Contents

SECTION 1

INTRODUCTION

1.1 Introduction and Overview

Adult Family Care homes are placement settings for adults that provide support, protection and security in a family setting. They 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 an assisted living facility or nursing home.

The Adult Family Care provider must be certified by the Department of Health and Human Resources. Once certified, the provider may provide care for up to three (3) adults. The provider receives payment for the care provided. This payment may come from the client placed in the home, the Department or a combination of these two (2) sources.

Note: If there is an active Health Care Surrogate or Guardianship case and a request is made for Adult Residential Services, a new intake must be entered in FACTS for Adult Residential Services.

The assignment of investigations/cases is done with service and continuity in mind. Investigations/cases are not assigned or reassigned arbitrarily and when appropriate, a worker is assigned at Intake or very early in the contact.

A reasonable attempt will be made to accommodate collateral contacts with disabilities and examples of this include: Auxiliary aids for individuals with disabilities where necessary to ensure effective communication with individuals with hearing, vision or speech impairments will be arranged and provided. All offices have the capability to accommodate individuals that utilize TTY equipment. If further assistance is needed, the worker will contact the local Division of Rehabilitation as well as the West Virginia Commission for Deaf and Hard of Hearing at (304) 558-1675. The TTY toll free number is 1-866-461-3578.

Culturally competent practice will be ensured by recognizing, respecting and responding to the culturally defined needs of individuals that we serve. If someone is in need of an interpreter, the worker must contact local resources to locate an interpreter. Examples include, but are not limited to, the Board of Education, local colleges and Division of Rehabilitation. If a local community resource cannot be located, the worker will seek other resources such as the Department of Justice Immigration and Naturalization Service at (304) 347-5766, 210 Kanawha Boulevard, West Charleston, WV 25302.

If an interpreter is used, confidentially must be discussed with this individual, reminding them that all information is confidential and must not be shared with

anyone.

1.2 Definitions

Abuse: The infliction or threat to inflict physical pain or injury on or the imprisonment of any incapacitated adult or facility resident according to WV Code §9-6-1. (Similar definition is contained in §61-2-29 that addresses penalties for abuse or neglect of incapacitated adult or elder person).

Adult Emergency Shelter Care Home: 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: 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: A placement setting within a family unit that provides support, protection and security for up to three (3) individuals over the age of eighteen (18).

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.

Assisted Living Facility: Any living facility, residence or place of accommodation available for four (4) or more residents, which is advertised, offered, maintained or operated by the ownership or management, for the express or implied purpose of having personal assistance or supervision, or both, provided to any residents therein who are dependent upon the services of others by reason of physical or mental impairment and who may also require nursing care at a level that is not greater than limited and intermittent nursing care.

Note: Previously defined Personal Care Homes and Residential Board and Care Homes are now defined in WV Code and policy as assisted living facilities.

Cognitive Deficit: An impairment of an individual's thought processes.

Emancipated Minor: A child over the age of sixteen (16) who has been emancipated by 1) order of the court based on a determination that the child can provide for his/her physical well-being and has the ability to make decisions for himself or 2) marriage of the child. An emancipated minor has all the privileges, rights and duties of an adult including the right to contract. (Refer to WV State Code §49-7-27).

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

FACTS: Acronym for the Family and Children's Tracking System and is the automated client information system used by the West Virginia Department of Health and Human Resources, Bureau for Children and Families.

Incapacitated Adult: Any person, who by reason of physical, mental or other infirmity, is unable to physically carry on the daily activities of life necessary to sustaining life and reasonable health. (**Note:** Incompetence of an adult is determined by a legal proceeding and is not **the same as a determination of incapacity.** Similar definition "incapacitated adult" is contained in §61-2-29 abuse or neglect of incapacitated adult or elder person regarding criminal penalties).

Legal representative: A person lawfully invested with the power and charged with the duty of taking care of another person or with managing the property and rights of another person, including, but not limited to, a guardian, conservator, medical power of attorney, trustee, or other duly appointed person.

