prior approval for this service from a HCBS Program Administrator, Aging Services, Department of Health and Human Services. The approval must be updated every six months.

The functional assessment measures the degree to which an individual can perform various tasks that are essential to independent living. Information on each of the ADLs or IADLs can be collected by observation, by direct questioning of the individual, or by interview with a significant other. The case manager shall maintain documentation supporting the level of impairment and shall include the following information if applicable:

1. Reason for inability to complete the activity or task
2. Kind of aid the individual uses (e.g., a grab bar or stool for bathing)
3. Kind of help the individual requires (e.g., preparing the bath, washing back and feet, complete bed bath) and the frequency of the need to have the help (e.g. units of services needed)
4. Who provides the help

5. The individual's health, safety and welfare needs that need to be addressed
6. Document the anticipated outcome as a result of service provision
7. Other pertinent information

Personal Care Service Tasks 535-05-20

(Revised 10/01/2024 ML #3871)

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An individual who is eligible for personal care service may receive assistance with the tasks identified in this section when supported by a documented need identified through a needs assessment and authorized by a case manager. Personal care services require prior authorization.

The following activities and tasks, as defined on the pre-authorization in the web-based case management system, may be authorized to be performed by a personal care service provider:

1. Bathing
2. Dressing/Undressing
3. Feeding
4. Toileting
5. Continence/Incontinence Care
6. Transferring, Turning, Positioning
7. Mobility
8. Meal Preparation
9. Housework
10. Laundry
11. Shopping
12. Medication Assistance
13. Eye Care
14. Nail Care
15. Skin Care
16. Hair Care
17. Teeth, Mouth, Denture Care
18. Money Management
19. Communication
20. Exercises
21. Indwelling Bladder Catheter Care
22. Medical gases assistance
23. Suppository assistance
24. Temperature, Blood Pressure, Pulse, Respiration Rate
25. Prosthesis/Orthotics assistance
26. Hoyer Lift/Mechanized Bath Chairs assistance

27. Ted Socks assistance
28. Ostomy Care
29. Postural/Bronchial Drainage
30. Jobst Stockings assistance
31. Ric Bed Care (Speciality Bed)

Limitations and Non-covered Services 535-05-25

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1. Personal care services may not include skilled services performed by persons with professional training.
2. An individual receiving personal care services may not be an inpatient or resident of a hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, a psychiatric residential treatment facility, or an institution for mental disease.
3. Personal care services may not include home delivered meals; services performed primarily as housekeeping tasks; transportation; social activities; or services or tasks not directly related to the needs of the individual such as doing laundry for family members, cleaning of areas not occupied by the individual, or shopping for items not used by the individual.
4. Meal preparation is limited to the maximum units set by the department. Laundry, shopping, and housework tasks when provided must be incidental to the provision of other personal care tasks and cannot exceed 30% of the total time authorized for the provision of all personal care tasks. Personal care service tasks of laundry, shopping, and housekeeping are limited to the maximum units set by the department, and the cap cannot be exceeded under other home and community-based services funding sources.
5. Services provided by a spouse, parent of a minor child, or legal guardian are not covered.
6. The tasks of laundry, shopping, housekeeping, meal preparation, money management and communication may be assessed for individuals whose provider is a relative listed under the definition of family home care under subsection 4 of the North Dakota Century Code section 50-06.2 02 or who is a former spouse beginning at the first required contact after 1/1/2021. Conditions that would benefit the consumer would include, but are not limited to, maintenance of the home environment, such as shared spaces as assigned by the case manager and individual's laundry.
7. Care needs of the individual that are outside the scope of personal care services are not covered.
8. Services provided in excess of the services or hours authorized by the case manager in the individual’s approved care plan are not covered.

9. Authorized personal care services may not exceed 120 hours (480 units) per month for Level A Personal Care Services or 240 hours (960 units) per month for Level B Personal Care Services, and 300 hours (1200 units) per month for Level C Personal Care Services.
10. Personal care services may be provided to a recipient who has natural supports. For purposes of this subsection, "natural supports" means an informal, unpaid caregiver that provides care to an applicant or recipient.
11. Personal care services may not be provided for tasks that are otherwise age appropriate or generally needed by an individual within the normal stages of development.
12. Per guidance given by the Centers for Medicare and Medicaid Services in the following 2001 HHS Survey and Certification memo, personal cares can be offered in conjunction with Hospice services.

    https://www.cms.gov/Medicare/Provider-Enrollment-and Certification/SurveyCertificationGenInfo/downloads/SCLetter01-013.pdf
13. The combination of personal care services and hospice service requires approval from the Department. The request must outline the individual's needs, the services that will be provided through Hospice, and the services being requested through MSP PC. The request must also contain an assurance that there is not a duplication of services.
14. The Hospice plan of care must include the need for personal care services and a copy must be maintained in the individual’s file.

Prior Authorization 535-05-30

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Prior authorization by a case manager is required for all personal care tasks provided to an individual who meets the qualifying criteria for personal care services. The case manager must complete Person-Centered Plan of Care authorizing the services and hours that may be provided per month. Services and hours may be authorized for a period not to exceed 6 months.

The case manager must submit Person-Centered Plan of Care in the web-based case management system and a preauth in the EVV system. The DDPM will submit the Person-Centered Plan of Care in the DD web-based case management system and a pre-auth will be entered by the Residential and Vocational Services Administrator in the Aging web-based case management system.

Payment for personal care services may not be made prior to completion of the comprehensive assessment, person-centered plan of care and pre-authorization.

Case Management 535-05-35

(Revised 10/01/2024 ML #3871)

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Case management for an individual applying for or receiving personal care services shall be the responsibility of an HCBS case manager except when the individual is also receiving a service(s) through the Developmental Disabilities section. Case management for personal care services for an individual receiving a service(s) through the DD section shall be the responsibility of a DD Program Manager (DDPM). If the individual is not receiving service(s) through the Traditional IID/DD HCBS Waiver, they have the right to choose the provider of case management services.

The case manager is responsible for assessing an individual's needs for personal care services, developing a comprehensive care plan that includes identification of tasks and times required to perform tasks, assisting the individual with obtaining a personal care service provider, monitoring and reassessing needs on a periodic basis, and terminating services when appropriate.

Part of completing an assessment includes determining an individual's overall support needs, whether the supports will be provided through HCBS or through other community resources. To coordinate services for an individual, case managers may need to make referrals and gather other collateral information. Not all communication requires a release of information, for example, case managers can share individual information with health care professionals working in the following settings: home health care, hospitals, clinics, PACE, and LTC facilities, as this communication is part of the continuum of care guidelines under HIPAA. Case Managers can also share information with other case management entities (i.e. DD, VR, behavioral health) within the Department of Health and Human Services, as well as eligibility workers under the Medical Services Division. Information shared without a release of information must be on a need-to-know basis to coordinate care for the individual, disclosing only the minimum necessary amount of information pursuant to 45 CFR 164.502(b). Disclosure of information related to psychological or substance abuse treatment requires that the individual sign a Release of Information.

Decisions regarding personal care services for an incapacitated individual are health care decisions that may be made pursuant to North Dakota Century Code section 23-12-13.

The applicant or guardian of the applicant shall provide information sufficient to establish eligibility for benefits, including a social security number, proof of age, identity, residence, blindness, disability, functional limitation, financial eligibility, and such other information as may be required by this chapter for each month for which benefits are sought.

The case manager must schedule an appointment for an initial assessment no later than 5 working days after receiving a request for personal care services and must complete an initial comprehensive assessment no later than 10 working days after receiving a request for personal care services. All contacts with an individual must be documented in the case file.

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/DDPM. A comprehensive assessment must be completed initially and annually thereafter for the individual or if there has been a significant change in personal care needs. The comprehensive assessment must include information on the individual's physical health, cognitive and emotional functioning, ability to perform activities of daily living or instrumental activities of daily living, informal supports, need for 24 hour supervision, social participation, physical environment, financial resources, and any other pertinent information about the individual or his/her environment.

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

NDAC 75-03-23-15. Proof of blindness, disability and functional limitation may include but is not limited to complying with all requests for medical records or an evaluation from PT, OT, Speech, neuro-psych evaluation etc. that would assist the case manager in completing a determination for HCBS services.

After completing the comprehensive assessment, the case manager and individual work together to develop a person-centered plan of care based on the individual's needs, situations, and problems identified in the assessment. The plan must include:

1. All problems identified, including those that will not be addressed through the provision of personal care services.
2. Desired outcome(s) for each problem must be documented in the comprehensive assessment for which units of personal care services have been authorized.
3. The type(s) of help needed to achieve each desired outcome.
4. Services and providers that can supply the need for help.
5. Provider(s) the individual selects.
6. The amount of personal care service to be provided and the specific time-period.
7. Documentation of the medical necessity to monitor vital signs and identify who is to be notified of an individual's vital signs readings.

The case manager shall identify personal care service providers available to provide the service required by the individual and provide the following information to the individual:

1. Name, address and telephone number of available personal care service providers.
2. Identify whether a provider is an agency or individual QSP or a basic care assistance provider.
3. Any limitations applicable to the available providers.
4. If applicable, any global or individual specific endorsements for specialized cares that available providers are qualified to perform.

The individual must select the personal care service provider(s) they want to deliver the service to meet their care needs. The case manager must then complete a person-centered plan of care and preauth for services provided within the community-setting or the SFN 662 for personal care services by a basic care provider.

The case manager must monitor and document that the individual is receiving the personal care services authorized on the preauth. The case manager must review the quality and quantity of services provided. A reassessment of the individual's needs and care plan must be completed at a minimum of six-month intervals. The case manager shall visit with an individual in his/her place of residence every six months and review and update the assessment and the individual's care plan as necessary.

A quarterly face-to-face visit is required for consumers receiving services under Level C. At each quarterly contact, the case manager will monitor the quality, quantity and frequency of services, assess and/or review any risks, and monitor all health/welfare/safety concerns. A narrative must be completed for each quarterly contact.

