

I. Intake

A. Definitions

Abuse: means infliction of or intent to inflict physical pain or injury on or the imprisonment of any incapacitated adult.

Adult Emergency Shelter Care Home: means a home that is available on a short-term, emergency basis for residential care type clients for whom no other appropriate alternatives currently exist, agreeing to accept placement on a twenty-four (24) hour basis.

Adult Emergency Shelter Care Provider: means an individual or family unit that has been certified by the Department of Health and Human Resources to provide support, supervision and assistance to adults placed in their home at any time on short notice.

Adult Family Care Home: means a placement setting within a family unit that provides support, protection and security for up to three individuals over the age of eighteen.

Adult Family Care Provider: an individual or family unit that has been certified by the Department of Health and Human Resources to provide support, supervision and assistance to adults placed in their home for which they receive payment.

Cognitive deficit: means impairment of an individual's thought processes.

Emergency: means a situation or set of circumstances which present a substantial and immediate risk of death or serious injury to an incapacitated adult.

Incapacitated Adult: means any person who by means of physical, mental or other infirmity is unable to independently carry on the daily activities of life necessary to sustaining life and reasonable health.

Neglect: means the failure to provide the necessities of life to an incapacitated adult or resident of a nursing home or other residential facility with the intent to coerce or physically harm such incapacitated adult or resident of a nursing home or other residential facility **or** the unlawful expenditure or willful dissipation of funds or other assets owned or paid to or for the benefit of an incapacitated adult or resident of a nursing home or other residential facility.

Physical deficit: means impairment of an individual's physical abilities.

B. Introduction and Overview

Adult Emergency Shelter Care homes are placement settings for adults that provide support, supervision, protection and security in a family setting. This may be an appropriate option for individuals who are no longer able to safely remain in their own homes due to physical, cognitive, and/or emotional deficits. Although an individual may be experiencing deficits in one or more of these domains, the deficits are not significant enough to warrant the level of care provided in a nursing home. Placement in this type of setting is limited to a maximum of thirty (30) days in a twelve (12) month period.

The Adult Emergency Shelter Care provider must be certified by the Department of Health and Human Resources. Once certified, the provider may provide care in their home for no more than three adults. The provider receives payment for the care provided in the form of a monthly stipend to ensure bed availability and an additional payment for each individual placed in the home by the department.

C. Eligibility Criteria

Adult Emergency Shelter Care and the associated services, including evaluation of need, placement, supportive services, supervision and discharge planning, are available to adults who are no longer able to remain in their own home and require an alternate living arrangement due to physical, mental, or emotional limitations. Eligibility for placement in this type of setting is not limited by type and amount of client income. (See [Payment](#) and [Comprehensive Assessment](#) for detailed information). In order to be eligible to receive Adult Emergency Shelter Care services, the individual must meet at least one (1) of the following criteria:

- he/she must be age sixty-five (65) or older;
- he/she must be at least eighteen (18) years of age and have an established or presumed disability that indicates the need for supervised care; **or**,
- he/she be at least eighteen (18) years of age is currently receiving Adult Protective Service or APS Preventive Services from the department; **and**,
- have not exhausted the maximum thirty (30) days of placement in ESC permitted in a twelve (12) month period.

In the case of eligibility based on an active APS or APS Preventive Services case, Adult Emergency Shelter Care must be needed to eliminate the abuse, neglect or exploitation that was verified during the APS investigation. Further, the identified problem area(s) and the use of ESC to address these must be documented in the client's service plan.

D. Required Information

Basic identifying information and detailed information about the client's needs are to be gathered during the Intake process. This information must be sufficient to determine the type of services and/or assistance being requested, the specific needs of the individual, and other relevant information. At a minimum, the following must be included if known:

- name of client;
- date of birth or approximate age of the client;
- social security number;
- client's current living arrangements;
- household composition of client's former home;
- physical address of client's former home;
- telephone number of client's former home;
- directions to client's former home;
- significant others - relatives, neighbors, friends;
- legal representative(s), if known;
- reporter/caller information, if different than client;
- type of service(s) reporter/caller is requesting;
- specific needs of the client;
- description of how needs are currently being met; and,
- other relevant information.

When the intake information is completed, the intake worker is to conduct a search to determine if the agency has had prior contact with the client. At a minimum, this search must include the FACTS system. When the search is completed the request to receive Adult Emergency Shelter Care services is to be forwarded to the appropriate supervisor for further action.

II. Assessment

Prior to a client being considered for placement in an Adult Emergency Shelter Care home, the social worker must gain a thorough knowledge of the client, their needs, wishes, strengths and limitations. Assessment is essential to gaining this level of understanding.

A. Screening of Referrals

Upon receipt of the referral, the supervisor will review the information collected during intake. If the intake appears to meet the criteria for Adult Emergency Shelter Care services, the supervisor will assign the referral to a social worker for additional follow-up, including completion of a Comprehensive Assessment. If the intake does not appear to meet the criteria for Adult Emergency Shelter Care services the supervisor may take one of four actions:

- screen the referral out and take no further action;
- screen the referral out for Adult Emergency Shelter Care and redirect the referral to another unit within the department that is appropriate to meet the identified need(s);

- screen the referral out and forward a referral to the appropriate entity(ies) outside of the department; or,
- assign the intake to a social worker to contact the client and/or referent to gather additional information so a determination may be made.

Whenever a referral is screened out by the supervisor for any reason(s), the reason for the screen out must be documented in FACTS. Finally, if not completed previously by the intake worker, the supervisor is to complete a search of the FACTS system to determine if other referrals/investigations/cases already exist for the identified client.

B. Comprehensive Assessment

A thorough assessment must be completed for each individual who has requested to receive Adult Emergency Shelter Care Services and is subsequently assigned to a social worker. In order to develop a detailed understanding of the client and their needs, the social worker must conduct a face-to-face contact with the client and complete the Comprehensive Assessment. Completion of the Comprehensive Assessment involves interviews with the client and other significant individuals. The information that is to be considered during the assessment phase and recorded on various screens in FACTS is outlined below. This information will then be used as the basis for the client's service plan.

Note: The Comprehensive Assessment form, when printed, will not necessarily reflect all of the information outlined in the following sections. It is, however, appropriate to gather all of the information as part of the assessment process.

1. Time Frames:

A Comprehensive Assessment, including face-to-face contact with the client and development of the service plan, must be completed for each individual who is assigned for assessment for Adult Emergency Shelter Care services. This assessment must be completed within thirty (30) calendar days following the date the case is assigned for assessment. Since placement in Adult Emergency Shelter is limited to thirty (30) days, it is essential that the Comprehensive Assessment be completed as soon as possible following placement in the ESC home to allow time to arrange alternate placement upon discharge from the ESC.

2. Information to Be Collected:

a. Identifying Information

Demographic information about the client, their family and their unique circumstances is to be documented. This includes information such as (not an all inclusive list):

- name;
- address (mailing and residence);
- telephone number;
- date of birth/age;
- household members;
- other significant individuals;
- legal representatives/substitute decision-makers (if applicable);
- identification numbers (SSN, Medicaid, Medicare, SSA Claim, etc.);
- gender/ethnicity;
- marital status; and,
- directions to the home.

b. Referent Information

Information about the person(s) making the referral is to be documented. With requests to receive Adult Emergency Shelter Care services the client frequently will make the request on their own behalf. If this is the case, the social worker must indicate that this is a self-referral and documentation of additional referent information is not necessary. When the referent is someone other than the client, the information to be gathered must include but is not limited to the following:

- referent name;
- referent address;
- referent telephone number
- relationship to the client
- how they know of the client's needs; and,
- other relevant information.

c. Services Requested

Document the specific services being requested. This should include information such as the following:

- the specific type(s) of assistance being requested;
- why assistance is being requested;
- how needs are currently being met; and,
- other relevant information.

d. Living Arrangements

Document information about the client's current living arrangements. This should include information about where the client currently resides such as the following:

- client's current location (own home, relative's home, hospital, etc.);

- is the current setting considered permanent or temporary;
- type of setting (private home/residential facility, etc.);
- household/family composition;
- physical description of the current residence (single family dwelling, duplex, townhouse, apartment, retirement community, foster home, group home, nursing facility, etc.);
- interior condition of the residence;
- exterior condition of the residence;
- type of geographic location (rural, urban, suburban, etc.);
- access to resources such as family/friends, transportation, shopping, medical care/services, social/recreational activities, religious affiliations, etc.

e. Client Functioning

Document information about the client's current physical and medical conditions. This should include information about the physical condition and description of the client during the face-to-face contact as well as information about their diagnosed health status. Included are areas such as:

- observed/reported physical conditions of the client;
- primary care physician;
- diagnosed health conditions;
- current medications;
- durable medical equipment/supplies used; and,
- nutritional status including special dietary needs, if applicable.

f. Mental/Emotional Health

Document information about the client's current and past mental health conditions. This should include information about how the client is currently functioning, their current needs and supports, and his/her past history of mental health treatment, if applicable. Included are areas such as:

- current treatment status;
- current mental health provider;
- mental health services currently receiving;
- medication prescribed for treatment of a mental health condition;
- prescribing/treating professional;
- observed/reported mental health/behavioral conditions; and,
- mental health treatment history.

g. Financial Information

Document information about the client's current financial status. This should include information about the client's resources and his/her ability to manage these independently or with assistance. The thoroughness and accuracy of financial information is especially critical for

clients who will receive other adult residential services that will be paid in part by the department. Included are areas such as:

- financial resources - type, amount and frequency;
- other resources available to the client: non-financial;
- assets available to the client (can not exceed a maximum of \$2,000 to be eligible for other adult residential services);
- outstanding debt(s) owed by the client;
- extraordinary expenses;
- health insurance coverage; and,
- information about the client's ability to manage their own finances.

h. Educational/Vocational Information

Document information about the educational/vocational training the client has received or is currently receiving. This should include information such as:

- last grade completed;
- field of study;
- history of college attendance/graduation; and,
- history of special licensure/training.

i. Employment Information

Document information about the client's past and present employment, including but not limited to sheltered employment. Information should include:

- current employment status;
- current employer;
- type of employment; and,
- prior employment history.

j. Military Information

Document information about the client's military history, if applicable. This should include information such as:

- branch of service;
- type of discharge received;
- date of discharge; and,
- service related disability, if applicable.

k. Legal Information

Document information about the client's current legal status. This should include information about all known legal representatives, and the specific nature/scope of that relationship. This should include information such as:

- assessment of the client's decision-making capacity by the social worker;

- information about legal determination of competence, if applicable;
- information about efforts to have the client's decision-making capacity formally evaluated; and,
- identification of specific individuals who assist the client with decision-making.