Neglect: Means A) The unreasonable failure by a caregiver to provide the care necessary to assure the physical safety or health of an incapacitated adult; or B) the unlawful expenditure or willful dissipation of the funds or other assets owned or paid to or for the benefit of an incapacitated adult or facility resident. (Similar definition is contained in §61-2-29 abuse or neglect of incapacitated adult or elder person regarding criminal penalties).

Physical Deficit: Impairment of an individual's physical abilities.

SECTION 2

INTAKE

2.1 Eligibility Criteria

Adult Family Care and the associated services, including pre-admission evaluation, 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. Payment by the Department, however, for placement in Adult Family Care is affected by the amount of income received by the client and the level of liquid assets available. Assets cannot exceed the established level, currently $2,000. In addition to this, the individual must be a US citizen and a West Virginia resident. (See Initial Assessment, Comprehensive Assessment, and Payment Agreement for detailed information).

In order to be eligible to receive Adult Family Care services, the individual must be a US citizen and a WV resident and meet at least one (1) of the following criteria:

a) He/she must be age sixty-five (65) or older and in need of supportive living;

b) He/she must be at least eighteen (18) years of age, or an emancipated minor, and have an established disability or a disability may be established by a thorough evaluation and documentation of the person's condition by a licensed physician and a determination by Adult Services staff that this medical evaluation does indicate the need for supervised care; and,

c) Currently receiving Adult Protective Service or APS Preventive Services from the Department. In the case of eligibility based on an active APS or APS Preventive Services case, Adult Family 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 AFC to address these must be documented in the client's APS Service Plan.

Note: If the client receives services from Title XIX Waiver program, the client is not eligible for a Supplemental Adult Family Care payment and the client's AFC case may be closed. In addition, the Adult Family Care home must be evaluated for closure. If the Adult Family Care home provider is certified as a Title XIX Waiver provider or employed as a Personal Care provider, the provider must decide if they want to continue being a provider with that program or if they want to be a provider through the AFC program. If the decision is to continue as a provider with the Title XIX Waiver program or as a Personal Care provider, the AFC provider record must be closed in FACTS. If the client receives services from any other agency that provides supervision or care for the client, this must be evaluated to determine if the client remains eligible to receive a supplemental payment from DHHR or remains

eligible for AFC placement.

An Adult Family Care provider cannot accept placement for an Aged and Disabled Waiver client. The qualified Aged and Disabled recipient requires more advanced care than Adult Family Care.

2.2 Required Information

Basic identifying information and detailed information about the client's needs are to be gathered during the Intake process and entered in FACTS as a Request to Receive Intake. 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:

a) Name of client;

b) Date of birth or approximate age of the client;

c) Social Security number;

d) Client's current living arrangements;

e) Household composition;

f) Physical and/or mailing address of client;

g) Directions to the client's home;

h) Telephone number of client;

i) Significant others - relatives, neighbors, friends;

j) Legal representative(s), if known;

k) Reporter/caller information, if different than client;

l) Type of service(s) reporter/caller is requesting;

m) Specific needs of the client;

n) Description of how needs are currently being met; and,

o) Other relevant information.

When the intake information is complete, the intake worker is to conduct a search to determine if the agency has had prior contact with the client. This search of the FACTS system is to determine if there are other referrals/assessments/cases as appropriate. If any are found, associations are to be made as appropriate. When the search is completed the Request to Receive Adult Family Care services is to be forwarded to the appropriate supervisor for further action including merging and associating all duplicate client ID numbers for this individual and making the decision to accept/screen out the referral.

2.3 Referral Triage/Disposition

The supervisor is the primary decision maker at the intake stage of the Adult Family

Care casework process. This is consistent with other Department policy which recognizes the unique blend of experience, skill, and leadership which supervisors provide.

2.3.1 The Supervisor's Role Includes

a) Ensuring that all referrals are appropriately considered to determine if the referral is to be assigned for an Adult Services Initial Assessment or screened out.

b) For those assigned for assessment, determination of the required response time for the initial contact based on the client's circumstances indicated in the referral information. Screening of the referral is to be done promptly, but in no instance is screening of the referral to exceed 10 (ten) days from the date of referral.