The State Medicaid Agency may waive the face to face requirement for case management services, based on specialized health care situations that may require a recipient to be out of state for other medical services. Any waiver of this requirement will require special approval from the Aging Services HCBS Program Administrator for Aging Services program participants or DD Residential and Vocational Services Administrator for DD program participants.

The case manager is responsible for following Department established protocols when abuse, neglect or exploitation of an individual is suspected.

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

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

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

- Case Managers employed by Aging Services who have sufficient knowledge and experience relating to the availability of alternative long term care services for elderly and disabled individuals.
- Developmental Disabilities Program Manager (DDPM) who is a Qualified Developmental Disability Professional (QDDP) or has one year experience as a DDPM with the Department.
- An Individual Case Manager or Agency Case Manager that has sufficient knowledge and experience relating to the availability of alternative long term 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 MSP-PC Service:

- Case Managers employed by Aging Services.
- Developmental Disabilities Program Managers (DDPM)
    - If the individual is a recipient of services funded by the SPED, Expanded SPED Programs, or MSP-PC the one case file will contain documentation of eligibility for TCM as well as for the service(s)

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

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

Targeted Case Management (TCM)

The individual receiving TCM will meet the following criteria:

1. Medicaid recipient.
2. Not a recipient of HCBS (1915c Waiver) services.
3. Not currently be covered under any other 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 ages of 22-64 who are served in Institutions for Mental Disease or inmates of public institutions.
6. Has "long-term care need." Document the required "long-term care need" on the Application for Services, SFN 1047. The applicant or legal representative must provide a describable need that would delay or prevent institutionalization.
7. The applicant or referred individual must agree to a home visit and participate in the assessment and person-centered planning.

Activities of Targeted Case Management

1-Assessment/Reassessment

2-Care Plan Development

3-Referral and Related Activities

4-Monitoring and Follow-up 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 individual's case file must contain documentation of eligibility for TCM. The HCBS Comprehensive Assessment must be entered into the SAMS

Web Based System or the THERAP System/MSP-PC Functional Assessment.

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

- The case record must include a HCBS Comprehensive Assessment and narrative which includes:

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

Limits:

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

Case file documentation must be maintained:

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

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

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

Instructions for completion of the HCBS Comprehensive Assessment

For Aging Services Case managers can be found here: Instructions for Completion of the HCBS Comprehensive Assessment 525-05-60-10 (nd.gov)

For DDPMs follow the instructions to complete the comprehensive assessment provided by the HHS DD Section

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

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

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

  Individuals must sign and be given a "Your Rights and Responsibilities" brochure annually.

  - DN 46, for Aging Services Case Managers.
  - Individual Service Plan (ISP) for DDPMs

  A signed copy of this must be kept in the individual's file.

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

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

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

The following service combinations require approval by the HCBS Program Administrator as indicated in the chart below (for DD, it will be noted separately in the following chart):

Approval	**Description**	**Frequency**
Hospice	Pre-approval is not needed. However, the combination of HCBS services and hospice service requires documentation in the case note that the individual continues to meet eligibility for the service and there is no duplication of services. The hospice service must also be noted on the "other community-based services" section of the person-centered plan. For MSP-PC cases only: The following information must also be sent to provider enrollment: · name of the individual, · ND number, · date hospice started, · provider name, · provider number, · document in the email assurance that the hospice plan is on file (the hospice plan must be kept in the individuals HCBS file.)	One-Time

Out-of-state care	If you are seeking to continue to authorize services for an individual while they are out of state: Include name, county of residence, funding source, description of situation for consideration, including whether medical treatment is being sought out of state.	Each instance
2-person assist	If more than one provider is needed to complete a service or task, include the name, county of residence, funding source, and description of need – why one provider is unable to safety complete the service or task. *DD – requested from the Residential and Vocational Service Administrator	Initial, every 6 months
MSP Level C	Include name, county of residence, description of need/functional status, number of personal care units/and assurance that no units are authorized for l/s/h *DD – requested from the Residential and Vocational Service Administrator	Initial, every 6 months
Reasonable Modifications	For reasonable modification requests, include all necessary information that is indicated on the reasonable modification template. For annual re-approval of a reasonable modification, include the information indicated on the reasonable modification template, as well the date of original approval and whether the modification needs to be modified or should continue.	Reasonable modifications need to be re-approved on an annual basis during the annual

		review or any time there is a change
Exceptions to services/ combinations/ situations not otherwise listed	Include name, county of residence, funding source, services, and detailed description of the request for approval. If a reasonable modification request, include the age of the individual, whether they would reasonably meet LOC, if they are on Medicaid or at risk of being on Medicaid, and why the approval would assist in preventing institutionalization/possible detrimental outcomes of not approving the request.	As needed depending on request

2. Person-Centered Planning (Care Plan Development)

Aging Services Reference HCBS Case Management 525-05-30-05 (nd.gov) Policy for Person-Centered Planning Requirements.

DDPM reference (Insert policy manual link here).

Rural Differential Rates 535-05-38

(Revised 10/01/2024 ML #3871)

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Reference HCBS Policy Manual Rural Differential Rates 525-05-38 (nd.gov)

Purpose

The purpose of the rural differential rate 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 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.

Payment for Services 535-05-40

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A personal care service provider enrolled as a qualified service provider (QSP) shall be paid based on 15 minute increments using a provider specific 15 minute unit rate, which may not exceed the maximum 15 minute unit rate established by the department.

A personal care service provider enrolled as a qualified service provider, who resides with an individual eligible to receive personal care services, will be paid a daily rate for each day personal care services are provided for at least 60 minutes. The daily rate may not exceed the maximum per day rate established by the department and may be paid to no more than one QSP.

A personal care service provider enrolled as a basic care assistance provider shall be paid a daily rate if personal care services are needed and provided every day. The daily rate is an average per day rate that is provider specific and may not exceed the maximum per day rate established by the department. The daily rate is applicable to all eligible individuals needing and receiving daily personal care services from the basic care assistance provider and does not vary based on the amount of services provided daily. If personal care services are provided intermittently to an individual, the basic care assistance provider shall be paid based on the maximum agency 15 minute unit rate for the services provided to that individual.

Case management activities must be documented in the case file before payment for case management can be requested. The authorizing agent may be paid for targeted case management (TCM) for a Medicaid eligible individual in need of long term care services only if the individual is not receiving case management under any HCBS waiver or other targeted case management provisions. No claim may be made for TCM when a change in funding source for case management occurs or if an individual is not eligible for Medicaid. When accessing Targeted Case Management

payment, documentation must support that the individual is at risk of requiring long-term care services this can be narrated on the SFN 1047, Application for Services.

Provider Billing Procedures and Standards for Qualified Service Providers 535-05-45

(Revised 10/01/2024 ML #3871)

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The personal care service provider is responsible for keeping written records documenting the delivery of care to each individual. The written record must include the date, the tasks performed, and the time required to perform the tasks.

Electronic Visit Verification Requirements

Electronic Visit Verification (EVV) uses a mobile device application on a phone, tablet, or laptop that records the beginning and ending time of services provided to individuals by providers. Data may also be captured using a fixed object device (FOD) issued to the provider by HHS. This electronically verifies the service was provided at a particular location where the service is authorized, as required by the law. EVV is a federal requirement from the 21st Century Cures Act and became effective January 1, 2021, it is used for billing and payment of services you provide as a QSP.

All QSPs are required to participate in an EVV system if they enroll in at least one of the services subject to EVV. QSPs must have access to a FOB, phone, tablet, or laptop to utilize this system. This is necessary to check in and out when providing services, receiving service authorizations, and submitting claims electronically. Not all services require EVV to bill for services provided.

EVV programming under Therap includes the option to enter and store the documentation that is required for QSP services. This programming is called ISP Data and meets the standard for QSP documentation. ISP Data is only available to QSPs using Therap for EVV.

The approved services on the preauth must identify the procedure code the provider is to use to bill for services provided.

A personal care service provider who is enrolled as a QSP must use the Turnaround Document for Home and Community Based Care for the Elderly/Disabled (TAD), SFN 925, or the QSP online billing option to bill for services.

Basic Care Personal Care service provider

- A personal care service provider enrolled as a basic care assistance provider must bill using the Basic Care Assistance billing process.

Unit Rate Personal Care Service Provider

- Procedure code T1019 must be used be used to bill on a 15-minute increment basis.
- Billing is limited to the time in performance of the authorized tasks provided. The provider must bill in 15-minute increments on a daily basis.
- 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.
    - The amount of time required to bill for a larger number of units is as follows:
        - 2 units: at least 23 minutes 6 units: at least 83 minutes
        - 3 units: at least 38 minutes 7 units: at least 98 minutes
        - 4 units: at least 53 minutes 8 units: at least 113 minutes
        - 5 units: at least 68 minutes
        - The pattern remains the same for allowable tasks performed in excess of 8 units (2 hours).

Daily Rate Service Rates.

- Each 15-minute increment is one (1) unit and the number of units of service provided on each day of care must be shown on the billing document.
- Procedure code T1020 must be used to bill a daily rate for a provider authorized to bill a daily rate. Only 1 unit per client may be billed per day for procedure code T1020. The provider may be paid the daily rate only for days on which personal care services were provided. The daily rate may not be paid for any days on which the individual was in the

hospital or a health-care facility or on leave from the residence, except payment is allowed for the day the individual returns to the provider's care. Payment may be claimed when personal care services are provided on the day of death.
- Providers must provide one hour of service to bill for daily rate services.

Live-In Paid Family or Household Members/Qualified Service Providers

- Reference policy Paid Family or Household Members/Qualified Service Provider (QSP) Service Agreement - Live in Paid Caregivers 525-05-40-50 (nd.gov)
- When an individual is eligible and chooses live-in daily rate personal care funded under Medicaid State Plan - Personal Care (MSP-PC) the HCBS Case Manager must complete a person-centered plan of care and a service agreement with the eligible individual and their legal decision maker, when the live in paid care provider has a close personal relationship with the eligible individual in need of care.
- A close personal relationship includes relative providers and individuals who had a close personal relationship with the eligible individual prior to paid care being established. Examples include but are not limited to relatives, significant other, or former spouse.