3. *Conclusion of Comprehensive Assessment:*

When the Comprehensive Assessment is completed, all the information and findings are to be documented in FACTS. This, along with the service plan that was developed as a result of the assessment findings, is then to be submitted by the social worker to the supervisor for approval.

C. Criteria for Selection of ESC Clients

It is important for the social worker to complete a thorough assessment of the client in order to determine if Adult Emergency Shelter Care is an appropriate placement option. If so, a client who is being considered for this type of placement setting must meet the following criteria. They must be:

- in need of supportive living in order to remain in or return to a community living setting;
- ambulatory and capable of self preservation - able to vacate the premises independently in an emergency (devices to aid ambulation such as a wheelchair or walker may be permitted only if the client is capable of using the device unassisted and he/she is able to remove themselves from the home by his/her own power);
- able to care for his/her own personal needs such as bathing and dressing with minimal assistance or has the capacity to develop these skills with training from the ESC provider and/or other professional;
- alert and stable enough to be able to express their wishes regarding their living arrangements and able to participate in planning for their needs **or** has been determined by a medical professional to be in need of Adult Emergency Shelter Care and able to benefit from placement;
- able, or have a legally appointed representative who is able, to understand what Adult Emergency Shelter Care is and expresses a desire for this type of placement;
- agreeable to placement in an ESC on a voluntary basis and willing to follow established "house rules";
- unable to live alone as a result of physical or mental incapacity;
- no other suitable living arrangements are available; and,
- free from communicable disease, to the best of the worker's knowledge, that would endanger the health of others.

In addition, they must **NOT**:

- be in need of nursing home care;
- be in need of acute medical or psychiatric care;

- be incontinent;
- be intoxicated by alcohol or drugs; or,
- dangerous to themselves or others (“dangerous” means a person who currently exhibits or has exhibited behavior that can or is likely to result in infliction of injury or damage to other persons or property)

III. Case Management

Once a client has been opened as a recipient of Adult Emergency Shelter Care services, various case management activities must occur. These include tasks such as:

- advising the client of their approval to receive Adult Emergency Shelter Care services;
- location and selection of an appropriate provider;
- arranging placement of the client in the Adult Emergency Shelter Care home;
- explaining the payment process to both the client and the provider;
- completing all documentation in FACTS necessary to generate the Payment Agreement;
- review the completed Payment Agreement with the provider and secure the necessary signatures;
- in conjunction with the client, the provider and other appropriate parties, develop the service plan;
- arrange for additional services for the client and/or provider as appropriate; and,
- monitor the case as required, making modifications and changes as indicated.

A. Placement

When placement of an adult in an Adult Emergency Shelter Care home is being considered, it is important to consider both the needs of the client and the characteristics of the Adult Emergency Shelter Care home. How successful the placement is often depends on how good a “match” there is between the client, the provider and other members of the Adult Emergency Shelter Care household, including other clients in placement. Careful consideration of these factors prior to placement can facilitate a successful placement and minimize placement disruptions later.

1. Selection of the Provider:

The successful placement of a client in an Adult Emergency Shelter Care home will depend largely on assuring a good “match” between the client being placed and the provider. In order to ensure as good a match as possible, the social worker must evaluate the client in the following areas:

- current physical health status and medical history;

- current mental/emotional/cognitive status and history;
- current medications and ability to self-administer medication;
- individual or special needs as viewed by the client, the physician, and the social worker;
- the client's expressed wishes regarding his/her living arrangements;
- family, friends and community ties, who and where these are located and assistance they are willing to provide to the client;
- family experiences of the client such as the kind of home life he/she had and attitude toward any remaining family;
- educational and employment history;
- religious preferences, interests, hobbies, likes and dislikes, and personal habits;
- household possessions or pets and plans for what will be done with these;
- physical appearance and personal characteristics (e.g. neat/untidy, withdrawn/outgoing);
- behavior problems that are currently present or that have been present in the past;
- problems with any prior placement;
- unusual habits that could be problematic for a provider; and,
- financial resources such as income, medical insurance and assets.

2. *Client Medical Evaluation:*

Whenever possible, the client must have a medical evaluation completed by their regular physician prior to placement in an Adult Emergency Shelter Care home. If completion prior to placement is not possible, the social worker must **arrange for** this evaluation to be completed within two (2) working days following placement. Completion of this form serves two purposes. It documents the current health status of the client and it indicates that he/she is free of communicable diseases to the best of the physician's knowledge.

The first section contains identifying information about the client and is to be completed by the social worker. The remaining portions of the form relate to the client's current condition(s), diagnosis, and special needs he/she may have. These portions are to be completed by the client's physician. The completed form is to be returned to the department. The social worker must enter all relevant medical information about the client and his/her physician in the appropriate areas of FACTS. Finally, the completed report must be filed in the client's case record (paper) and the location of this evaluation noted in FACTS.

Note: The Client Medical Evaluation is available as a DDE and may be accessed through the reports area of FACTS.

3. *Ongoing Medical Care for ESC Clients:*

All clients placed in an Adult Emergency Shelter Care home are to receive ongoing medical care throughout their placement. If the client does not have an attending physician at the time of

placement, he/she will be assisted in the selection of one of his/her choice. The physician is to be consulted as needed regarding any medication, special diet, or other routine health supervision.

4. *Required Notification of Placement:*

At the time placement of the adult in the Adult Emergency Shelter Care home is completed, the social worker must send/ensure notification of the placement to certain parties. Specifically, if the adult is receiving any services through Office of Family Support (e.g. Food Stamps, Medicaid, Emergency Assistance, etc.), written notification is to be provided advising them of the placement. This notification is to be done using the Interdepartmental Referral Form (DHS-1) and must include the type of placement the client resides in, the date placement became effective, the client's new address and telephone number, client identifying numbers such as SSN, SSA Claim number, Medicaid number, etc., the name of the provider, and the monthly amount paid by the client to the provider for his/her care.

Also, notification of the client's change of address and living arrangements must be sent to all of the client's sources of income. This notification may be done by the client, the provider, or another responsible party. The social worker, however, should follow up with the individual designated to provide this notification to ensure that this is done promptly. If not handled promptly, problems may result in the provider receiving payment from the client in a timely manner. In the event the social worker sends this notification, the Interagency Referral Form is to be used.

5. *Contact by the Social Worker:*

During the first week following placement, the client and provider will need regular guidance and support from the social worker to ensure a smooth adjustment. The social worker is to maintain regular contact with the client and provider during this adjustment period to monitor the client's and the provider's adaptation to the new placement and to assess the client's functioning in the home. The social worker must conduct a visit to the home when the client first arrives, and a follow-up visit within one (1) week following placement. The social worker must maintain frequent contact throughout placement in order to facilitate appropriate discharge.

6. *If the ESC Placement Fails:*

It is essential that the social worker carefully consider the characteristics and needs of the client and the characteristics and resources of the provider in order to ensure as good a match as possible. If, after placement, problems arise, the social worker will work with the provider to arrange the assistance and/or training necessary to aid the provider in furnishing appropriate care to the client. If, after the social worker has provided or arranged for all appropriate assistance,

the arrangement remains unworkable, the social worker shall arrange for placement of the client with another provider who is better able to address the client's needs.

After a successful match is found and the client is placed with a new provider, the social worker must monitor the new placement carefully. While it is important to maintain regular contact with both the provider and client during the week immediately following any placement, this is especially important when the placement has occurred as a result of a failed placement in another setting. Frequent contact with the client and provider will ensure the support and opportunity necessary to promptly identify problems, should these occur, and seek appropriate resolution.

B. Payment by the Office of Social Services

Providers of Adult Emergency Shelter Care services may receive reimbursement from the department in one of two ways, automatic payment and demand payment. Reimbursement to the provider for the care and supervision furnished to the client will be done by automatic payment. Demand payments are available for a very limited and specific set of expenses that may occur in an Adult Emergency Shelter Care setting.

1. Automatic Payments:

Payment due to an Adult Emergency Shelter Care provider is done automatically by FACTS. The provider receives a monthly payment for each approved bed. The stipend rate is established by the department (current stipend rate is \$84/bed/month). In addition, the provider receives a payment for each individual placed in their home at the maximum monthly/daily Adult Family Care (AFC) rate in effect during the period of placement. The monthly stipend payment is generated by FACTS based on selection of the Emergency Shelter Care provider type. In addition, payment to the provider for the care of each individual placed in their home is automatically created by FACTS, based on the enter/exit dates entered.

In order to assure that payments to the provider are accurate and received by the provider without delay, it is essential that the social worker enter the required information in a timely manner. Payment information and supervisory approval must be completed by noon on the fourth working day of the month following the month in which placement was made in order to prevent inaccurate or delayed automatic payment. Payment information that is not entered and approved by noon on the fourth working day will require the social worker to request a demand payment for the purpose of doing a payment adjustment/correction.

Finally, prior to the end of business on the fourth working day the social worker must review the monthly payment approvals screens in FACTS in order to verify that the payment information in the system and due for release during the next payment cycle is accurate. If there are errors

detected, the social worker must make the necessary changes prior to the fourth working day of the month. If no errors are detected, the social worker must verify the payment shown.

2. *Payment Agreement*

This agreement, which is completed during the case management phase of the case work process, is the document which sets forth the terms of payment for placement. This form also is a placement agreement that the social worker completes with the client and the provider. This agreement specifies: 1) the terms of payment, 2) a statement by the client that he/she agrees to temporary placement in the ESC and, 3) a statement by the provider that they are willing to accept the client in placement.