2.4 Accept/Screen Out

2.4.1 The Supervisor Will:

a) Review the information collected at intake for thoroughness and completeness;

b) Identify/verify the type of referral;

c) If not previously completed by intake worker, conduct a search of the FACTS system to determine if other referrals/investigations/cases already exist for the identified client;

d) Creates associations in FACTS between the current referral and other referrals/assessments/investigations/cases as appropriate, as well as merge all duplicate client ID numbers; and,

e) Determine if the referral will be accepted for an initial assessment or if the referral will be screened out and not accepted for an initial assessment.

In determining whether to accept or screen out the referral, the supervisor must consider:

1. The presence of factors which do/could present a risk to the adult;

2. The information related to the identified client and their current circumstances;

3. Whether the information collected appears to meet the eligibility criteria for adult family care;

4. The sufficiency of information in order to locate the individual/family; and,

5. The motives and truthfulness of the reporter.

2.4.2 If the Referral is Accepted

a) Determine the appropriate response time for the referral based on the information presented on the intake; and,

b) Assign the referral for initial assessment.

2.4.3 If the Referral is Screened Out

a) Document the decision regarding screening;

b) Document the reason(s) for the screen-out decision; and,

c) Make referrals to other resources within and outside of the Department, if appropriate.

2.5 Response Times

A face to face contact must be made with the identified client within fourteen (14) days from the date the referral is received by the agency. Depending on the degree of risk to the client's health, safety and well-being, contact with the adult may require a face-to-face contact in less than fourteen (14) days. The policy rules for determining response time are as follow:

2.5.1 Response Time Options

a) Response - Within five (5) Days: This time frame will apply in cases where it is determined that, based on the referral information, a situation where a prompt response is critical (i.e., a situation or set of circumstances which present a substantial and immediate risk to the adult). Face-to-face contact with the identified client must be made within five (5) days. This contact is to occur in the adult's usual living environment whenever possible.

b) Response - Within fourteen (14) Days: This time frame will apply in cases where it is determined that, based on the referral information, a situation where a prompt response is critical does not currently exist and/or is not expected to develop without immediate intervention. Face-to-face contact with the client must be made within fourteen (14) days. This contact is to occur in the adult's usual living environment whenever possible.

Note: If Time Critical Need is selected by the intake worker, FACTS will trigger a response time of five (5) days. If this is not selected by the intake worker, the response time will default to the fourteen (14) days response time. The supervisor can change the response time recommended by the intake worker as long as this is done prior to the supervisor's approval of the intake.

c) Determination of Response Time

Considerations in determining response time to assist with the determination of the appropriate response time for initiation of an Adult Family Care Initial Assessment, the supervisor should consider the following:

1. Whether the information reported indicates the presence of a situation requiring prompt attention;
2. The location of the adult at the time the intake is received;
3. Whether the circumstances that exist could change rapidly;
4. Whether the living arrangements are life threatening or place the adult at risk;
5. Whether the adult requires medical attention;
6. Whether the adult is without needed assistance and supervision;
7. Whether the adult is capable of self-preservation/protection;
8. Whether the adult/family is transient or new to the community;
9. Whether the adult is currently connected to any formal support system;
10. Whether there is any family or friends available for support;
11. Whether there is a caregiver(s) and if so, are they physically, cognitively and emotionally able to provide needed care to the adult;
12. Whether there is a past history of referrals or current referrals requesting assistance;
13. Whether there are injuries; and,
14. Other relevant information.

d) When Determination is Made

Once the supervisor has made a determination regarding the response time they will:

1. Document the decision in FACTS and if accepted, indicate the selected response time and the date of this decision.
2. If accepted, assign the referral to an Adult Service worker to begin the Initial Assessment.
3. Follow-up to assure that the assigned Adult Service worker adhered to the designated response time.

SECTION 3

ASSESSMENT

3.1 Introduction

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

3.2 Adult Initial Assessment

Once the referral is assigned to an Adult Service worker, completion of the Initial Assessment is to begin promptly and must be completed and documented in FACTS within thirty (30) calendar days from the date of the intake.