Case Managers should determine units in each of the categories of ADLs, Medication Assistance, Meal Preparation, Laundry/shopping/housekeeping, and Other. Some flexibility is anticipated in the provision of tasks amongst the categories of ADL, Other, and Medication Assistance and the provider is allowed to bill up to the total units approved; however, the provider may not bill for units in excess of the units authorized in the category of laundry, shopping and housekeeping and Meal Preparation.

Paid Family or Household Members/Qualified Service Provider (QSP) Service Agreement - Live in Paid Caregivers

The FLSA Final Rule recognizes the unique nature of programs in which the care provider and the eligible individual live together and have pre-existing family ties or a pre-existing shared household. There is both a familial or household relationship and an employment relationship.

Full Policy for Standards of Qualified Service Providers can be found at the following policy links:

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

Qualified Service Provider Enrollment 525-05-45-10

Referrals for Qualified Service Providers 525-05-45-20

Qualified Service Provider (QSP) Complaints 525-05-45-30

Qualified Service Provider (QSP) Overtime 525-05-45-40

Paid Family or Household Members/Qualified Service Provider (QSP) Service Agreement - Live in Paid Caregivers 525-05-45-50

Agency Quality Service Provider (QSP) Quality Improvement Program 525-05-45-60

Reductions, Denials, and Terminations 535-05-50

(Revised 10/01/2024 ML #3871)

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An individual dissatisfied with a decision made regarding personal care services may appeal that decision to the Department of Human Services under the fair hearing rules set forth in N.D.A.C. 75-01-03-03. An individual must be informed of the right to appeal any actions by the case manager or the department that result in denial, suspension, reduction, discontinuance, or termination of personal care services. Refer to Service Chapter 448-01-30 for more information with regard to Hearings and Appeals.

Denial/Termination/Reduction

The applicant/individual must be informed in writing of the reason(s) for the denial/termination/reduction.

The HCBS Notice of Denialor Termination form (SFN 1647/DD - SFN 1008) is dated the date of the 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; and may include a policy and procedures manual reference(s). The citation used to complete the SFN 1647 must be obtained from a HCBS Program Administrator or the HCBS Unit Supervisor of Aging Services. The citation used to complete the SFN 1008 must be obtained from the Residential and Vocational Services Administrator.

The individual must be notified in writing at least 10 days (it may be more) prior to the date of terminating or denying services **(UNLESS** it is for one of the reasons stated in this section that does not require a 10-day notice). The date entered on the line, the effective date field, is 10 calendar days from the date of mailing the Notice (SFN 1647) (SFN 1008 for DD) or the next working day if it is a Saturday, Sunday, or legal holiday.

1. **Termination** of a service is discontinuing the service. The individual must be informed in writing of the termination by providing the individual with a completed SFN 1647 (SFN 1008 for DD) or the individual may provide a written statement indicating they no longer want the service.
2. **Denial** of a service may include denying the service to a new applicant or denying the number of units a current individual requests.

    - When denying units the individual has requested, the individual must be informed in writing of the Denial by providing the individual a completed SFN 1647 (SFN 1008 for DD).
    - When an individual contacts the HCBS Case Manager or DDPM per phone for general information about the service, the applicant must be made aware that a formal determination of eligibility for the service cannot be made by phone. The individual 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 individual must be informed in writing of the Denial by providing theindividual with a completed SFN 1647 (SFN 1008 for DD) or the individual may provide a written statement indicating they do not want the service.

    - When a home visit is completed to assess or inform an applicant about services, an application for service is implied by the individual and a completed SFN 1647 (SFN 1008 for DD) must be provided informing the individual of the Denial or the client can provide a written statement indicating they do not want the service.

3. **Reduction** in services may include reducing the number of units or reducing the tasks in a specific category. A written reduction notice is required (the individual agreeing with the reduction is not sufficient).

    If the service is reduced the individual must be informed in writing of the reason(s) for the reduction in service on the SFN 662, the effective date of the reduction must be no sooner than 11 days after the

individual signs the SFN 662 and the individual must be given a copy of the appeal rights printed on back of the SFN 662.

Any of the reasons below do not require a 10-day notice:

1. The individual enters a nursing home.
2. Aging Services (Developmental Disabilities Section for DD) or Human Service Center has received in writing the individual's decision to terminate services.
3. Individual's whereabouts are unknown and attempt to contact the individual are supported by documentation in the client's file.
4. State or federal government initiates a mass change which uniformly and similarly affects all similarly situated applicants, recipients, and households.
5. Case Management has factual information confirming the death of the individual.

Personal Care Service has not been used in 60 days:

The authorization for personal care service may be terminated if the service is not used within 60 days, or if services lapse for at least 60 days, after the issuance of the authorization to provide personal care services.

Health Welfare and Safety:

The department may deny or terminate personal care services when service to the individual presents an immediate threat to the health or safety of the individual, the provider of the service, or others, or when the services that are available are not adequate to prevent a threat to the health or safety of the individual, the provider of services, or others.

The individual is no longer eligible for Medicaid:

Case Manager must send a letter to the individual that eligibility for MSP-PC is dependent on eligibility for Medicaid (the right to appeal the closure of the Medicaid benefit is sent to the individual by Economic Assistance).

Provider Qualifications 535-05-55

(Revised 10/1/2024 ML #3871)

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To provide personal care services, an individual or agency must be enrolled with the Medical Services Division as a qualified service provider (QSP). A residential care provider must be licensed and enrolled as a basic care provider. Agency providers must ensure that each employee meets the required standards for a QSP before an employee can provide personal care services. Residential providers must ensure that each employee meets the required standards in the Basic Care Licensing Standard outlined by the North Dakota Department of Health.

A QSP must be at least 18 years of age and must provide evidence that he or she meets the general QSP standards included at NDAC 75-03-23-07. Competency of meeting standards required to provide personal care services for which a global or individual specific endorsement is required can be verified by a health care professional or applicable certifications or licensure.

The provider agreement with a qualified service provider shall be terminated for cause under the provisions of NDAC 75-03-23-08.

Home and Community Based Services Qualified Services Provider policy can be found at:

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

Qualified Service Provider Enrollment 525-05-45-10

Referrals for Qualified Service Providers 525-05-45-20

Qualified Service Provider (QSP) Complaints 525-05-45-30

Qualified Service Provider (QSP) Overtime 525-05-45-40

Paid Family or Household Members/Qualified Service Provider (QSP) Service Agreement - Live in Paid Caregivers 525-05-45-50

Agency Quality Service Provider (QSP) Quality Improvement Program 525-05-45-60

Critical Incident Reporting 535-05-57

(Revised 10/01/2024 ML# 3871)

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Critical Incident

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

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

This chapter includes all individuals receiving personal care service, including those that receive MSP-PC in a Basic Care setting.

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 requires care that would not be routinely provided by a primary care provider
4. Wandering or elopement
5. Restraint violations
6. Death of any HCBS individual who has an open case, regardless of where the death occurred or if it was witnessed by the provider. A Report of an individual's death must include and the cause (including death by suicide)
7. Medication errors or omissions

- Medication errors that occur in a setting other than a basic care facility include all medication errors and omissions
- Medication errors in a basic care facility are defined to align with the reporting requirements of the Department of Health. A reportable medication error for the purposes of this chapter is defined as "a medication error by facility staff member which results in a negative outcome to a resident or a pattern of medication errors"

8. Any event that has the potential to jeopardize the individual's health, safety or security if left uncorrected.
9. Changes in health or behavior that may jeopardize continued services.
10. Illnesses or injuries that resulted from unsafe or unsanitary conditions.

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

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

Apart from a critical incident that occurs within a basic care facility, 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.

<u>Incident reporting requirements</u>

Any paid provider or paid family member who is with an individual, involved, witnessed, or responded to an event that is defined as a reportable incident, is required to report the critical incident. If the incident is a death an incident report must be completed even if the death is not witnessed by the paid provider or paid family member.

Note: A General Event Report (GER) in the Therap case management system is the same as a Critical Incident Report (CIR) referenced in this policy.

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

1. Reported to the HCBS Case Manager and
2. A Critical Incident Report (CIR) must be completed and submitted to the HCBS Case Manager within 24 hours of learning or knowing of the incident. The CIR must be submitted using a General Event Report (GER) within Therap, or by completing the GER offline form.

    a. The GER offline form can be accessed here: GER Offiline Forms
    b. The GER Event Report along with the GER Event Type form (e.g. medication error, injury, etc.) must be completed and submitted together.
    c. The HCBS Case Manager/DDPM and program administrator will receive the incident report once submitted for review in Therap. If the GER offline form is used, the HCBS Case Manager/DDPM will fax the form to (701) 328-4875 or email: dhshcbs@nd.gov. The program administrator will then enter the GER Event Report and Event Type into Therap.

Examples

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

Example 2: If a family member informs the case manager or the facility that an individual is in the hospital due to a stroke, a critical incident report is not required because the case manager was made aware of the ER visit and/or hospital admission. If the individual dies while in the hospital an incident report must be submitted if the individual's HCBS case is still open.

Example 3: If an employee in the facility comes to an individual's room and the individual is found on the floor and the staff member calls 911 so the individual may receive medical attention, a critical incident report is

required because the individual required medical attention AND the facility staff is aware of the incident.

Example 4: If an individual was not given a dose of digoxin and developed heartbeat irregularity a critical incident report is required because the medication error resulted in a negative outcome.

Department Responsibilities

Within 24 hours or 1 business day of receiving the report from the HCBS case manager, the department will submit a medical case incident report for incident reports involving suspicious deaths and events that have the potential for litigation or legal involvement into the ND Risk Management Incident Reporting system.

The program administrator will also enter GER offline reports into Therap within 24 hours of receiving report or 1 business day.