This payment agreement is created by FACTS based on information entered by the social worker. After all required documentation is completed, the Payment Agreement may be printed and all required signatures obtained. Finally, a copy of the signed agreement is to be furnished to the provider and the client, the original signed document filed in the client case record (paper record), and record in document tracking where the original signed document is located.

This form is available in the FORMS section of this policy for informational purposes. In addition it is available as a DDE in FACTS and may be accessed through the report area. It may be opened as a WordPerfect document, populated with information that has been entered in FACTS.

The completed document must then be saved to the FACTS file cabinet for the case. Creation of this form must be documented in the document tracking area of FACTS. Finally, after printing the Payment Agreement, the worker must secure all required signatures, provide the client and all signatories with a copy, file the original signed document in the client case record (paper record), retain a copy in the provider record, and record in document tracking where the original signed document is located.

3. *Demand Payments:*

Most costs associated with the care of an adult placed in an Adult Emergency Shelter Care home will be included in the monthly reimbursement paid to the provider by automatic payment. There are, however, certain specific costs that may be incurred that are not included in that monthly reimbursement. The demand payment process may be used to request reimbursement for certain costs incurred for/on behalf of clients placed in an Adult Emergency Shelter Care home by the department **or** for specific expenses incurred by the Adult Emergency Shelter Care home

provider that are not client specific. The need for a demand payment of any type must be determined jointly by the social worker and the provider **prior** to any cost being incurred and must be reflected in the client's service plan.

Some demand payment types require a two-tiered approval meaning they must first be approved by the supervisor and then must also be approved by the Office of Social Services. Those payment types that require a two-tiered approval are marked with an (*) in the list below. The demand payment will not be generated by FACTS and sent to the provider until the required approval(s) is done. **Only the following demand payment types are permitted:**

Payments requiring supervisory approval

- payment adjustment (to correct underpayment to provider);
- client medical evaluation;
- co-payment on prescription medications;
- provider training incentive payment (not client specific);
- annual provider medical report (not client specific);

Payments requiring both supervisory and Office of Social Services approval

- *durable medical equipment and supplies;
- *food supplements;
- *over-the-counter drugs/DESI drugs or prescriptions not covered by insurance/Medicaid;
- *non-Medicaid covered services; and,
- *other demand payments.

Demand payments are done on a weekly basis, based on information entered in FACTS by the social worker. Information that is required in order for FACTS to generate demand payments include:

- information identifying the provider to be paid;
- client for whom request is being made, if applicable;
- invoice date;
- service month;
- amount to be paid;
- payment type; and,
- explanation of why the payment is necessary.

When a demand payment is needed, the social worker must enter the required information in FACTS. The payment information must then be forwarded to the supervisor for approval. Demand payments require supervisory approval. For certain demand payment types, approval by the Office of Social Services is also required in addition to the supervisory approval.

Finally, after the required approval(s) is granted, the social worker must review the payment on the demand payment verification screen to ensure that the amount to be paid to the provider is accurate. If the payment is accurate, verify the payment. If not, identify and resolve the problem(s).

Note: In order for any provider or vendor to receive payment through FACTS, the provider/vendor must be set up as a provider in FACTS.

a. Payment Adjustment

This demand payment type is to be used for the purpose of correcting an under payment to an Adult Emergency Shelter Care provider. An under payment may occur when the social worker is unable to complete the placement process, including all applicable documentation in FACTS, prior to the deadline for entering payment/placement information. A payment adjustment may be requested to reimburse the provider for any unpaid portion due.

b. Client Medical Evaluation

Each client placed in an Adult Emergency Shelter Care home (ESC) should have a current medical evaluation (within three months prior to placement in the ESC). If the client has not had a medical evaluation completed within the three months prior to placement in the ESC **OR** if the worker believes there is need for a more current evaluation due to changes in the client's functioning/circumstances, the social worker is to arrange for a medical examination within two (2) working days following placement in an Adult Emergency Shelter Care home. If the ESC provider arranges for payment for the evaluation, the provider may submit the receipt to the department to request reimbursement. If the ESC provider does not pay for the evaluation, the doctor must submit a invoice to the local Department of Health and Human Resources (DHHR) to request reimbursement. The social worker must then prepare a request for reimbursement for the client medical evaluation. Upon completion of the demand payment request, the social worker must forward the request to the supervisor for approval.

c. Co-Payment on Prescription Medications

The cost incurred for co-payments for medications may be reimbursed for adults who have been placed in an Adult Emergency Shelter Care home by the department. Reimbursement by the department may only be considered after it has been determined by the social worker that there is no other personal or community resource that can meet this need. In addition, the medications to which the co-payment applies and for which payment is requested must:

- be prescribed by the adult's physician;
- meet an identified need on the adult's service plan; and,
- be necessary to prevent the need for a higher level of care;

In order to request reimbursement for this type of expense, the provider must submit documentation of the medical necessity of the medications and the receipt for the required medications after they have been purchased. The social worker must then prepare a request for a

demand payment in order to reimburse the provider for the cost incurred. The request must address each of the identified areas. Upon completion of the demand payment request, the social worker must forward the request to the supervisor for approval.

d. Provider Training Incentive Payment

Approved Adult Emergency Shelter Care providers are entitled to receive reimbursement for approved training they receive. This reimbursement is offered as an incentive to encourage providers to participate in relevant training opportunities to enhance their skills and knowledge as Adult Emergency Shelter Care providers. Training that would be acceptable in order to qualify for this payment would include training provided by the department or training that is furnished by another agency/entity that has been approved in advance by the department.

In order to be eligible to receive this training allowance, the provider must attend a minimum of six (6) hours of approved training during the quarter for which reimbursement is being requested. The quarters to be used for determining this allowance are based on the calendar year. Specifically, the quarters to be used are January - March; April - June; July - September; and October - December. Upon completion of the required hours of approved training, the provider may request payment of the training allowance by the department. Verification of attendance of the approved training must be submitted at the time reimbursement is being requested. Without verification that training was attended, payment shall not be made.

Upon receipt of the required verification of attendance of at least six (6) hours of approved training during the quarter, the social worker may then prepare a request for a demand payment in the amount of \$25.00. Upon completion of the demand payment request, the social worker must forward the request to the supervisor for approval.

Note: The training allowance can not be prorated. If a full six (6) hours of training is not completed within the quarter, the provider is not eligible for this payment. Additionally, homes that are approved as a combination home (AFC/ESC) may only receive one training incentive payment per quarter - not one incentive payment as an AFC **AND** another incentive payment as an ESC provider.)

e. Annual Provider Medical Report

After an Adult Emergency Shelter Care home becomes an approved provider, the person(s) in the household who is primarily responsible for furnishing care to the clients placed in the home is required to have a medical evaluation completed annually. The purpose of this evaluation is to ensure that the provider remains in good health and able to provide the necessary care and support to adults placed in their home.

The provider is to arrange for completion of the annual medical report with their physician. When arranging for completion of this evaluation, providers are to be encouraged to request that

their physician complete this evaluation during a regularly scheduled medical appointment whenever possible.

If the provider has no other resources or insurance coverage to pay for this annual report, they may request reimbursement by the department for this expense. To request reimbursement, the provider must submit a receipt, along with the completed medical report, to the department and indicate that reimbursement is being requested. If the report is paid in part by insurance, the provider may request reimbursement by the department for their out-of-pocket co-pay, if applicable. Reimbursement for completion of the medical report by the physician may not exceed the current Medicaid rate for a medical report. Reimbursement for out-of-pocket co-pay may not exceed the actual expense incurred.

f. Durable Medical

In certain situations the cost of obtaining durable medical equipment or supplies may be reimbursed for adults who have been placed in an Adult Emergency Shelter Care home by the department. Reimbursement by the department may only be considered after it has been determined by the social worker that there is no other personal or community resource that can meet this need. In addition, the durable medical equipment/supplies for which payment is requested must:

- be prescribed by the adult's physician;
- meet an identified need on the adult's service plan;
- be necessary to prevent the need for a higher level of care;
- be a one (1) time only expense rather than a reoccurring cost; and,
- not exceed the current Medicaid rate.

In order to request reimbursement for this type of expense, the provider must submit the receipt for the equipment/supplies after they have been purchased. The social worker must then prepare a request for a demand payment in order to reimburse the provider for the cost incurred. The request must address each of the identified areas. Upon completion of the demand payment request, the social worker must forward the request to the supervisor for approval. This demand payment type requires approval by the Office of Social Services in addition to the supervisory approval (two-tiered approval). The demand payment will not be generated by FACTS and sent to the provider until the required approval(s) is done.

g. Food Supplements

In unique situations, food supplements may be required by an adult placed by the department in an Adult Emergency Shelter Care home in order to maintain sound nutritional status. In certain situations the cost of obtaining these food supplements may be reimbursed by the department. Reimbursement by the department may only be considered after it has been determined by the social worker that there is no other personal or community resource that can meet this need. In addition, the food supplements for which payment is requested must:

- be prescribed by the adult's physician;

- meet an identified need on the adult’s service plan; and,
- be necessary to prevent the need for a higher level of care.

In order to request reimbursement for this type of expense, the provider must submit documentation of the medical necessity and the receipt for the food supplements after they have been purchased. The social worker may then prepare a request for a demand payment in order to reimburse the provider for the cost incurred. The request must address each of the identified areas. Upon completion of the demand payment request, the social worker must forward the request to the supervisor for approval. This demand payment type requires approval by the Office of Social Services in addition to the supervisory approval (two-tiered approval). The demand payment will not be generated by FACTS and sent to the provider until the required approval(s) is done.

h. Over-the-Counter Drugs/DESI Drugs or Rx Not Covered

In certain situations medications may be required by an adult placed by the department in an Adult Emergency Shelter Care home that are not covered by Medicaid or other insurance. These include items such as over-the-counter medications, DESI drugs, or other prescription medications that are medically necessary but not covered by insurance. The cost of these medications may be reimbursed by the department. Reimbursement by the department may only be considered after it has been determined by the social worker that there is no other personal or community resource that can meet this need. In addition, the medications for which payment is requested must:

- be prescribed/ordered by the adult’s physician;
- meet an identified need on the adult’s service plan; and,
- be necessary to prevent the need for a higher level of care.