Completion of the Initial Assessment involves gathering a variety of information about the client and his/her current status.

a) Information is to be gathered by conducting a series of interviews with:

1. The client;
2. Caregiver (if applicable); and,
3. Other individuals having knowledge of the situation.

b) This is the initial assessment phase for Adult Family Care services. Information gathered during this initial assessment process will be focused on determining:

1. The level of risk the client's circumstances present to their well-being and safety;
2. Whether or not Adult Family Care services are indicated based on the adult's circumstances;
3. If Adult Family Care services are not indicated, what other services may be needed; and,
4. The role the Department is to play beyond the initial assessment.

c) The Adult Service worker must gather and document demographic information about the client

1. The client's living arrangements;
2. Living environment;
3. Capacity;
4. Functioning;

5. Health;
6. Finances;
7. Education;
8. Employment;
9. Military information; and,
10. In addition if the client has a caregiver, whether formal or informal, this must also be documented.

d) If a decision maker does/does not exist, this must be documented on the Decision Maker Screen as well any information about a Living Will.

In addition to gathering information, several critical questions must be considered when completing the Initial Assessment and determining whether the case is to be opened for Adult Family Care services or the Initial Assessment closed.

These include the following:

1. Is the adult safe or can his/her safety be arranged/assured through resources available to him/her? (Resources include financial, social, family, etc.);
2. Does the adult appear to meet eligibility criteria for Adult Family Care services?
3. Has there been a medical determination that the adult does/does not have decision-making capacity?
4. Does the adult have an acting substitute-decision maker? (Guardian, conservator, de facto guardian, de facto conservator, health care surrogate, medical power of attorney, power of attorney, representative payee, etc.);
5. Does the adult have any advance directive in effect? (Living Will, DNR, Power of Attorney, Medical Power of Attorney, etc.); and,
6. If Adult Family Care services will not be provided, are referrals to other resources needed?

Note: In the event there is already a Request to Receive Services case (Guardianship/Health Care Surrogate) open and a Request is received for placement in an Adult Residential setting, a new Request to Receive Intake must be entered in FACTS. When the referral is assigned for assessment, the worker is still to assess the client's situation related to Adult Family Care services; however, it is not necessary for the worker to complete the Adult Initial Assessment in FACTS unless it is necessary to update information required on the Initial Assessment. If it is not necessary for the worker to complete the Initial Assessment, this can be documented as an Incomplete Assessment in FACTS and record the information in the Case Focus as applicable. A face to face

contact must be completed with the client within the assigned time frame on the intake as well as updating any information that has changed since the last contact.

In addition:

a) The Case Connect screen must reflect that the intake is being connected to an open case; and,

b) The Summary Screen in the Case Focus must reflect the Adult Residential services case as the primary case type and the Health Care Surrogate or Guardianship case as the secondary case type.

3.3 Time Frames

Time frames for initiation of the Initial Assessment are determined by the supervisor. It is critical that the Adult Service worker complete a face-to-face contact within the assigned time frame. The options are within five (5) days and within fourteen (14) days. Contacts and attempted contacts are to be documented in FACTS as soon as possible of completion of the contact/attempt. Documentation is to be pertinent and relevant to carrying out activities necessary to complete the Initial Assessment.

The initial assessment process, including all applicable documentation in FACTS, must be completed within thirty (30) calendar days from the day the referral is received. In order to complete the initial assessment process, in addition to the identified client, the caregiver (if applicable), current decision-makers (if applicable), involved family members, and all other relevant parties must also be interviewed. All interviews are to be completed face-to-face unless extenuating circumstances exist which prohibit this.

3.4 Short-Term Service Planning

As a part of the Initial Assessment, the Adult Service worker is to develop a short-term Service Plan. This is required if:

1. A case will be opened for any social service; and/or,
2. A case will not be opened for any social service but there is some additional follow-up that is required in order to bring the initial assessment to resolution.

Consideration is to be given to both short and long term planning including planning for eventual discharge from Adult Family Care services as appropriate. These two (2) situations are described below.