The department will hold quarterly critical incident team meetings to review all critical incident reports for trends, need for increased training and education, additional services, and to ensure proper protocol has been followed. The team consists of the ND DHS Aging Services Division Director, HCBS program administrator(s), HCBS nurse administrators, Vulnerable Adult Protective Services (VAPS) staff, LTC Ombudsmen, and the DHS risk manager.

The Department of Justice (DOJ) agreement coordinator (Aging Services Division Director) is responsible to ensure that critical incidents are reported as described in the settlement agreement to the DOJ and the subject matter expert (SME) within 7 calendar days of the receipt of the critical incident.

Remediation Plan

A remediation plan is required to be developed and implemented for each incident except for death by natural causes as required by the DOJ and the Aging Services Division. The department will be responsible to monitor and follow up as necessary to assure the remediation plan was implemented.

The remediation plan will include corrective actions taken, a plan of future corrective actions, and a timeline to complete the plan if applicable. The HCBS case manager and program administrator are responsible to follow up with the QSP to ensure the remediation plan is acceptable.

Activities of Daily Living (ADLs) Scoring 535-05-60-01

(Revised 10/01/2024 ML #3871)

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Case managers require specific information regarding the activities an individual can perform in order to arrange for services which enable the client to remain at home.

This section allows the case manager to determine the level of impairment an individual's is experiencing, based on specific medical, emotional and cognitive status. It is based on standard scale which have been tested and validated in programs serving the individuals with physical disabilities.

The questions measure the degree to which an individual can perform various tasks that are essential to independent living. These tasks, called Activities of Daily Living (ADLs), include: bathing, dressing/undressing, eating, toileting, continence, transfer in/out of bed or chair, and indoor mobility.

The scale used to measure independence in ADLs uses ratings from 0 to 3. A score of zero represents complete independence (no impairment), while 3 represents complete dependence (impairment). Each item measures the level of impairment of the individual, regardless of how much help they might be receiving at present. In completing the section, the case manager should check the number which best corresponds to the individual's impairment level. The following general definitions must determine the ratings.

Information on each of the ADLs can be collected by observation, from the individual, a significant other, or collateral contact.

Information will need to be provided on how the individual usually performs a task, i.e., most of the time. An individual who has occasional difficulty should be coded based on their usual performance. However, occasional difficulties should be noted in the corresponding narrative/note.

Barthel Scale Scoring (as defined by C.V. Granger, July, 1974) Mahoney FI, Barthel D. "Functional evaluation: the Barthel Index." Maryland State Med Journal 1965;14:56-61. Used with permission. Permission is required to modify the Barthel Index or to use it for commercial purposes.

0: Completely Able - Activity completed under ordinary circumstances without modification, and within reasonable time. (A "reasonable time" involves an amount of time the client feels is acceptable to complete the task and an amount which does not interfere with completing other tasks, as well as the professional judgment of the Case Manager based on the client's age, health condition, (e.g. arthritis) and situation.

1: Able with Aids/Difficulty - Activity completed with prior preparation or under special circumstances, or with assistive devices or aids, or beyond a reasonable time.

2: Able with Helper - Activity completed only with help or assistance of another person, or under another person's supervision for safety, or by cuing. ANOTHER HUMAN IS INVOLVED IN ACTIVITY; but client performs at least half the effort him/herself.

3: Unable - Client assists minimally (less than half of effort), or is totally dependent.

Some general concepts govern the manner in which an individual is compared with the assessment criteria: The individual is considered as a "whole entity." The case manager does not measure physical capacity, cognitive ability, or affective state separately, but rather one's functioning as a whole. For example, if one has ample physical strength and skill to complete a task, but also has cognitive limitations which prevent the individual from doing so, that person cannot complete it. The case manager also measures the individual's level of functioning in the present. What the individual could or could not do in the past is not an issue nor is what the individual, under hypothetical conditions, might be able to do in the future. Each task must be looked at as the sum of its parts. One must be able to complete all parts of a task in order to complete the task.

Further information to assist with evaluating the functional impairment includes the following: the case manager indicates the level of impairment

in the Functional Assessment by choosing one of the four (4) selections (the number behind the description of the impairment indicates the points associated with the level of impairment). The total impairments and associated points are automatically added on the final screen of the functional assessment in the assessment tool. A Rating 2 OR 3 ON THE ASSESSMENT OF AN ADL INDICATES AN IMPAIRMENT.

The four (4) options for level of impairment under each ADL task is as follows:

- Completely able: Able to complete the task independently and without difficulty.
- Able with aids/difficulty: Able to complete the task without the assistance of another person, but does so with difficulty, use of equipment, or takes an inordinate amount of time to complete.
- Able with helper: Needs another person to assist with the activity, but the individual is able to perform at least half the effort of completing the task.
- Unable: Unable to complete or assists minimally (less than half the effort), or is totally dependent on another person to complete the activity.

For each ADL the case manager must note the reason individual is not able to independently complete the ADL task as follows:

- If an ADL is scored a 0 or 1, skip to next ADL.
- If scored a 2 or 3 and informal supports assists, complete a and b, and c just stating who assists.
- If formal HCBS supports are authorized to assist, complete a,b, c, d and outcomes fully
    a. I need support with this activity because [justify impairment score]
        - In the narrative box provided, indicate the justification for the impairment in sentence form.

          Example: I need support with bathing due to overall weakness and unsteadiness getting in and out of the shower.

The note may include:

- The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.
- Type of equipment used, if any. Any problems with equipment?

b. I like to [task] [frequency] times a week/day in the [morning/night/afternoon/no preference].

- In the box provided describe the individuals request for when they would like the task completed and the frequency.

Example: I want assistance with bathing three times a week before bedtime.

The note may include:

- Is individual able to complete the task as frequently as needed or wanted?

(Helpful hint: this is where the case manager starts to calculate how many units are needed for the overall service that the task fits under. Which will be noted under (c.) of the ADL. Such as bathing, dressing and nail care are all personal care tasks and would be authorized under the overall service of personal care.

For example: The frequency of the task for bathing would be as follows: The individual needs assistance with bathing for 30 minutes three times a week, and there are 5 weeks in a month. The individual would need 30 units of personal care services (PCS) for bathing.

Additionally, the individual needs one unit three times a week for dressing (frequency of bathing indicates 15 units a month) and 1 unit a week for nail care (5 units a month). This would add up to 50 overall units of PCS for the individual would need to be authorized. In letter (c.) the overall units for the authorized service (ie. PCS) will be noted.

c. [Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

- Who assists with the task?
- What service does this task fall under.
- Indicate the overall number of units authorized for this service type.

Example: QSP will support me with this task as part of the overall service of personal care. Total units authorized for personal care services are **not to exceed** 50 units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

- To maintain hygiene and prevent injury/burning.
- To prevent skin breakdown and keep odor free.
- Other (3)

[if Other] Describe.

d. Other information you should know about my [ADL]:
   - In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

   Example: I get anxious and panicky when water runs over my face in the shower. It makes me feel like I am going to suffocate.

A full description of the specific ADL and required documentation in the assessment is as follows:

1. Bathing

This item measures the individual’s applicant's/client's ability to bathe or shower or take sponge baths independently for the purpose of maintaining adequate hygiene as needed for the client's individual’s circumstances. Consider minimum hygiene standards, medical prescription, or health related considerations such as incontinence, skin ulcer, lesions, cognitive ability, and balance problems. Consider ability to turn faucets, regulate water temperature, wash and dry completely.

- Completely able: Able to complete the task independently and without difficulty.
- Able with aids/difficulty: Able to complete the task without the assistance of another person, but does so with difficulty, use of equipment, or takes an inordinate amount of time to complete.
- Able with helper: Needs another person to assist with the activity, but the individual is able to perform at least half the effort of completing the task.
- Unable: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity.

For each ADL the case manager must note the reason individual is not able to independently complete the task in section a. of the ADL as follows:

a. I need support with this activity because [justify impairment score]
    - In the narrative box provided, indicate the justification for the impairment in sentence form.

Example: I need support with bathing due to overall weakness and unsteadiness getting in and out of the shower.

The note may include:

- The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.
- Type of equipment used, if any. Any problems with equipment?

b. I like to [task] [frequency] times a week/day in the [morning/night/afternoon/no preference].

- In the box provided describe the individuals request for when they would like the task completed and the frequency.

Example: I want assistance with bathing three times a week before bedtime.

The note may include:

- Is individual able to complete the task as frequently as needed or wanted?

c. [Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is med.

- Who assists with the task?
- What service does this task fall under?
- Indicate the overall number of units authorized for this service type.

Example: QSP will support me with this task as part of the overall service of personal care. Total units authorized for personal care services are not to exceed 70 units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

- To maintain hygiene and prevent injury/burning.
- To prevent skin breakdown and keep odor free
- Other (3)

[if Other] Describe

d. Other information you should know about my [ADL]:
   - In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

Example: I get anxious and panicky when water runs over my face in the shower. It makes me feel like I am going to suffocate.

2. Eating

This item refers to the individual's ability to feed themselves, including cutting meat and buttering bread. Consider individual's ability to chew, swallow, cut food into manageable size pieces, and to chew and swallow

hot and cold foods/beverages. It does NOT refer to meal preparation. (This is covered in Meal Preparation).

- Completely able: Able to complete the task independently and without difficulty.
- Able with aids/difficulty: Able to complete the task without the assistance of another person, but does so with difficulty, use of equipment, or takes an inordinate amount of time to complete.
- Able with helper: Needs another person to assist with the activity, but the individual is able to perform at least half the effort of completing the task.
- Unable: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity.
  a. I need support with this activity because [justify impairment score]
     - In the narrative box provided, indicate the justification for the impairment in sentence form.

       Example: I need support with eating due to overall weakness and limited dexerity.

The note may include:

- The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.
- Type of equipment used, if any. Any problems with equipment?

b. I like to [task] [frequency] times a week/day in the [morning/night/afternoon/no preference].