In order to request reimbursement for this type of expense, the provider must submit the receipt for the after they have been purchased. The social worker must then prepare a request for a demand payment in order to reimburse the provider for the cost incurred. The request must address each of the identified areas. Upon completion of the demand payment request, the social worker must forward the request to the supervisor for approval. This demand payment type requires approval by the Office of Social Services in addition to the supervisory approval (two-tiered approval). The demand payment will not be generated by FACTS and sent to the provider until the required approval(s) is done.

Note: DESI Drugs (Drug Efficiency Study Implementation) - These are older drugs that have since been replaced by newer versions and are now considered to be “less than effective”. In some situations, however, an individual can not tolerate the newer versions of the drugs or experience higher degree of side effects and the physician chooses to continue prescribing the older version of the drug.

i. Non-Medicaid Covered Services

Clients placed in Adult Emergency Shelter Care by the department may, at times, incur expenses that are medically necessary but are not reimbursable by Medicaid. Reimbursement by the department for these costs may only be considered after it has been determined by the social worker that there is no other personal or community resource that can meet this need. In addition, the services for which payment is requested must:

- be recommended/authorized by the adult's medical/mental health professional;
- meet an identified need on the adult's service plan; and
- be necessary to prevent the need for a higher level of care.

In order to request reimbursement for this type of expense, the provider must submit the receipt for the services after they have been provided. The social worker may then prepare a request for a demand payment in order to reimburse the provider for the cost incurred. The request must address each of the identified areas. Upon completion of the demand payment request, the social worker must forward the request to the supervisor for approval. This demand payment type requires approval by the Office of Social Services in addition to the supervisory approval (two-tiered approval). The demand payment will not be generated by FACTS and sent to the provider until the required approval(s) is done.

j. Other Demand Payment - Not Specified

In certain situations the cost of obtaining needed supplies or services may be reimbursed for adults who have been placed in an Adult Emergency Shelter Care home by the department. Reimbursement by the department may only be considered after it has been determined by the social worker that there is no other personal or community resource that can meet this need. In order for the department to reimburse the provider for these costs, the provider must submit receipts for the costs incurred. Examples of costs that may be reimbursable include legal expenses, conservator fees, etc. This demand payment type requires approval by the Office of Social Services in addition to the supervisory approval (two-tiered approval). The demand payment will not be generated by FACTS and sent to the provider until the required approval(s) is done.

4. Special Medical Authorization:

Most clients who are placed in an Adult Emergency Shelter home will be eligible for Medicaid or some other type of medical insurance to cover the cost of needed medical care. If the client does not have coverage for medical care, the social worker must thoroughly explore all potential options for securing appropriate medical coverage. If, after this exploration, the client does not have the resources to pay for needed medical care, use of the special medical authorization may be requested.

Lack of resources means that:

- the client does not have funds to pay for medical care; and,

- is not eligible for any type of medical coverage; **or**,
- is eligible for medical coverage but benefits are not currently available (recent application - not yet approved for coverage).

Regardless of the reason(s) resources are not available, use of the special medical authorization to cover the cost of certain medical care or services may only be used when: 1) it is used to meet an emergent need, or prevent an emergency from occurring, 2) the medical authorization is directly related to the client's medical need, and 3) the request does not exceed six (6) months. Continued need for special medical authorization must be reviewed and renewed if applicable at a minimum every six (6) months as part of the case review. Typically, medical costs that would be covered include physician services and/or necessary prescription medications.

a. Allowable Costs

Special medical authorization is available for use by adults placed by the department in Adult Emergency Shelter Care in very limited situations. This authorization may only be used when all the following conditions exist:

- the client is currently a resident in an Adult Emergency Shelter Home;
- the client was placed by the department or was placed by another party but the placement was approved by the Department (If the Department is not making a supplemental payment, a policy exception is required in advance.);
- the medical treatment or medication for which authorization is being requested is prescribed by the client's physician; and,
- the medical treatment or medication is needed to remedy an emergency medical situation or to prevent a medical emergency from developing.

Note: The special medical authorization may be used to cover certain medical costs however, all Medicaid eligible services are not necessarily covered by this authorization (Such as: hospitalization IS NOT covered by the special medical authorization; nor is case management services at behavioral health centers). The limits and types of coverage are determined by the Bureau for Medical Services.

b. Required Procedures

If a client, who has been placed in an Adult Emergency Shelter Care home by the department, has no medical coverage, does not have the resources to pay for and is determined by their physician to be in need of medically necessary treatment or medication, special medical authorization may be requested to cover the cost. To request special medical authorization, the social worker must prepare a request in FACTS. This request must be approved before a special medical authorization letter can be generated by FACTS. The approval process is slightly different dependent on whether or not the department is making a supplemental payment for the AFC placement at the time of the request.

If the department **is** making a supplemental payment for the ESC placement at the time of the request, the approval for use of a special medical authorization must be done by the supervisor. If the department **is not** making a supplemental payment for the ESC placement at the time of the request, the approval for use of a special medical authorization, after approved by the supervisor, must then be approved by the state Office of Social Services as a **policy exception**.

Whether the supervisor or the Office of Social Services does the requested approval, the request by the social worker must ensure the following information, at a minimum, be documented in FACTS:

- client's goal related to providing the requested treatment/medication;
- explanation of how provision of the requested treatment/medication will prevent movement of the client to a higher level of care;
- list the specific treatment/medication payment is being requested for and associated cost which can not exceed the current Medicaid rate. (since medications may be adjusted periodically by the physician, requests for medications may include the statement "medication as prescribed by physician" rather than listing each medication individually on the authorization letter. Specific medications, however, must be documented on the medical screens in FACTS when this statement is used.);
- statement that all potential resources have been explored and there are no other resources available to meet the cost;
- anticipated duration of request (not to exceed six months);
- name of provider;
- income amount and source;
- amount of supplemental payment being made by the department; and,
- any other relevant information.

Much of the required documentation should be recorded on various screens within FACTS (e.g. medications should be recorded on the medical screens, income should be documented on the income screens, etc.) In addition, any other required and/or supporting information to justify the need for a special medical authorization that is not recorded elsewhere, must be documented on the contact screen.

If approved:

The social worker must print the special medical authorization letter and review the printed document to ensure that all information is complete and accurate. The social worker must furnish the vendor with this authorization who will then be providing the service. While eligibility will be effective immediately upon issuance of the special medical authorization letter, verification by the vendor with the Bureau of Medical Services will not be available for approximately three days following approval.

If denied:

The social worker may provide additional information and re-submit the request if the denial was based on insufficient information, otherwise the social worker must seek alternate resources to cover the services requested.

NOTE: In rare instances a vendor may refuse to accept the special medical authorization letter or provide services, until eligibility can be verified with Medicaid. If emergency treatment/medication is needed and no other resources are available the “zero medical number” may be used. When authorization is done using this process, the form titled “Authorization for Medical Services for Adults (SS-AS-001) is to be used and the “zero medical number” is assigned manually. This number is composed of a prefix that indicates the appropriate program (**13** For Emergency Shelter Care), seven zeros and the last two digits being the two digit county identifier. This should only be considered in situations when **no other options are available** and the medical treatment/ medication is needed on a short term emergency basis. Use of the zero medical number should be one time only and time limited until the special medical authorization can be generated through FACTS. When this option is used, vendors are required to attach a copy of the authorization letter to the billing form submitted to Medicaid. Billing on a zero medical number **cannot** be billed electronically by the vendor.

C. Service Planning

Following completion of the assessment process, a service plan shall be developed to guide the provision of services. Development of the service plan is to be based on the findings and information gathered during completion of the assessment process. Based on this information, goals must be identified and set forth in the service plan. These will provide the milestones for assessing progress and success in the implementation of the plan. The service plan provides a written statement of the goals and desired outcomes related to the problem areas identified in the assessment process.

Development of the service plan is to be a collaborative process between the social worker, the client, the ESC provider and others such as service providers or a legal guardian. In addition, the principle of self-determination, which is essential in intervention with adults, extends to the client’s right to decide with whom they associate and who should be included in the service planning for them. Those individuals who are involved in development of the service plan should also be involved in making changes/modifications to the plan.

The service plan must be reviewed and updated when they exit the Emergency Shelter placement. However, the service plan can and should be reviewed and modified as appropriate, any time there is a significant event or change in the client’s circumstances.

Document the details of the service plan in FACTS, clearly and specifically delineating the plan components. When completed, forward the plan, along with the Comprehensive Assessment, to the appropriate supervisor for approval. After approval by the supervisor, a copy of the service plan is to be printed and required signatures obtained. Required signatures include the client or their legal representative, and all other responsible parties identified in the service plan. The signed copy is then to be filed in the client record and its location documented in FACTS. A copy of the completed service plan is to be provided to all of the signatories.

Note: The service plan is available as a DDE in the reports area of FACTS.

1. *Inclusion of the Incapacitated Adult in Service Planning:*

Inclusion of incapacitated adults in the service planning process presents the social worker with some unique challenges. Although legally determined to lack decision-making capacity, the client may have the capacity to participate in the development of the service plan and should be permitted and encouraged to participate in its development as well as signing of the completed document. Some special considerations for the social worker include the following:

- When there has been a legal determination that the client lacks decision-making capacity and has a court appointed representative, the representative must be respected as the spokesperson for the client and their consent must be obtained in completion of the service plan. If the court appointed representative is the perpetrator in the Adult Protective Services case, or is unwilling or unable to take/permit the action(s) necessary to carry out the service plan, that individual shall not participate in development of the service plan nor shall they sign the completed document. In this situation, the service plan must address seeking a change in the client's legal representative.
- When the client has an informal representative (e.g. close relative or friend), this individual should be included in the service planning process and may sign the service plan. The relationship of the informal representative is to be documented in the client record.
- When the client appears to lack decision-making capacity, but does not have a court appointed or informal representative, the social worker may complete the service plan without the client's consent and involvement if the primary goal in the plan is to obtain appropriate legal representation.
- When a client appears to have decision-making capacity and could benefit from intervention but is resistant, it is appropriate for the social worker and the provider to work cooperatively to try to overcome some of this resistance. Ultimately, however, a client with decision-making capacity has the right to refuse services. In this situation, the client's refusal and the reason(s) for their refusal are to be documented.