- **Department will provide social services beyond initial assessment:** In this situation, the short-term Service Plan is to briefly document the tasks that are to be accomplished in the immediate future. This Plan should be very limited in duration, and should in no instance exceed thirty (30) days. This Plan will be in effect until the Comprehensive Assessment and regular Service Plan are completed.

- **Department will NOT provide social services beyond initial assessment:** In this situation, the short-term Service Plan is to document the tasks that have been accomplished during the initial assessment process. A brief statement of the task is to be documented on the Plan (i.e. referral for in-home services, referral for home delivered meals, etc.). Specific information regarding a) who was contacted, b) when contact was made and c) the results of the contact(s) are to be made on the Contact Screen in FACTS. In this situation, the short-term Service Plan will end at the point the Initial Assessment is approved and closed.

Note: The short-term Service Plan is primarily intended to be a way for the worker to document what tasks the Agency has implemented/is going to implement until the Initial Assessment is completed or prior to completion of the regular Service Plan. This may also include tasks assigned to other parties. It is part of the initial assessment and does not require signatures.

3.5 Conclusion of Initial Assessment

The final step in the initial assessment process is to determine, based on the information gathered, whether or not Adult Family Care services provided by the Department are needed and an Adult Family Care services case opened. In order for an Adult Family Care services case to be opened, the adult must have been determined to meet the applicable eligibility criteria. (See Eligibility Criteria for detailed information).

The following requirements apply regarding disposition of Adult Family Care referrals/assessments:

1. Any time an individual is open in the FACTS system for multiple case types under Request to Receive Services, (i.e. Adult Residential, Guardianship, Health Care Surrogate), the Adult Residential case type (Adult Family Care) takes priority since there are associated payments.
2. If the worker is unable to complete an Initial Assessment for a legitimate reason (death of client, unable to locate/moved out of state, etc.) it should be recorded as an Incomplete Assessment in FACTS.

3.6 Initial Assessment Disposition Options

When the Initial Assessment is completed, all the information and findings are to be documented in FACTS. All areas identified as a problem area in the Initial Assessment process must be addressed on the Service Plan. The Adult Service worker will then submit the Initial Assessment, along with their recommendation about disposition of the assessment, to the supervisor for approval. The possible dispositions available to the social worker are:

1. Close the Initial Assessment and open an Adult Family Care case;
2. Close the Initial Assessment and refer to other resources (internal/external to Department);

3. Close the Initial Assessment with no additional action needed; or,
4. Incomplete assessment.

The disposition shall be based on all the information gathered during completion of the Initial Assessment. From this information, the Adult Social worker will determine eligibility of the client for Adult Family Care services provided by the Department. Notification of the disposition is to be provided to the client or their legal guardian by completion of the Notification of Application for Social Services (SS-13). When completed, a copy of this must be saved to the File Cabinet in FACTS. The Case Connect screen must be completed, with the appropriate action.

Note: If the application is denied, the Adult Service worker must send the Notification of Application for Social Services Letter (SS-13) within five (5) working days advising the applicant of the denial, stating the reason(s) for the denial. This form is available in FACTS as a DDE and may be added to the file cabinet and Document Tracking by using the 'Save to FACTS' functionality. This functionality may be found in Microsoft Word under the 'Add – Ins' menu and then selecting 'Save to FACTS'; then FACTS will automatically add this document to the File Cabinet and the Document Tracking screen. If this automatic functionality is not used you may manually enter the report into the FACTS Document Tracking screen and saving a copy of the letter into the Investigation Filing Cabinet by using the import functionality. This negative action letter is a two (2) part letter and serves as written notification of the grievance procedure which is available to the applicant and is to be filed in the File Cabinet for the client record in FACTS. (See Common Chapters Manual for detailed information about the grievance procedure).