- In the box provided describe the individuals request for when they would like the task completed and the frequency.

Example: I need assistance with eating three times a day for breakfast, lunch and dinner.

The note may include:

- Is individual able to complete the task as frequently as needed or wanted?

c. [Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall

service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

- Who assists with the task?
- What service does this task fall under.
- Indicate the overall number of units authorized for this service type.

Example: QSP will support me with this task as part of the overall service of personal care. Total units authorized for personal care services are **not to exceed** 70 units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

- To ensure adequate nutrition
- To prevent choking or other safety concerns
- Other

[if Other] Describe

d. Other information you should know about my [ADL]:

- In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

Example: I prefer to eat soft foods due to mouth soreness.

3. Mobility Inside

This item measures an individual’s indoor mobility. The HCBS case manager may ask an applicant/client, "How do you usually get around inside?"

- Do not consider transferring in and out of bed or chair.

- Completely able: Able to complete the task independently and without difficulty.
- Able with aids/difficulty: Able to complete the task without the assistance of another person, but does so with difficulty, use of equipment, or takes an inordinate amount of time to complete.
- Able with helper: Needs another person to assist with the activity, but the individual is able to perform at least half the effort of completing the task.
- Unable: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity.
    a. I need support with this activity because [justify impairment score]
        - In the narrative box provided, indicate the justification for the impairment in sentence form.

          Example: I need support with mobility inside due to overall weakness.

The note may include:

- The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.
- Type of equipment used, if any. Any problems with equipment?

    b. I need suport with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].
        - In the box provided describe the individuals request for when they would like the task completed and the frequency.

          Example: I need assistance with ambulating around the house 5 times a day.

The note may include:

- Is individual able to complete the task as frequently as needed or wanted?

    3. [Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing

for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

- Who assists with the task?
- What service does this task fall under.
- Indicate the overall number of units authorized for this service type.

Example: QSP will support me by providing stand by assistance and a gait belt as part of the overall service of personal care. Total units authorized for personal care services are **not to exceed** 70 units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

- To prevent falls, to maintain independence or access within home environment
- To have no or minimal discomfort
- Other

[if Other] Describe

d. Other information you should know about supporting me with mobility in my home:
   - In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

4. Transfer in/out of bed/chair

This item measures the level of assistance the individual needs in transfers.

Include the ability to reach assistive devices and appliances necessary to ambulate, and the ability to transfer (to/from) between bed and wheelchair, walker, etc.; the ability to adjust the bed or place/remove handrails, if applicable and necessary. Do not consider ambulation, itself, as this is considered under Get Around Inside.

- Completely able: Able to complete the task independently and without difficulty.
- Able with aids/difficulty: Able to complete the task without the assistance of another person, but does so with difficulty, use of equipment, or takes an inordinate amount of time to complete.
- Able with helper: Needs another person to assist with the activity, but the individual is able to perform at least half the effort of completing the task.
- Unable: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity.
  a. I need support with this activity because [justify impairment score]
     - In the narrative box provided, indicate the justification for the impairment in sentence form.

       Example: I need support with mobility inside due to overall weakness.

The note may include:

- The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.
- Type of equipment used, if any. Any problems with equipment?
  b. I like to [task] [frequency] times a week/day in the [morning/night/afternoon/no preference].
     - In the box provided describe the individuals request for when they would like the task completed and the frequency.

       Example: I need assistance with ambulating around the house 5 times a day.

The note may include:

- Is individual able to complete the task as frequently as needed or wanted?
  c. [Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall

service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

- Who assists with the task?
- What service does this task fall under.
- Indicate the overall number of units authorized for this service type.

Example: QSP will support me by providing stand by assistance with a gait belt as part of the overall service of personal care. Total units authorized for personal care services are **not to exceed** 70 units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

- To prevent falls, to maintain independence or access within home environment
- To have no or minimal discomfort
- Other

[if Other] Describe

d. Other information you should know about supporting me with transferring:
   - In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

5. Dress/Undress

This item measures the individual's ability to dress or undress. Consider individual's needs of appropriate dress for weather or street attire. Consider ability to get clothes from closets and drawers as well as putting them on. Also include ability to put on prosthesis or assistive devices. Consider fine motor coordination for buttons and zippers, and strength for

undergarments or winter coat. Do not include style or color coordination. Do not include tying shoes.

- Completely able: Able to complete the task independently and without difficulty.
- Able with aids/difficulty: Able to complete the task without the assistance of another person, but does so with difficulty, use of equipment, or takes an inordinate amount of time to complete.
- Able with helper: Needs another person to assist with the activity, but the individual is able to perform at least half the effort of completing the task.
- Unable: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity.
    a. I need support with this activity because [justify impairment score]
        - In the narrative box provided, indicate the justification for the impairment in sentence form.

          Example: I need support with dressing after my shower due to overall fatigue and unsteadiness.

The note may include:

- The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.
- Type of equipment used, if any. Any problems with equipment?
    b. I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].
        - In the box provided describe the individuals request for when they would like the task completed and the frequency.

          Example: I need support with dressing after my shower three days a week.

The note may include:

- Is individual able to complete the task as frequently as needed or wanted?

c. [Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

- Who assists with the task?
- What service does this task fall under.
- Indicate the overall number of units authorized for this service type.

Example: QSP will support me by providing stand by assistance with dressing as part of the overall service of personal care. Total units authorized for personal care services are **not to exceed** 70 units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

- To maintain appearance and keep odor free
- To dress appropriately for weather
- To maintain prevent injury

[if Other] Describe

d. Other information you should know about supporting me dressing/undressing:
    - In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

6. Toileting.

This item deals with the individual's ability to get to the bathroom, get on/off the toilet, clean him/herself, manage clothes, and flush.

Consider frequency of need and need for reminders.

- Completely able: Able to complete the task independently and without difficulty.

- Able with aids/difficulty: Able to complete the task without the assistance of another person, but does so with difficulty, use of equipment, or takes an inordinate amount of time to complete.
- Able with helper: Needs another person to assist with the activity, but the individual is able to perform at least half the effort of completing the task.
- Unable: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity.
  a. I need support with this activity because [justify impairment score]
    - In the narrative box provided, indicate the justification for the impairment in sentence form.

  Example: I need support with dressing after my shower due to overall fatigue and unsteadiness.

The note may include:

- The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.
- Type of equipment used, if any. Any problems with equipment?
  b. I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].
    - In the box provided describe the individuals request for when they would like the task completed and the frequency.

      Example: I need support with toileting 7 times a day.

The note may include:

- Is individual able to complete the task as frequently as needed or wanted?
  c. [Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

  In the box provided describe how this need is met.
    - Who assists with the task?

- What service does this task fall under.
- Indicate the overall number of units authorized for this service type.

  Example: QSP will support me by physical assistance on and off of the toilet and assisting with readjusting clothing as part of the overall service of personal care. Total units authorized for personal care services are **not to exceed** ?? units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

- To maintain dryness, keep odor free, and prevent falls
- To prevent skin breakdown and keep odor free
- To maintain prevent injury

d. Other information you should know about supporting me with toileting:
   - In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

7. Bowel and Bladder Continence

Indicate the individual's bowel and bladder continence level.

- Completely able: Able to complete the task independently and without difficulty.
- Able with aids/difficulty: Able to complete the task without the assistance of another person, but does so with difficulty, use of equipment, or takes an inordinate amount of time to complete.
- Able with helper: Needs another person to assist with the activity, but the individual is able to perform at least half the effort of completing the task.
- Unable: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity.

a. I need support with this activity because [justify impairment score]

- In the narrative box provided, indicate the justification for the impairment in sentence form.

  Example: I need support continence to include assistance with changing undergarments and incontinence supplies due to limited strength and impaired ability to bend or move body.

The note may include:

- The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.
- Type of equipment used, if any. Any problems with equipment?

b. I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].

- In the box provided describe the individuals request for when they would like the task completed and the frequency.

  Example: I need support with continence three times a day in the morning, afternoon and at bedtime.

The note may include:

- Is individual able to complete the task as frequently as needed or wanted?

c. [Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

- Who assists with the task?
- What service does this task fall under.
- Indicate the overall number of units authorized for this service type.

  Example: QSP will support me by providing physical assistance to change incontinence products and assisting with readjusting clothing as part of the overall service of personal care. Total units authorized for personal care

services are **not to exceed** ?? units a month. Indicate the appropriate outcome of the service authorized, if other indicate in the

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

- To be clean, dry and odor free
- To maintain dignity
- To prevent skin breakdown

d. Other information you should know about supporting me with continence:
   - In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

8. 8. If support person cannot assist me with these ADLS, (contingency plan).

Instrumental Activities of Daily Living (IADLs) Scoring 535-05-60-10

(Revised 10/01/2024 ML #3871)

View Archives

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

This section deals with an individual's ability to carry out tasks which may not need to be done every day but are important for living independently. Intervention may be required to help an individual adapt to difficulties experienced in performing IADL activities. IADL items include meal preparation, housework, laundry, shopping, taking medicines, getting around outside, transportation, money management, and communication. Performance of IADL items requires mental as well as physical capacity. For example, taking medications and managing money require memory, judgment, and intellectual ability. The IADL scale measures the functional impact of emotional, intellectual, and physical impairments.

Not all individuals have the opportunity to perform IADL tasks. For example, an individual who lives with a relative or spouse might not prepare meals simply because another person routinely does this task. Similarly, some individuals do not manage their own money because a spouse does it. However, the IADL scale is designed to measure an individual's physical and cognitive ability to perform these tasks, regardless of the individual's opportunity to perform them. In asking individuals about IADL tasks, case managers must stress what the person can do rather than what he/she is doing, for example: "Can you prepare meals, do housework, shop, etc.?"

The Case Manager will want to know how the individual usually performs a task, i.e., most of the time. Individuals who have occasional difficulty should be scored based on their usual performance, noting occasional difficulties in the narrative/note.