The situations listed above are the most likely to occur and require consideration by the social worker. Variations, however, may occur and could require consultation between the social worker and their supervisor to determine the most appropriate approach.

2. *Determining the Least Intrusive Level of Intervention:*

In the provision of services to adults, the principle is well established both in law and policy that the least intrusive means of intervention should always be used. When applying this principle to individual situations there is some discretion in determining the appropriateness of the manner in which the Department intervenes in the life of the client and the level of care/assistance required in order to meet the client's needs. Intervention is to begin with the least intrusive approach that is appropriate to meet the client's needs. Intervention is to move from the least intrusive to the most intrusive option(s).

Dedication to the principle of least intrusive intervention requires a commitment to the maximum level of self-determination by the client. The client and/or their court appointed representative need to be presented with options, educated about the benefits and consequences of each, and then permitted to make decisions. The service plan is used to document these choices and to guarantee the integrity of the decision-making process.

It is important to clearly document the efforts made to assure the least intrusive level of intervention. In the event these efforts are unsuccessful, this fact and the reason(s) they were not successful must also be clearly documented in the case record. This becomes increasingly important if legal intervention becomes necessary.

3. *Required Elements - General:*

The service plan must be completed as part of the Comprehensive Assessment process. Based on the information gathered in that assessment, including but not limited to discussions with the client and the provider, the social worker is to create the service plan. The service plan must contain all the following components in order to assure a clear understanding of the plan and to provide a means for assessing progress.

- ▶ specific criteria which can be applied to measure accomplishment of the goals;
- ▶ specific, realistic goals for each area identified as a problem. This will include identification of the person(s) for whom the goal is established, person(s)/agency responsible for carrying out the associated task(s), identification of services, and frequency/duration of services;
- ▶ specific tasks which will be required in order to accomplish the goal. These are tasks or activities that are designed to help the client progress toward achieving a particular goal and should be very specific and stated in behavioral terms (specifically stating what

- action is to occur e.g. Mary Jones will attend AA meetings at least once weekly). These tasks are typically short-term and should be monitored frequently; and
- ▶ identification of the estimated date for goal attainment. This is a projection of the date that the worker, the client, and the provider expect that all applicable tasks will be achieved, that minimal standards associated with change will have been attained.

Other important considerations for the service planning process are:

- ▶ the client's real and potential strengths;
- ▶ attitudes, influences and interpersonal relationships and their real or potential impact on implementation of the service plan; and,
- ▶ levels of motivation of both the client and the ESC provider.

All information required for the creation of the service plan must be documented in FACTS. When completed, the service plan is to be forwarded along with the Comprehensive Assessment to the supervisor for approval. Once approved, the social worker must print a copy of the service plan, review the printed document with the client and the provider, and secure all required signatures. Finally, a copy of the service plan must be provided to the client, the ESC provider and all other signatories. The original signed service plan is to be filed in the client's case record (paper file) and recorded in document tracking. The service plan is to be reviewed periodically (see Case Review for detailed information)

Note: Service plan is available in FACTS as a DDE and can be accessed through the report area.

4. *Developing a Plan to Reduce Risk/Assure Safety:*

When it is determined through the assessment process that risk factors exist which compromise the safety of the adult, the identified problem areas must be addressed in the service plan. When developing a plan to assure safety of the client, it is important to involve them in the discussion of the behaviors which are problematic, options for managing the behaviors and, the formalization of a plan to address the behaviors and their cause(s).

D. Case Review

1. *General Considerations:*

Evaluation and monitoring of the Adult Emergency Shelter Care case and the progress being made should be a dynamic process and ongoing throughout the life of the case. For ESC regular monitoring is essential in order to evaluate progress, identify potential problems and seek prompt resolution. At a minimum, the case must be reviewed by the social worker at the time the client is being discharged from the Emergency Shelter placement. Review must be completed

more frequently if the client's circumstances, living situation, level of care, income, etc. should change prior to the scheduled review date.

2. Purpose:

The purpose of case review is to consider and evaluate progress made toward achievement of goals identified in the service plan. Re-examination of the service plan is a primary component of the review process. The social worker must consider issues such as progress made, problems/barriers encountered, effectiveness of the current plan in addressing the identified problem areas, and whether or not modifications/changes are indicated.

3. Time Frames:

At a minimum, the social worker must have face-to-face contact with the client at least weekly and a formalized case review must occur at the end of placement in the Emergency Shelter home. However, the service plan can and should be reviewed and modified as appropriate, any time there is a significant event or change in the client's circumstances. These time frames have been established as minimum standards. The need for contact more frequently than the minimum requirement is to be determined based on the unique circumstances of the case and stability of the placement.

4. Conducting the Review:

A formal review of the case must be completed at the time of discharge from the ESC home. The review process consists of evaluating progress toward the goals identified in the current service plan. This requires the social worker to review the service plan and have a face-to-face contact with the client and the ESC provider. Follow-up with other individuals and agencies involved in implementing the service plan, such as service providers, must also be completed. During the review process, the social worker is to determine the following:

- summary of changes in the individual or family's circumstances;
- summary of significant case activity since the last review;
- assessment of the extent of progress made toward goal achievement;
- whether or not the identified goals continue to be appropriate and, if not, what changes and/or modifications are needed;
- barriers to achieving the identified goals; and,
- other relevant factors.

Based on the results of the case review, a new service plan must be developed if services are to be continued. (See [Service Planning](#) for detailed information)

Note: The Case Review Summary (SS-4) is to be used to guide the social worker through the review process. This form is available as a FACTS merge document and may be accessed the

hard drive of you PC (C:\). A copy of this form is also available in the **FORMS** section (section V, H) of this policy.

5. *Documentation of Review:*

At the conclusion of the review process the social worker must document the findings in FACTS. This includes reviewing the service plan in FACTS and end dating any goals that have been achieved or are to be discontinued or modified for some other reason(s). Goals that have not been end dated must be continued on the new service plan and additional goals may be added as appropriate.

When completed, the social worker must submit the review and new service plan to the supervisor for approval. Once approved, the social worker must print a copy of the revised service plan and secure all required signatures. Finally, a copy of the service plan must be provided to the client, the applicable(s) provider and all other signatories. The original signed service plan is to be filed in the client's case record (paper file) and recorded in document tracking.

E. *Reports*

1. *Comprehensive Assessment:*

The Comprehensive Assessment is completed in the assessment phase of the case process. It is a compilation of elements from a several areas of the system and is available as a DDE in FACTS, accessible through the report area. This report may be opened as a WordPerfect document, populated with information that has been entered in FACTS. The social worker then has the ability to make modifications, as appropriate, before printing the document. The completed document must then be saved to the FACTS file cabinet for the case. Finally, creation of this form must be documented in the document tracking area of FACTS. A copy of this form is available in the **FORMS** section of this policy for informational purposes.

2. *Client Medical Evaluation:*

Clients who are placed in Adult Emergency Shelter Care by the department are required to have a medical evaluation completed during the placement process if one has not be completed recently and annually thereafter. This process is completed during the case management phase of the case work process. The Client Medical Evaluation form is available as a FACTS document. A copy of this form is also available in the **FORMS** section of this policy for informational purposes.

3. *Payment Agreement:*

This agreement, which is completed during the case management phase of the case work process, is the document which sets forth the terms of payment for placement. This form also is a placement agreement that the social worker completes with the client and the provider. This agreement specifies: 1) the terms of payment, 2) a statement by the client that he/she agrees to temporary placement in the ESC and, 3) a statement by the provider that they are willing to accept the client in placement.

This payment agreement is created by FACTS based on information entered by the social worker. After all required documentation is completed, the payment agreement may be printed and all required signatures obtained. Finally, a copy of the signed agreement is to be furnished to the provider and the client, the original signed document filed in the client case record (paper record), and record in document tracking where the original signed document is located.

This form is available in the FORMS section of this policy for informational purposes. In addition it is available as a DDE in FACTS and may be accessed through the report area. It may be opened as a WordPerfect document, populated with information that has been entered in FACTS.

4. *Service Plan:*

The Service Plan is completed in the case management phase of the case process. This form is available as a DDE in FACTS and may be accessed through the report area. It may be opened as a WordPerfect document, populated with information that has been entered in FACTS. The social worker then has the ability to make modifications, as appropriate, before printing the document. The completed document must then be saved to the FACTS file cabinet for the case. Creation of this form must be documented in the document tracking area of FACTS. Finally, after printing the service plan the worker must secure all required signatures, provide the client and all signatories with a copy, file the original signed document in the client case record (paper record), and record in document tracking where the original signed document is located. A copy of this form is available in the FORMS section of this policy for informational purposes.

5. *Case Review Summary:*

The case review process is to occur during the case management phase of the case process. A formal review of the case must be completed at the time of discharge from the Emergency Shelter placement. In addition, a formal case review must be completed at any time there is a significant change in the client's circumstances. When completing a case review the Case Review Summary must be followed to document the results of the review. This form is available

as a DDE in FACTS and may be accessed through the report area. It may be opened as a WordPerfect document, populated with information that has been entered in FACTS. The social worker then has the ability to make modifications, as appropriate, before printing the document. The completed document must then be saved to the FACTS file cabinet for the case. A copy of this form is available in the **FORMS** section of this policy for informational purposes.

6. *Negative Action Letter:*

Any time a negative action is taken in an Adult Emergency Shelter Care case, such as case closure or a reduction in services, the client or their legal representative must be provided with written notification of the action being taken. This notification must be clearly and specifically stated, advising the client/legal representative of the action being taken and the reason(s) for the action. In addition to notification of the negative action, the client or their legal representative must be made aware of their right to appeal the decision and advised of what they must do to request an appeal. A form letter titled "Notification Regarding Application for Social Services" is to be used for this purpose. This form is available as a FACTS document. A copy of this form is also available in the **FORMS** section of this policy for informational purposes.

F. Record Keeping

Upon placement of the client in the home or shortly thereafter, information about the client and his/her needs is to be given to the provider by the social worker. The provider is to establish a file for each individual placed in their home and maintain all information about the client for reference as needed. Information that must be given to the provider by the social worker and maintained in the client file by the provider includes the following:

- identifying information about the client;
- information about significant others such as family members, friends, legal representatives, etc.;
- information about the client's interests, hobbies and church affiliation;
- medical status including current medications, precautions, limitations, attending physician, hospital preference;
- advance directive(s) in force;
- information about client's burial wishes, plans and resources;
- copy of the current Payment Agreement; and,
- copy of the current service plan;

All other information received by the provider that is specifically related to the client is to be maintained in the provider's client file. This applies to information provided by the social worker as well as information from other sources.

G. Confidentiality

1. Confidential Nature of Adult Services Records:

Legal provisions concerning confidentiality have been established on both the state and federal levels. In federal law, provisions are contained in the Social Security Act. On the state level, provisions related to confidentiality of client information is contained in §9-2-16 & 17 of the Code of West Virginia. Additionally, requirements related to confidentiality specifically related to Adult Protective Services cases are contained in §9-6-8.

2. When Confidential Information May be Released:

All records of the Office of Social Services concerning an Adult Services client shall be kept confidential and may not be released except as follows:

- In APS cases, a copy of any substantiated report of abuse, neglect, or emergency situation involving a perpetrator shall be provided in writing to the prosecuting attorney, and in the case of death, to the appropriate medical examiner or coroner's office. Substantiated cases of self abuse and/or neglect do not need to be reported to the prosecutor unless court action becomes necessary.

All other reports of abuse and neglect shall be maintained by the Department and shall be made available, upon request, to the prosecuting attorney and any law enforcement agency; and in reports involving facilities, to the appropriate licensing body within the department (See [Adult Protective Services Policy](#) for specific information about what information is shared and with whom.)

- In APS cases, specific information may be shared with other offices within the Department of Health and Human Resources who are also mandated to maintain client confidentiality (e.g. Medicaid Fraud and OHFLAC) **if this sharing will facilitate the provision of Adult Protective Services to the client.**
- In APS cases, certain information may be shared with the State and local Ombudsman. This information is limited to 1) the name of the facility where the abuse/neglect occurred, 2) general information about the nature of the allegations, and 3) whether or not abuse/neglect of an adult was substantiated. Specific information regarding the APS case is confidential and shall not be released, including but not limited to the name of the client and the name of the reporter.
- In APS cases, upon request, information about developmentally disabled adults may be shared with West Virginia Advocates. They too must agree to keep all information shared confidential.

- In many instances courts will seek information for use in their proceedings. The process by which a court commands a witness to appear and give testimony is typically referred to as a subpoena. The process by which the court commands a witness who has in his/her possession document(s) which are relevant to a pending controversy to produce the document(s) at trial is typically referred to as subpoena duces tecum.

Records shall be released to a court only upon receipt of a valid subpoena duces tecum or court order. Immediately upon receipt of a subpoena or subpoena duces tecum the social worker must follow the protocol established to contact the Assistant Attorney General (regional attorney) in order to determine if further assistance or review is necessary. For example, in some instances the request for document(s) in a subpoena duces tecum may not be relevant or their release may violate state or federal law. The attorney should make this determination and may file a motion to quash the subpoena duces tecum when this is appropriate.

If there is insufficient time to consult the Assistant Attorney General, seek the advice of the local prosecuting attorney. If there is insufficient time to obtain legal advice from either the Assistant Attorney General or the local prosecutor prior to the hearing, the Department must comply with the subpoena or the subpoena duces tecum. Failure to do so may result in the social worker or the Department being held in contempt. Also, the Department should always comply with an order of the court unless that order is amended by the court or over-turned. Questions regarding the validity of a court order may be submitted to the Office of Social Services for possible submission to the Assistant Attorney General for review.

- For reporting and statistical purposes, non-identifying information may be released for the preparation of non-client specific reports.

The statutes further permit the circuit court or supreme court of appeals to subpoena the case record, but shall, before permitting their use in connection with any court proceeding, review them for relevancy to the issues being addressed in the proceeding and may, based upon that review, issue an order to limit the examination and use of the information contained in the case record.

3. *Subpoenas, Subpoena duces tecum & Court Orders:*

The department may be requested by the court or other parties to provide certain information regarding adult services cases with which we have/have had involvement. The various mechanisms that may be used are 1) subpoena, 2) subpoena duces tecum, or 3) court order. Upon

receipt of any of these, the department MUST respond. Failure to comply is contempt of court and could result in penalties.

A subpoena commands a witness to appear to give testimony while a subpoena duces tecum commands a witness, who has in his/her possession document(s) that are relevant to a pending controversy, to produce the document(s) at trial. Subpoenas may be court ordered or administrative (ordered by a party other than the court). Though all subpoenas must be responded to, the manner in which this response occurs is somewhat different dependent on who issues the subpoena.

a. Court ordered Subpoenas:

These include subpoenas issued by the circuit court, the magistrate court or the mental hygiene commissioner. There may be times when a questionable court order or a subpoena requesting that confidential information be provided is received. In this event, the social worker must advise his/her supervisor immediately and promptly refer the matter to the appropriate Assistant Attorney General (regional attorney) for review and possible legal action, including filing a motion to quash. The locally established protocol is to be followed whenever a referral is being made to the Assistant Attorney General. In the event there is not sufficient time for the assistant attorney general to become involved in the situation, prior to the scheduled hearing, the department should request a continuance until such time as legal representation can be arranged. If a continuance is not granted, the department should comply with the subpoena or court order.

b. Administrative Subpoenas:

These include subpoenas issued by an attorney or administrative law judge (other than a DHHR administrative law judge). These subpoenas generally request that the social worker appear to provide testimony and/or produce the case record. Workers are to advise their supervisor immediately and promptly refer the matter to the appropriate Assistant Attorney General (regional attorney) for review and possible legal action, including filing a motion to quash. The locally established protocol is to be followed whenever a referral is being made to the Assistant Attorney General. The department is to respond to the subpoena by certified mail advising the issuing party that the requested information is confidential and can not be provided in accordance with §9-6-8 of the West Virginia Code. In the event the department is ordered to appear even after being advised that information may not be released, the department should comply with the subpoena and appear but testimony must be limited to advising those present that the requested information is confidential and can not be provided in accordance with §9-6-8 of the West Virginia Code.

H. Transfer of ESC Cases

Due to the short-term nature of Emergency Shelter placement, case transfers from one county to another should be a rare occurrence. In situations where a client is placed in an Emergency

Shelter home **AND** the long term plan is for the client to remain in that county after discharge from the ESC, a case transfer would be appropriate. If, however, a client is placed in an other county but the plan after discharge is to return to their county of origin, the case should not be transferred. When it is appropriate for a client to transfer from one county to another, this is to be a planned effort with close coordination, between the sending worker/county and the receiving worker/county.

1. *Sending Worker/County Responsibilities:*

When it is necessary to transfer an Adult Emergency Shelter Care case from one worker/county to another, the sending worker/county is responsible for completing the following tasks (**Note:** The following instructions are written specific to a county to county transfer, however, the same steps are applicable for transfers between workers within the same county):

- prior to arranging or actually completing a transfer to a provider in another county, the supervisor in the sending county must call the supervisor in the receiving county to notify them that a client is being transferred to their county or to request placement assistance;
- provide a summary about the client's needs (e.g. reason for the transfer, problems in other settings, disturbing behaviors, family and financial resources, insurance coverage, and legal representative(s), if applicable);
- provide transportation for the client to the new placement, if placement is approved;
- inform and prepare the client, prior to the move to the new residence, explaining where s/he is going, why s/he is going and what to expect upon arrival; and,
- arrange for adequate clothing and medication to accompany the client to the ESC home (a clothing allowance is not available for clients in ESC - community resources must be explored if clothing is needed);
- complete all applicable case documentation prior to case transfer;
- immediately upon transfer of the client to the receiving county, send the updated client record to the receiving county; and,
- notify the DHHR Family Support staff, the Social Security Administration office, and all other appropriate agencies of the client's change of address.

2. *Receiving Worker/County Responsibilities:*

The receiving county is responsible for completing the following tasks in preparation for the transfer:

- be involved in preparing the new provider thoroughly for the client's arrival;
- notify the DHHR Family Support staff of the client's arrival when the transfer is complete;
- complete all applicable documentation;
- assist the client, and provider if applicable, with adjustment to the new arrangement; and,
- assist with arranging or initiating any needed community resources.

When an Adult Emergency Shelter Care case has been transferred, problems that arise following the transfer are to be addressed jointly between the counties. When this occurs, the receiving county may request assistance from the sending county. If such a request is received, the sending county is to work cooperatively with the receiving county to resolve the problem(s). The social worker should maintain frequent contact during this initial adjustment period to ensure a smooth transition for both the provider and the client. This will permit timely resolution of problems that may occur during this time. If the placement in the receiving county becomes permanent, and if problems occur within the first six (6) months that can not be resolved, the sending county must be willing to re-assume responsibility for the client upon the request of the receiving county.

IV. Closure

A. Case Closure - General

A final evaluation must be completed as part of the case review process prior to closure of the case. Upon completion, the social worker must document the results of this assessment in FACTS, including the reason(s) case closure is being recommended. The completed review is then submitted to the supervisor for approval of recommendation for case closure. Upon supervisory approval, the case is to be closed for Adult Emergency Shelter Care services.

B. Notification of Case Closure

If the case is closed for Adult Emergency Shelter Care services for any reason other than client death, written notification to client or his/her legal representative is required. A form letter titled "Notification Regarding Application for Social Services" is to be used for this purpose. This form is available as a FACTS document. A copy of this form is also available in the **FORMS** section of this policy for informational purposes.