The case manager obtains information regarding IADL impairments by observation, interview with family or friends, or by direct self-report of the

client. The scale used to rate each IADL task differs slightly from the ADL scale.

It includes three basic categories of functioning:

0: Without help. 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: Can't 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:

9. Meal preparation

The case manager may ask the individual, "Can you prepare your own meals?" Regardless of whether the individual actually does prepare meals, ask whether they can.

Consider the individual's ability to prepare hot and/or cold meals that are nutritionally able to sustain the client or therapeutic, as necessary. Consider individual's cognitive ability, such as ability to remember to prepare meals, individual's ability to prepare food, to open containers, to properly store and maintain foods, and to use kitchen appliances. Do not consider clean up because it is part of housework. Do not include canning of produce or baking of such items as cookies, cakes, and bread.

- Without help: Able to complete the task without the assistance of another person.
- With help: Needs some assistance from another person to complete the task.
- Cannot do at all: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity.
    a. I need support with this activity because [justify impairment score]
        - In the narrative box provided, indicate the justification for the impairment in sentence form.

          Example: I need support with meal preparation due to overall fatigue and I cannot stand for any length of time.

The note may include:

- The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.
- Type of equipment used, if any. Any problems with equipment?
    b. I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].
        - In the box provided describe the individuals request for when they would like the task completed and the frequency.

          Example: I need support with meal preparation, the need for meal preparation is met by receiving home delivered meals for 7 days a week.

The note may include:

- Is individual able to complete the task as frequently as needed or wanted?
    c. [Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

  In the box provided describe how this need is met.

  - Who assists with the task?
  - What service does this task fall under.
  - Indicate the overall number of units authorized for this service type.

    Example: HDM's supports me by providing a meal 7 days a week. Total units authorized for home delivered meals 31 units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

- To maintain proper nutrition & hydration.
- To ensure compliance with special diet or weight control.
- To prevent injury
    a. Other information you should know about supporting me eating:
        - In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

10. Communication

This item refers to the individual's ability to use the telephone, as well as comprehend oral and written communication. Include getting telephone numbers and placing calls. The individual must be able to reach and use the telephone, answer the telephone, dial, articulate and comprehend. If the individual uses special adaptive telephone equipment, score the client based on the ability to perform this activity with that equipment.

In scoring communication, the case manager must look at each task as the sum of its parts. In determining an individual's functional impairment, we must consider whether the individual is impaired in communication using their primary language. For example, an individual who may not be able to fluently speak or understand English, but is able to communicate in their primary language, would not be considered impaired. However, if the individual's physical and cognitive ability to perform these tasks in their native language is impaired, the individual would be scored according to their level of impairment.

Special equipment in common use includes:

- amplifiers for people with speech and hearing impairments.
- enlarged dials or number stickers for the visually impaired.
- modified telephones for those with hearing aids.
- telephones hooked up to teletypewriters for those with speech impairments.
- signals (tone ringers, loud bells or lights) to indicate that the telephone is ringing.
- speaker telephones and headsets for persons who cannot hold receivers.

(NOTE: The use of an emergency response system device should not be considered when scoring this item because it can only be used for emergencies and does not enable its user to make or receive other essential calls such as arranging physician appointments or grocery deliveries.)

The tasks of routine writing/reading fall within the scope of the IADL of communication. Include the ability to understand and effectively respond to business mail, such as insurance mailings, applications for benefits, etc. If the individual needs a routine regimen of assistance with routine writing or reading of correspondence, this functional impairment may be documented within the scope of the IADL of communication. Again, when determining whether an individual is scored as impaired in communication, the case manager must consider the ability of the individual to complete related tasks involving their primary language.

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

- Without help: Able to complete the task without the assistance of another person.
- With help: Needs some assistance from another person to complete the task.
- Cannot do at all: Unable to complete or assists minimally (less than half the effort), or is totally dependent on another person to complete the activity. (2)
  a. I need support with this activity because [justify impairment score]
     - In the narrative box provided, indicate the justification for the impairment in sentence form.

       Example: I need support with communication to organize my mail and assist with arranging appointments as it is challenging to organize my thoughts and tasks since my last hospitalization.

The note may include:

- The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.
- Type of equipment used, if any. Any problems with equipment?
  b. I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].
     - In the box provided describe the individuals request for when they would like the task completed and the frequency.
     - Example: I need support twice weekly with mail and arranging appointments.

The note may include:

- Is individual able to complete the task as frequently as needed or wanted?
  c. [Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing

for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

- Who assists with the task?
- What service does this task fall under.
- Indicate the overall number of units authorized for this service type.

Example: QSP will support me by providing assistance with mail and making appointments as part of the overall service of homemaker. Total units authorized for homemaker services are **not to exceed** 70 units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

- To maintain social interaction with family and friends.
- To access emergency assistance and maintain independent living
- To maintain services

d. Other information you should know about supporting me communication:

- In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

11. Laundry

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

Can the applicant/client sort, carry, load and unload, fold and put away clothes? Consider the ability to work a coin-operated machine. Do not score if the only problem is that laundry facilities are located outside the home as the need for transportation is covered in Transportation. Consider the individual's cognitive ability to complete these tasks. Consider individual's physical and cognitive ability to complete these tasks even if applicant/client lives with others who do them for the individuals.

- Without help: Able to complete the task without the assistance of another person.
- With help: Needs some assistance from another person to complete the task.
- Cannot do at all: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity. (2)
  a. I need support with this activity because [justify impairment score]
     - In the narrative box provided, indicate the justification for the impairment in sentence form.

       Example: I need support with laundry due to overall weakness and difficulties bending, lifting and carrying laundry.

The note may include:

- The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.
- Type of equipment used, if any. Any problems with equipment?
  b. I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].
     - In the box provided describe the individuals request for when they would like the task completed and the frequency.

       Example: I need support with laundry on.

The note may include:

- Is individual able to complete the task as frequently as needed or wanted?
  c. [Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

- Who assists with the task?
- What service does this task fall under.
- Indicate the overall number of units authorized for this service type.

  Example: QSP will support me washing laundry once a week. Total units authorized for homemaker are not to exceed 70 units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

- To keep clothing and linens clean and odor free
- To maintain health and hygiene
- To prevent injury

d. Other information you should know about supporting me with laundry:
   - In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

12. Taking Medication

This item measures the ability of the individuals to take medicine by oneself. This is defined as: remembering to take medicine; getting the medicine from the place it is kept within the home; measuring the proper amounts; swallowing the pill; applying the ointment; or giving oneself injections (including the filling of syringe).

Score 0 for individuals who has no needs for medication or who perform tasks independently. Score according to client's ability to perform the task even if commonly done by others. Score need for service monitoring of medications due to possibility of overdose as a (2.) Do not include obtaining of medication from pharmacy as this is covered under Transportation.

- Without help: Able to complete the task without the assistance of another person.

- With help: Needs some assistance from another person to complete the task.
- Cannot do at all: Unable to complete or assists minimally (less than half the effort or is totally dependent on another person to complete the activity. (2)
  a. I need support with this activity because [justify impairment score]
     - In the narrative box provided, indicate the justification for the impairment in sentence form.

       Example: I need with medication due to overall weakness and diminished dexterity.

The note may include:

- The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.
- Type of equipment used, if any. Any problems with equipment?
  b. I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].
     - In the box provided describe the individuals request for when they would like the task completed and the frequency. Example: I need support with medication twice a day.

The note may include:

- Is individual able to complete the task as frequently as needed or wanted?
  c. [Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

  In the box provided describe how this need is met.
     - Who assists with the task?
     - What service does this task fall under.
     - Indicate the overall number of units authorized for this service type.

Example: QSP will support me opening my pill container and bringing me a glass of water. Total units authorized for personal care services are **not to exceed** ?? units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

- To ensure access to medications
- To maintain medication health
- To prevent injury
- Other

d. Other information you should know about supporting me with medications:
   - In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

13. Shopping

This item measures the individual ability to shop for groceries and other essentials assuming transportation or delivery is available.

Consider ability to make shopping lists, to function within the store, to locate and select items, to reach and carry purchases, to handle shopping carts, to communicate with store clerks, and to put purchases away. Do not consider banking, posting mail, monetary exchanges, or availability of transportation in scoring this item. Individual's ability to access transportation is measured under Transportation and ability to manage money is measured under Management of Money.

- Without help: Able to complete the task without the assistance of another person.
- With help: Needs some assistance from another person to complete the task.

- Cannot do at all: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity. (2)
  a. I need support with this activity because [justify impairment score]
     - In the narrative box provided, indicate the justification for the impairment in sentence form.

       Example: I need support carrying my items with shopping as I cannot bend lift and carry due to pain and overall weakness.

The note may include:

- The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.
- Type of equipment used, if any. Any problems with equipment?

  b. I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].
     - In the box provided describe the individuals request for when they would like the task completed and the frequency.

       Example: I need support with shopping one times a week.

The note may include:

- Is individual able to complete the task as frequently as needed or wanted?

  c. [Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

- Who assists with the task?
- What service does this task fall under.
- Indicate the overall number of units authorized for this service type.

  Example: QSP will support me by providing physical assistance with shopping under the overall service of

homemaker. Total units authorized for homemaker are **not to exceed** ?? units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

- To maintain independent living
- To obtain needed items, supplies and groceries
- To prevent injury

d. Other information you should know about supporting me with shopping.
   - In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

14. Mobility outside the home.

This item refers to the individual's ability to move around outside, to walk or get around by some other means (i.e., wheelchair), and to do so without assistance. Consider ability to negotiate stairs, streets, porches, sidewalks, and entrances and exits of residence and destination.

- Without help: Able to complete the task without the assistance of another person.
- With help: Needs some assistance from another person to complete the task.
- Cannot do at all: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity.

a. I need support with this activity because [justify impairment score]
   - In the narrative box provided, indicate the justification for the impairment in sentence form.

     Example: I need support mobility outside the home to access essential services such as shopping, due to overall weakness and needing assistance with my wheelchair.