C. Client's Right to Appeal

A client has the right to appeal a decision by the department at any time for any reason. To request an appeal, the client must complete the bottom portion of the "Notification Regarding Application for Social Services" and submit this to the supervisor within thirty (30) days following the date the action was taken by the department. The supervisor is to schedule a pre-hearing conference to consider the issues. If the client is dissatisfied with the decision rendered

by the supervisor, the appeal and all related information is to be forwarded by the supervisor to the hearings office for further review and consideration.

V. Forms

Form - A

Comprehensive Assessment

**COMPREHENSIVE ASSESSMENT
ADULT SERVICES PROGRAMS**

ASSESSMENT INFORMATION:

Date of Referral: _____ Date of Initial Contact: _____
Completed By: _____ Completion Date: _____

IDENTIFYING INFORMATION:

Client Name: _____ FACTS Identification #: _____
Associated Case Name: _____ FACTS Identification #: _____
Date of Birth: _____ SSN: _____ - _____ - _____ Gender _____
Race: _____ SSA Claim #: _____

Other Household Members:

<u>Name</u>	<u>Relationship to Client</u>	<u>Date of Birth/Age</u>	<u>Gender</u>

Mailing Address: _____ Physical Address: _____

Directions to the home: _____

Phone #: _____

Marital Status: _____ Religious Preference: _____

Emergency Contact Person: _____ Phone: _____

REFERENT INFORMATION:

Name: _____ Relationship to Client: _____
Address: _____ Phone#: _____
Mandatory Referent: Yes _____ No _____
Follow-up Requested: Yes _____ No _____

Service(s) Requested:

- | | | |
|--|---|--|
| <input type="checkbox"/> Adult Protective Services | <input type="checkbox"/> Adult Emergency Shelter Care | <input type="checkbox"/> Homeless Services |
| <input type="checkbox"/> Guardianship | <input type="checkbox"/> Residential Board & Care | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Health Care Surrogate | <input type="checkbox"/> Personal Care Home | <input type="checkbox"/> Other (specify) _____ |

Living Arrangements:

Household/Family Composition:

- | | |
|---|---|
| <input type="checkbox"/> Alone | <input type="checkbox"/> With spouse |
| <input type="checkbox"/> With spouse & dependent children | <input type="checkbox"/> With dependent child(ren) |
| <input type="checkbox"/> With adult child(ren) | <input type="checkbox"/> With other relative(s) (specify) _____ |
| <input type="checkbox"/> With other non-relative(s) (specify) _____ | |

Type of Residence:

- | | |
|---|--|
| <input type="checkbox"/> Private Home (house/mobile home) | <input type="checkbox"/> Private Apartment |
| <input type="checkbox"/> Low Income/HUD Housing | <input type="checkbox"/> Adult Emergency Shelter Care Home |
| <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Residential Board & Care Home |
| <input type="checkbox"/> Homeless | <input type="checkbox"/> Personal Care Home |
| <input type="checkbox"/> Other (specify) _____ | |

Physical Structure: (Mark all that apply based on worker interview(s) & observations)

Condition of Residence - Exterior

- | | |
|--|--|
| <input type="checkbox"/> Unsound structure | <input type="checkbox"/> Unsafe heating source |
| <input type="checkbox"/> Unsafe access to interior of the home | <input type="checkbox"/> Other (specify) _____ |

Condition of Residence - Interior

- | | |
|---|---|
| <input type="checkbox"/> Inadequate toilet facilities | <input type="checkbox"/> No/inoperable refrigerator |
| <input type="checkbox"/> No heat/no access to fuel | <input type="checkbox"/> Other utilities lacking _____ |
| <input type="checkbox"/> Accumulated debris | <input type="checkbox"/> Unsafe access to sleeping quarters |
| <input type="checkbox"/> Unsafe access to living quarters | <input type="checkbox"/> Other (specify) _____ |

Social Support:

<u>Name</u>	<u>Relationship to Client</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Comments: _____

Client Functioning:

Activities of Daily Living: (Indicate functioning level for each activity)

	Independent	Needs Assistance	Dependent
Transfer to/from bed or chair			
Ambulation			
Bathing			
Grooming			
Dressing			
Eating			
Toileting			
Reading and/or writing			
Pay bills			
Banking/cashing checks			
Shop for food			
Purchase/pick up prescription medication			
Use automobile or public transportation			
Do household chores - inside home			
Do household chores - outside home			
Prepare meals			
Take medications as prescribed*			
Other: (specify) _____			
Other: (specify) _____			

ADL needs are currently being met by: (Mark all that apply)

- Self
- Adult child(ren)
- Neighbor (specify) _____
- Home Health Agency (specify) _____
- ADL needs are currently not being met
- Parent(s)
- Other relative (specify) _____
- Friend (specify) _____

Are ADL needs adequately met by caregiver(s)? Yes ____ No ____ (If no, complete the following)

- Caregiver(s) at times neglectful of responsibilities _____
- Caregiver(s) refuses to use client's funds to meet essential needs _____
- Caregiver(s) incapacitated for physical reasons _____
- Caregiver(s) incapacitated for mental health reasons _____
- Caregiver(s) incapacitated for substance abuse reasons _____
- Other (specify) _____

Describe Client's Physical Appearance: _____

Physical Health:

Observed/Reported Physical Condition: (mark all that apply)

- | <u>Condition</u> | <u>Condition</u> |
|--|---|
| <input type="checkbox"/> Soiled body/clothing | <input type="checkbox"/> Broken bones or wounds |
| <input type="checkbox"/> Fecal/urine odor | <input type="checkbox"/> Rope marks |
| <input type="checkbox"/> Bedsores | <input type="checkbox"/> Injuries in varied stages of healing |
| <input type="checkbox"/> Ulcerated sores | <input type="checkbox"/> Injuries in odd places |
| <input type="checkbox"/> Observable skin disorder | <input type="checkbox"/> Untreated medical conditions |
| <input type="checkbox"/> Multiple or severe bruises, cuts or abrasions | <input type="checkbox"/> Physically restrained (including locked in room) |
| <input type="checkbox"/> Multiple or severe burns | <input type="checkbox"/> Does not get/take medications |
| <input type="checkbox"/> Other (specify) _____ | |
| <input type="checkbox"/> Other (specify) _____ | |
| <input type="checkbox"/> Handicapping Condition (specify) _____ | |

Primary Care Physician: _____
Address: _____

Phone: _____ *Last Doctor's Exam:* _____

Diagnosed Health/Medical Conditions:

- Diagnosis
1. _____
2. _____
3. _____

Current Medications:

<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Condition Prescribed For</u>

Durable Medical Equipment/Appliances/Supplies:

<u>Type of Equipment/Supplies</u>	<u>Frequency of Use</u>	<u>Medical Supplier</u>

Nutritional Status: (Mark all that apply based on worker interview(s) & observations)

- | <u>Condition</u> | |
|---|--|
| <input type="checkbox"/> Good nutritional status | <input type="checkbox"/> Malnourished |
| <input type="checkbox"/> Poor eating habits | <input type="checkbox"/> Unable to feed self |
| <input type="checkbox"/> Dehydrated | <input type="checkbox"/> Unable to prepare appropriate meals |
| <input type="checkbox"/> Special Diet (specify) _____ | |

Mental/Emotional Health:

Currently Receiving Mental Health Services? Yes _____ No _____ (If yes, complete the following)

Provider of Mental Health Services:

Provider/Agency: _____ Physician: _____
Address: _____ Therapist/Counselor: _____
_____ Phone: _____
_____ Last Appointment: _____

<u>Service</u>	<u>Frequency</u>	<u>Diagnosis</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Medications for Mental Health Condition Yes _____ No _____ (If yes, complete the following)

Prescribing Physician: _____ Phone: _____

<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Condition Prescribed For</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Observed/Reported Mental Health/Behavioral Condition: (Mark all that apply)

- | <u>Condition</u> | |
|--|--|
| <input type="checkbox"/> Overly dependent on others | <input type="checkbox"/> Wandering behavior |
| <input type="checkbox"/> Behaviors indicate fear of harm | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Suicidal thoughts/gestures/attempts | <input type="checkbox"/> Difficulty remembering |
| <input type="checkbox"/> Self mutilating/ injurious behaviors | <input type="checkbox"/> Irrational fears |
| <input type="checkbox"/> Eating disorder/unusual eating habits | <input type="checkbox"/> Hallucination (Visual/auditory/sensory) |
| <input type="checkbox"/> Refuses treatment (medical/mental health) | <input type="checkbox"/> Sleep disturbance (too much/too little) |
| <input type="checkbox"/> Unusual behaviors (specify) _____ | |
| <input type="checkbox"/> Other (specify) _____ | |
| <input type="checkbox"/> Other (specify) _____ | |

Mental Health Treatment History:

Previously Received Mental Health Services Yes _____ No _____ When _____

Provider/Agency: _____
Therapist/Counselor: _____
Address: _____ Phone: _____

Comments: _____

Household Financial Resources:

Income Source:

<u>Type</u>	<u>Recipient</u>	<u>Amount/Frequency</u>
<input type="checkbox"/> No Income	_____	
<input type="checkbox"/> Employment	_____	\$ _____
<input type="checkbox"/> Social Security	_____	\$ _____
<input type="checkbox"/> SSI	_____	\$ _____
<input type="checkbox"/> SSDI	_____	\$ _____
<input type="checkbox"/> Black Lung	_____	\$ _____
<input type="checkbox"/> Veterans	_____	\$ _____
<input type="checkbox"/> RR Retirement	_____	\$ _____
<input type="checkbox"/> Retirement (other)	_____	\$ _____
<input type="checkbox"/> Other (specify)	_____	\$ _____
<input type="checkbox"/> Other (specify)	_____	\$ _____

Other Resources:

<u>Type</u>	<u>Recipient</u>	<u>Amount/Frequency</u>
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Assets: (complete all that apply)