The note may include:

- The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.
- Type of equipment used, if any. Any problems with equipment?

b. I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].

- In the box provided describe the individuals request for when they would like the task completed and the frequency.

Example: I need support with mobility outside the home one time per week.

The note may include:

- Is individual able to complete the task as frequently as needed or wanted?

c. [Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.]. In the box provided describe how this need is met.

- Who assists with the task?
- What service does this task fall under.
- Indicate the overall number of units authorized for this service type.

Example: QSP will support me by providing physical assistance to get outside my home to push my wheelchair as part of the overall service of personal care. Total units authorized for personal care services are not to exceed ?? units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

- To maintain independent health and living.

- To ensure safe arrival and departure
- To prevent injury or getting lost.
  d. Other information you should know about supporting me with mobility outside of my home:
    - In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

15. Transportation

This item measures an individual's ability to use transportation. For this question only, ability to use transportation includes access to a means of transportation.

Consider ability to negotiate entering and exiting of vehicle. Consider the ability to secure appropriate and available transportation and to know locations of home and essential places. Lack of appropriate and available transportation as needed, will increase the score. Consider cognitive as well as physical ability to use transportation.

- Without help: Able to complete the task without the assistance of another person.
- With help: Needs some assistance from another person to complete the task.
- Cannot do at all: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity. (2)
  a. I need support with this activity because [justify impairment score]
    - In the narrative box provided, indicate the justification for the impairment in sentence form.

      Example: I need support accessing transportation by scheduling transportation for appointments and navigating getting in and out of the vehicle due to weakness and confusion with organizing tasks.

*(For DD - This section is used to gather information as a part of the Person-Centered Planning Process. It is used to identify other needs the

individual may need to be linked with, but cannot be authorized under Medicaid State Plan)

The note may include:

- The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.
- Type of equipment used, if any. Any problems with equipment?

b. I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].

- In the box provided describe the individuals request for when they would like the task completed and the frequency.

  Example: I need support with transportation one time per week.

The note may include:

- Is individual able to complete the task as frequently as needed or wanted?

c. Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

In the box provided describe how this need is met.

- Who assists with the task?
- What service does this task fall under.
- Indicate the overall number of units authorized for this service type.

  Example: QSP will support me by providing physical assistance scheduling appointments as part of the overall service of personal care. Total units authorized for personal care services are **not to exceed** ?? units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

- To maintain health and independent living
- To access community services
- To prevent injury
    d. Other information you should know about supporting me transportation:
        - In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

16. Housework

This item refers to the individual's ability to do routine housework.

The HCBS case manager might ask the individual "Are you able to do routine housework (such as dusting)?" and "Are you able to do heavy housework (such as washing floors)?" Again, be sure to stress ability, physical and cognitive, rather than actual performance.

Consider minimum hygienic conditions required for individual's health and safety. Do not include laundry. Do not include refusal to do tasks if refusal is unrelated to the impairment.

- Without help: Able to complete the task without the assistance of another person.
- With help: Needs some assistance from another person to complete the task.
- Cannot do at all: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity. (2)
    a. I need support with this activity because [justify impairment score]
        - In the narrative box provided, indicate the justification for the impairment in sentence form.

          Example: I need support housework due to overall weakness and fatigue.

The note may include:

- The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.
- Type of equipment used, if any. Any problems with equipment?
  b. I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].
    - In the box provided describe the individuals request for when they would like the task completed and the frequency.

      Example: I need support with housework once a week for 2 hours.

The note may include:

- Is individual able to complete the task as frequently as needed or wanted?
  c. [Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

  In the box provided describe how this need is met.
    - Who assists with the task?
    - What service does this task fall under.
    - Indicate the overall number of units authorized for this service type.

      Example: QSP will support me by providing physical assistance housework as part of the overall service of homemaker. Total units authorized for personal care services are **not to exceed** 70 units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

- To prevent injury
- To maintain a safe and healthy environment
- Other [if Other] Describe

d. Other information you should know about supporting me housework:
   - In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

17. Money Management

This item refers to the individual'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 individuals may have a legal representative (guardian, conservator or representative payee).

- Without help: Able to complete the task without the assistance of another person.
- With help: Needs some assistance from another person to complete the task.
- Cannot do at all: Unable to complete or assists minimally (less than half the effort) or is totally dependent on another person to complete the activity. (2)

a. I need support with this activity because [justify impairment score]
   - In the narrative box provided, indicate the justification for the impairment in sentence form.

     Example: I need support with money management and organizing the associated paperwork due to confusion and inability to track tasks that need to be completed.

The note may include:

- The reasons why this is or is not appropriate for the individual's circumstances. Indicate if individual has been offered the service but refuses assistance.

- Type of equipment used, if any. Any problems with equipment?
  b. I need support with this task [frequency] times a [week/day/month] in the [morning/night/afternoon/no preference].
    - In the box provided describe the individuals request for when they would like the task completed and the frequency.Example: I need support money management one time per week.

The note may include:

- Is individual able to complete the task as frequently as needed or wanted?
  c. [Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].

  In the box provided describe how this need is met.
    - Who assists with the task?
    - What service does this task fall under.
    - Indicate the overall number of units authorized for this service type.

      Example: QSP will support me by providing assistance with going through my mail and paperwork as part of the overall service of homemaker. Total units authorized for personal care services are **not to exceed** 70 units a month.

Indicate the appropriate outcome of the service authorized, if other indicate in the text box the appropriate outcome.

Outcomes

- To maintain independence
- To ensure timely and accurate payment of bills
- other
  d. Other information you should know about supporting me money management:

- In this box indicate any other information that the individual may want the provider to know about how or why they prefer cares a certain way.

18. If Support person cannot assist me with these IADLS, (contingency plan).

Individual Specific Needs 535-05-60-25

(Revised 10/01/2024 ML #3781)

View Archives

Some individual needs require additional training and expertise for a qualified service provider to assist the individual with their individual specific needs. The specific needs are grouped into two categories and may require the QSP to get additional education. The case manager must ensure that the authorized QSP has the correct global endorsements or have been trained in the "Client Specific Needs" and this is listed on their QSP status in order for the QSP to be able to perform the task.

The Global Endorsements are:

A. Maintenance Exercise
B. Catheter Care
C. Medical Gases-Limited to oxygen
D. Suppository-non-prescription
E. Cognitive/Supervision (REQUIRED for RESPITE CARE, SUPERVISION & COMPANIONSHIP SERVICES) (Not available through DD as there is a specific service for this need)
F. Taking Blood Pressure, Pulse, Temperature, Respiration Rate
G. Ted Stockings (surgical stockings)
H. Prosthesis/Orthotics/Adaptive Devices
I. Hoyer Lift/Mechanized Bath Chair

The following Client Specific Endorsements (J-N) require verification of the provider's ability to provide the service for a particular client who requires the endorsement. Note: Send the completed Request for Client Specific Endorsement, SFN 830 to Medical/HCBS Services only if the client's case manager has authorized service for that endorsement.

J. Ostomy Care
K. Postural Bronchial Drainage
L. Jobst stockings (compression stockings)
M. Rik/Specialty Bed Care
N. Apnea Monitoring (is available only to a provider meeting the standards for Respite Care)

19. Individual specific needs/other services/global endorsements

- Apnea monitor*
- Cognitive/supervision*
- Community integration
- Exercises*
- Eye care
- Fingernail care (may not be authorized if individual has diabetes, heart or other circulatory conditions)
- Hair care/shaving
- Hoyer lift*
- Indwelling bladder catheter*
- Jobst stockings
- Ostomy care
- Oxygen/medical gases*
- Postural/bronchial drainage
- Prosthesis/orthotics*
- Skin care
- Social appropriateness
- Specialty bed (Ric)*
- Suppository/Bowel Program*
- Ted socks*
- Teeth, mouth, denture care
- Vital signs**
- Care Coordination
- Emergency Response System
- Nurse Education
- Extended Personal Care
- Extended Personal Care – Nurse
- Chore per Job
- Chore Labor
- Chore Labor (lawn)
- Chore Labor (snow removal)

The tasks with an asterisk require additional information and documentation on file. The additional information is as follows:

A written, signed recommendation for the task of Vital Signs provided by a nurse or higher credentialed medical provider must be on file which

outlines the requirements for monitoring, the reason vital signs should be monitored, and the frequency.

When the tasks of Temp/Pulse/Respiration/Blood Pressure are authorized, the individual to be contacted for readings must be listed on the PreAuth in Therap.

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

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

Specialized Support

a. I need support with these activities because [justify impairment score]
b. I need support with this task [frequency] times a [day/week/month] in the [morning/night/afternoon/no preference].
c. [Provider/Natural support] will support me with this task as part of the overall service of [example: personal care, respite care, community supports, etc]. Total units authorized for this overall service are not to exceed [total monthly units you are authorizing for the overall service such as personal care, respite care, community supports, etc.].
d. Other information you should know in supporting me with specific needs

Quality Review 535-05-60-30

(NEW 10/01/2024 ML #3781)

View Archives

Case Managers are required to continuously monitor to ensure an individual is being afforded the rights of privacy, dignity and respect, and freedom from coercion and restraint (including the limited use of restraints that are allowable under Adult Residential Services). The Quality Review process is used to obtain information from individuals/responsible parties that is related to quality and quantity of services. The information is aggregated and reviewed by the department to develop quality measures and services.

The Quality Review is to be completed for all individuals, regardless of funding source, with the exception of Basic Care. The Quality Review helps to determine an individual's satisfaction with services but is also used to determine compliance with the HCBS settings rule. Any violations of rights must be reported to Program Administration. This section is to be completed during the annual assessment and six-month review. This section is not to be completed during an initial assessment, as services have not yet been implemented.

Caregiver Assessment 535-05-60-35

(NEW 10/01/2024 ML #3781)

View Archives

The caregiver assessment must be completed initially and every six months for all formal/paid live-in providers, including unit and daily rate paid live-in providers.

Discuss options for respite care and other programming that may provide caregiver supports and relief. Options may include support groups, Powerful Tools for Caregiver evidence-based training, socialization opportunities, the Alzheimer's Association, etc. This assessment may be done via telephone if the individual is not able to participate in a face-to-face meeting.

Risk Assessment and Health Safety Plan 535-05-60-40

(NEW 10/01/2024 ML #3781)

View Archives

Home and Community Based Services Policies and Procedures 525-05

Risk Assessment & Health and Safety Plan 525-05-60-120

Notes and Narratives 535-05-65

(Revised 10/01/2024 ML #3871)

View Archives

Include all information relevant to the individual obtained during the assessment process that was not entered in a comment or note field for ADLs or IADLs. A signed and dated hard copy of the assessment including the narrative must be kept in the individual file.

All contacts relating to a individual must be noted in the narrative section of the comprehensive assessment. Notes maintained in any other format are not considered valid. When applicable, notes/narrative should include the following:

- Date
- Reason for contact (i.e. initial, annual, six month, collateral, returned call, received call)
- Location of visit (i.e. home visit, care conference, hospital visit, office visit, telephone contact, letter sent)
- A description of the exchange between the case manager and the client or the collateral contact
- Whether the exchange was face to face or by other means
- Individual satisfaction and follow-up plan

HCBS Case Managers Record Management System

- HCBS Case Management Records Including- Service Activities, Standards of Performance, and Documentation of HCBS Case Management Activities are maintained in a secure web-based case management system and individual case files.
    - All case files, or in the web-based case management system should have (at a minimum):
        1. Application for Service SFN 1047
        2. A signed copy of Your Rights and Responsibilities brochure (DN 46)

3. Preauth for Medicaid Waiver, SPED/Ex-SPED, and MSP (updated every six months)
4. HCBS Notice of Denial or Termination SFN 1647 (if applicable)
5. HCBS Case Closure/Transfer Notice SFN 474 (if applicable)
6. An end dated or deleted Preauth (if applicable)

DD Case Managers Record Management System

- The DD Case Managers comprehensive assessment consists of three components;

1. Case Plan in THERAP that identifies the desires outcomes and all services the individual is receiving.
2. Progress Assessment Review (PAR) in THERAP that includes information regarding diagnoses, medications, behavioral issues, psychiatric, legal and support needs. The PAR and Case Action Form also serve as the ICF/MR level of care screening.
3. Personal Care Eligibility and Needs Assessment for DD that determines whether the specific eligibility for Personal Care Services are met.

Notes and Narratives 535-05-65

(Revised 4/1/12 ML #3326)

View Archives

Include all information relevant to the client obtained during the assessment process that was not entered in a comment or note field for ADLs or IADLs. A signed and dated hard copy of the assessment including the narrative must be kept in the client file.

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. When applicable, notes/narrative should include the following:

- Date
- Reason for contact (i.e. initial, annual, six month, collateral, returned call, received call)
- Location of visit (i.e. home visit, care conference, hospital visit, office visit, telephone contact, letter sent)
- A description of the exchange between the case manager and the client or the collateral contact
- A listing of identified needs
- Service delivery options
- Summary of care plan
- Client satisfaction and follow-up plan
- Initial's of Case Manager completing the note or narrative

HCBS Case Managers Record Management System

- The HCBS Comprehensive Assessment is a web-based product of Synergy Technologies. 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.

DD Case Managers Record Management System

- The DD Case Managers comprehensive assessment consists of three components;

    1. Case Plan in THERAP that identifies the desires outcomes and all services the individual is receiving.
    2. Progress Assessment Review (PAR) in THERAP that includes information regarding diagnoses, medications, behavioral issues, psychiatric, legal and support needs. The PAR and Case Action Form also serve as the ICF/MR level of care screening.
    3. Personal Care Eligibility and Needs Assessment for DD that determines whether the specific eligibility for Personal Care Services are met.

Forms 535-05-70

Instructions for Completing Personal Care Services Plan, SFN 662 535-05-70-01

(Revised 10/01/2024 ML #3871)

View Archives

A Basic Care Case Manager or Developmental Disabilities Program Manager will complete an SFN 662 for each initial assessment, annual assessment, or when changes in level of care occur.

Section I – Client Information

Case Manager will fill in the individual's name, ND number, physical address, county of residence, city, state, zip code, and date the comprehensive assessment occurred.

Section 2 – Personal Care Services Eligibility

Activities of Daily Living (ADL) Scoring

Case manager will assess the individual's activities of daily living (ADL) to determine if the applicant or individual's meets the functional eligibility requirements. The individual must score a 2 in at least one area to meet impairment requirements to screen by ADL scoring.

1. Bathing
2. Eating
3. Inside Mobility
4. Transferring
5. Dressing
6. Toileting
7. Continence

Instrumental Activities of Daily Living (IADLs) Scoring

Only four IADLs are used when determining if an individual is eligible to receive personal care service. **The individual must score at minimum a**

1 on three out of four IADLS including meal preparation, laundry, medications, or housework. If an individual is eligible for personal care services, he/she may receive assistance with IADLs that are not considered when determining the eligibility for personal care services but have been scored a 1 or 2.

1. **Meal Preparation**
2. **Housework**
3. **Laundry**
4. **Taking Medication**

Instrumental Activities of Daily Living (IADLs) Not Considered in Determining Eligibility for Personal Care Services

1. **Shopping**
2. **Mobility Outside**
3. **Management of Money**
4. **Communication**

Obtain information regarding ADL or IADL impairments by observation, interview with family or friends, or by direct self-report of the individual. Narratives must be included in the electronic health record for each ADL or IADL identified as an impairment. Narratives must include:

- Reason for inability to complete the task.
- The kind of aids (grab bars, bath stool etc) the individual uses
- The kind of help the individual is receiving and frequency of assistance
- What services and the frequency the individual require to meet needs
- Outcome anticipated as a result of service provision
- Other relevant information

Section III – Approved Services

Case manager will enter:

1. **Provider** – Must be an approved provider listed on the "Basic Care Authorized Facilities" spreadsheet
2. **Provider Number** – Enter provider number listed on the "Basic Care Authorized Facilities" spreadsheet
3. **Provider NPI Number**– Enter provider's NPI number listed on the "Basic Care Authorized Facilities" spreadsheet
4. **Billable days** – Enter "31"

Section IV – Assessment Type and Reductions

Case manager will:

1. Service Reduced: Check mark "Yes" or "No" if there is a service reduction
2. If the answer was "Yes"
    a. Reference Medicaid State Plan – Personal Care Services Policy, "Reductions, Denials, and Terminations 535-05-50"
    b. Obtain citation code from Medicaid State Plan Program Administrator
    c. Services are reduced in accordance with 42 CFR 440.230 and N.D. Admin. Code 75-02-02-09.5 for the following reason(s): Enter reason(s)

3. Review the reduction citation with the individual and/or legal decision maker
4. Enter date which service reduction will be effective (must be no sooner than 11 days after the individual signs the Personal Care Service Plan) Review the reduction citation with the individual and/or legal decision maker
5. Reason for Completing Plan or Change in Existing Care Plan – Mark whether the Personal Care Service Plan of Care was an initial assessment, annual assessment, other change – describe, or current care plan terminated – date.
6. Review assurances with individual including:
    a. I selected the services and providers listed above.
    b. I am aware that I may have a recipient liability.
    c. I am aware that if my Medicaid Eligibility terminates, I will no longer be eligible for services listed above.
    d. I am aware that the services and estimated cost is subject to change based on legislative action.

e. I have been given a copy of my appeal rights (Right to Hearing).
f. f. I am not in agreement with this plan.

Section V – Authorized Tasks

Case manager will check mark all applicable services the individual is eligible to receive.

Case manager will enter:

1. Effective Date of Plan:
    a. Initial assessments:
        i. "From" date will be the approval date received from Long-Term Care Medicaid Eligibility Unit
        ii. "To" date will be no more than three-hundred and sixty-five (365) days from initial functional assessment.
    b. Annual assessment:
        i. "From" date will be the first day of the month preceding the assessment date, e.g., a functional assessment was completed on 8/16/2024, the effective date of the plan would be 9/1/2024.
        ii. "To" date will be no more than 365 days following the annual assessment, e.g., From: 9/1/2024 – To: 8/31/2025.

2. Review Personal Care Services Plan of Care and Authorization in a Licensed Basic Care Setting with the individual and legal decision maker
3. If the individual and/or legal decision maker agree with the plan, ask the responsible person to sign and date the care plan.
4. Sign the care plan, check mark if the case manager is an HCBS or DDCM, and date the care plan.
5. Route signed copies of the care plan to the individual and/or legal decision maker preferred method of communication, email to DHHS Fax Line (dhshcbs@nd.gov), the basic care, and retain a copy in the individual e-file.

Instructions for Completing HCBS Notice of Reduction, Denial or Termination, SFN 1647 and SFN 1009 (DD) 535-05-70-10

(Revised 10/01/2024 ML #3871)

View Archives

Reference: HCBS Policy HCBS Notice of Denial or Termination, SFN 1647 525-05-60-75

HCBS Case Closure/Provider Termination, SFN 474 or SFN 1008 (DD) 535-05-70-13

(Revised 10/01/2024 ML #3781)

View Archives

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

Application for Service, SFN 1047 535-05-70-15

(10/1/09 ML #3199)

View Archives

Purpose: For individuals to formally request Home and Community Based Services and Medicaid State Plan Personal Care Service.

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

- Date – date of application;
- Agency – County Social Service Board of applicant's physical county;
- Name – print the name of the applicant (one SFN 1047 per applicant);
- I apply for services to assist me with – the applicant indicates what services or programs for which the applicant is requesting assistance;
- FOR YOUR INFORMATION – applicant must read this section prior to signing;
- The applicant must check to acknowledge the receipt of the "Your Rights and Responsibilities" brochure. (The Brochure # is DN46;
- Signature section – the applicant and/or the legal representative must sign and date the application form.