<u>Type</u>	<u>Owner</u>	<u>Institution</u>	<u>Amount/Value</u>
<input type="checkbox"/> Checking	_____	_____	\$ _____
<input type="checkbox"/> Savings	_____	_____	\$ _____
<input type="checkbox"/> Insurance	_____	_____	\$ _____
<input type="checkbox"/> Burial Fund	_____	_____	\$ _____
<input type="checkbox"/> Other (specify)	_____	_____	\$ _____

Health Insurance Coverage: (mark all that apply)

Medicare Part A (Indicate #) _____
 Medicare Part B

Medicaid (Indicate #) _____
 CHAMPUS (Indicate #) _____

Private Insurance Carrier: _____ Policy #: _____

Other (specify) _____ Policy #: _____

Other (specify) _____ Policy #: _____

Financial Management:

Income insufficient to meet shelter/fuel needs
 Failure to pay bills

Hoarding of resources
 Irresponsible use of funds/credit

Uncashed checks
 Inaccurate/no knowledge of finances

Gives money away
 Unexplained disappearance of valuables

Other (specify) _____

Education/Vocational History:

Last Grade Completed: _____ Field of Study: _____

College Graduate with degree: N ___ Y ___ Field of Study: _____

Post-Graduate Education with degree: N ___ Y ___ Field of Study: _____

Business, technical or professional license: _____

Employment History:

Current Status:

Employed Unemployed Retired Disabled:

Current Employment:

Employer: _____ Address: _____
Phone: _____
Title: _____ Salary: _____
Supervisor: _____ How long Employed: _____

Prior Employment:

Employer: _____ Address: _____
Phone: _____
Title: _____ Salary: _____
Supervisor: _____ How long Employed: _____

Prior Employment:

Employer: _____ Address: _____
Phone: _____
Title: _____ Salary: _____
Supervisor: _____ How long Employed: _____

Military History:

Branch: _____
Type of Discharge: _____ Discharge Date: _____
Service Related Disability: Yes _____ No _____
(if yes, specify) _____

Comments: _____

Legal Status:(Mark & complete all that apply)

1. Based on the social worker's observation, does the client appears to have the ability to make sound decisions on their own behalf? Yes _____ No _____
2. If no, has there been a legal determination of competence/incompetence? Yes _____ No _____
3. If no, has a physician or psychologist completed an evaluation? Yes _____ No _____

Date of Evaluation: _____ Date of Court Action: _____

Judge/Mental Hygiene Commissioner: _____

Does the client have any of the following to assist in decisions made on their behalf? (Mark and complete all that apply)

- Attorney
Name: _____ Phone: _____
Address: _____
- Guardian Ad Litem
Name: _____ Phone: _____
Address: _____
- Medical Power of Attorney
Name: _____ Phone: _____
Address: _____
- Durable Power of Attorney
Name: _____ Phone: _____
Address: _____
- Health Care Surrogate
Name: _____ Phone: _____
Address: _____
- Court Appointed Guardian (specify type) _____
Name: _____ Phone: _____
Address: _____
- Court Appointed Conservator
Name: _____ Phone: _____
Address: _____
- Representative Payee
Name: _____ Phone: _____
Address: _____

Summary Comments: _____

Form - B

Client Medical Evaluation

West Virginia Department of Health and Human Resources
Adult Emergency Shelter Care
Client Medical Evaluation

Date Sent to Physician _____

Section I (to be completed by social worker)

A. *Client Identifying Information:*

Name: _____ Social Security #: _____ - _____ - _____

Address: _____ Medicaid #: _____

_____ Medicare #: _____

_____ Other Insurance: _____

Date of Birth: _____ Carrier: _____

Gender: Male _____ Female _____ Claim #: _____

If the client is currently under the care of a physician, enter the physician's name and indicate the reason for care: _____

B. *Department of Health and Human Resources Identifying Information:*

District Office Requesting Report: _____

Social Service Worker: _____

ESC Provider: _____

Return completed form to: _____

Section II (to be completed by examining physician)

A. Does this individual demonstrate evidence of impairment: Yes _____ No _____

B. If yes, describe impairment(s): _____

C. Primary Diagnosis: _____

Secondary Diagnosis: _____

Other Diagnosis: _____

D. Major Disability: _____

Secondary Disability: _____

E. Indicate which area(s) of functioning are affected:

Physical _____ Mental _____ Emotional _____

- F. 1. To the best of your knowledge, is this person free of communicable disease? Yes ____ No ____
2. Has this individual been tested for communicable disease? If yes, enter date testing was completed and the results.

Communicable Disease	No	Yes	Date	Results
Tuberculosis				
Venereal Disease/STD				
Hepatitis				
Other (specify) _____				

- G. If the individual is *female*, has a pap smear and examination been done in the past six (6) months?
 Yes ____ No ____ If yes, indicate results: _____

- G. Is this person physically and/or mentally able to do the following for themselves?
Bathe: Yes ____ No ____ *Feed*: Yes ____ No ____ *Toilet*: Yes ____ No ____
- I. Has this individual progressed or regressed physically, mentally and/or emotionally during the last 12 months? Yes ____ No ____ If yes, explain: _____

Section III - Special Needs (to be completed by examining physician)

- A. Does this individual require a special diet? Yes ____ No ____
 If yes, explain: _____
- B. List all prescribed medications:

<u>medication</u>	<u>dosage</u>	<u>frequency</u>	<u>prescribing physician</u>
_____	_____	_____	_____
_____	_____	_____	_____
- C. Can this individual administer their own medication? Yes ____ No ____
- D. What other medical services does this individual require? _____
- E. Does this individual exhibit symptoms of severe emotional, mental, and/or behavioral problems?
 Yes ____ No ____
- F. Does this individual have difficulty communicating their needs? Yes ____ No ____
- G. Additional Comments: _____

 (Physician's Signature)

 (Date of Examination)

 (Physician's Name-Please type/print)

 (Physician's Address-Please type/print)

Form - C

ESC Payment Agreement

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
ADULT EMERGENCY SHELTER CARE HOMES**

PAYMENT AGREEMENT

This is to advise that _____, has been approved for
(client name)
Emergency Shelter Care in the home of _____. In addition
(provider name)
to the monthly subsidy payment, the provider will receive a boarding care payment in the amount
of \$_____ per day, including the date of placement _____ and
(date of placement)
excluding the date of discharge. Any deviation from the conditions agreed to in the Provider
Agreement for Participation shall be cause for termination of this agreement.

Social Service Worker: _____ *Date:* _____

AGREEMENT FOR RECEIPT OF EMERGENCY SHELTER CARE

I, _____, agree to placement in the home of _____
(client name)
_____, for Emergency Shelter service until alternate arrangements may be
(provider name)
made for my care. I understand that this placement is temporary in nature and may not exceed a
maximum of thirty (30) days in a twelve month period.

Client Signature: _____ *Date:* _____

AGREEMENT FOR PROVISION OF EMERGENCY SHELTER CARE

I agree to provide Emergency Shelter Care for _____ to
(client name)
include room, board, personal services and supervision at the rate indicated above and in
accordance with the terms set forth in the Provider Agreement for Participation.

Provider Signature: _____ *Date:* _____

Form - D

Adult Services - Service Plan

Adult Services Service Plan

Client Name: _____ **FACTS Case #:** _____
Date Initiated: _____ **Date Reviewed:** _____

Problem/Need Statement	Goal	Task/Service	Responsible Party	Frequency	Duration	Goal Begin Date	Estimated Completion Date

 Client Signature Date

 Provider Signature Date

 Worker Signature Date

 Supervisor Signature Date

Form - E

Case Review Summary

Form - F

Negative Action Letter

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

Dear

This letter is to notify you of action taken on your application for social services. Please refer to the item(s) checked below to indicate what action was taken.

- 1. Your application for _____
has been approved.

- 2. Your application for _____
has been denied because :

Please refer to the information on the back of this letter concerning your right to a conference or hearing.

- 3. The fee for the service you receive is _____
per _____.

- 4. You are no longer eligible for _____
after _____ because _____

Please refer to the information on the back of this letter concerning your right to a conference or hearing.

If you have a concern or complaint about the quality of service you are receiving or whether the service is meeting your needs, please contact me about the Department of Human Services' grievance procedure. In addition, your right to a conference concerning the decision shown above and your right to a hearing are explained on the back of this letter.

Should you have any questions, please contact me.

Sincerely,

Signature of Worker

Date

REQUEST FOR A CONFERENCE REGARDING THE PROPOSED
ACTION TAKEN ON YOUR APPLICATION

If you are not satisfied with the proposed action to be taken on your application or need further explanation, you have a right to discuss it with the Department worker who made the decision. If you are not satisfied with the results of this conference, you may wish to request a hearing.

REQUEST FOR A HEARING BEFORE A MEMBER OF THE
STATE BOARD OF REVIEW

If you are not satisfied with the decision made on your application, you have the right to a hearing before a State Hearing Officer who is a member of the State Board of Review.

THE LENGTH OF TIME YOU HAVE TO REQUEST A CONFERENCE OR HEARING

If you wish a conference, please contact this office at once. If you wish a hearing, you must notify this office within ninety (90) days from the date of the action. You may request a conference or hearing by contacting this office in person or by completing the statement at the bottom of this letter. Detach it and mail the request to this office.

CONTINUATION OF SERVICES DURING THE HEARING PROCESS

If you request a hearing within thirteen (13) days of this notice, services may be continued or reinstated pending a decision by the State Hearing Officer.

WHO MAY HELP YOU AT THE CONFERENCE OR HEARING

At the conference or hearing, you may present your information yourself or in writing. You have the right to be represented by a friend, relative, attorney, or other spokesperson of your choice. A Department representative will be available to assist you if you need help in preparing the hearing and advise you regarding any legal service that may be available in your community.

------(DETACH)-----
--

IMPORTANT !!

If you want a conference or hearing, please check one of the blocks below and mail this statement to:

I want a pre-hearing conference because:

I want a hearing before the State Hearing Officer because:

Signature of Claimant: _____ Date: _____

(PLEASE DATE AND SIGN)