3.7 Multiple Request to Receive

In the event there is already a Request to Receive Services case (Guardianship/Health Care Surrogate) open and a Request is received for placement in an Adult Residential setting, a new Request to Receive Intake must be entered in FACTS. When the referral is assigned for assessment, the worker is still to assess the client's situation related to Adult Family Care services; however, it is not necessary for the worker to complete the Adult Initial Assessment in FACTS unless it is necessary to update information required on the Initial Assessment. If it is not necessary for the worker to complete the Initial Assessment, this can be documented as an Incomplete Assessment in FACTS and record the information in the Case Focus as applicable. A face to face contact must be completed with the client within the assigned time frame on the intake as well as updating any information that has changed since the last contact.

1) The Case Connect screen must reflect that the intake is being connected to an open case; and,

2) The Summary screen in the Case Focus must reflect the Adult Residential Services case as the primary case type and the Health Care Surrogate or Guardianship case as the secondary case type.

SECTION 4

CASE PLAN

4.1 Comprehensive Assessment

A thorough assessment must be completed for each individual who is opened for Adult Family Care services. In order to develop a detailed understanding of the client and his/her needs, a Comprehensive Assessment must be completed. For Adult Family Care cases, information gathered while completing the Initial Assessment will carry forward into the case area of FACTS to create the first Comprehensive Assessment. The Adult Service worker will use the information gathered during completion of the Comprehensive Assessment as the basis for the client's Service Plan. The Comprehensive Assessment screens will not necessarily reflect all of the information outlined in the following sections. However, it is appropriate to gather all of the following information as part of the assessment process. The information will be documented on the Comprehensive Assessment screens as well as various other screens in FACTS.

Information for completion of the Comprehensive Assessment is to be obtained by conducting interviews with the client and all other relevant parties. Interviews are to be conducted face-to-face unless there are extenuating circumstances which prevent this.

4.2 Time Frames

A Comprehensive Assessment, including the development of the Service Plan, must be completed for each individual who is opened for Adult Family Care services. This Assessment must be completed within thirty (30) calendar days following the date the case is opened. A new Comprehensive Assessment must be completed annually. Changes that occur in the client's circumstances before the next annual completion of the Comprehensive Assessment are to be documented as a modification to the existing Comprehensive Assessment and are to be documented within forty-eight (48) hours of the time the worker becomes aware of the change. It is important for the worker to document any changes on the Modification Tab prior to the next annual completion of the Comprehensive Assessment because FACTS re-sets the tickler when a new Comprehensive Assessment is completed.

4.3 Information to Be Collected

4.3.1 Identifying Information

Demographic information about the client, their family and their unique circumstances is to be documented. Information about individuals with whom the client has a relationship should be documented on the Client screens and/or on the Collateral screens as appropriate. This includes information such as (not an all inclusive list):

a) Name;

b) Address (mailing and residence);

c) Telephone number;

d) Date of birth/age;

e) Household members;

f) Other significant individuals;

g) Current legal representatives/substitute decision-makers (if applicable);

h) Identification numbers (SSN, Medicaid, Medicare, SSA Claim, etc.);

i) Gender/ethnicity;

j) Marital status;

k) Advance Directives in effect; and,

l) Directions to the home.

4.3.2 Services Requested

The Adult Service worker will document the specific services being requested.

This should include information such as the following:

a) The specific type(s) of assistance being requested;

b) Why assistance is being requested;

c) How needs are currently being met; and,

d) Other relevant information.

4.3.3 Living Arrangements

The Adult Service worker will document information about the client's current living arrangements. This should include information about where the client currently resides such as the following:

a) Client's current location (own home, relative's home, hospital, etc.);

b) Is the current setting considered permanent or temporary?

c) Type of setting (private home/residential facility, etc.);

d) Household/family composition;

e) Physical description of the current residence (single family dwelling, duplex, townhouse, apartment, retirement community, foster home, group home, nursing facility, etc.);

f) Interior condition of the residence;

g) Exterior condition of the residence;

h) Type of geographic location (rural, urban, suburban, etc.); and,

i) Access to resources such as family/friends, transportation, shopping, medical care/services, social/recreational activities, religious affiliations, etc.

4.3.4 Client Functioning

The Adult Service worker will document information about the client's personal characteristics. This should include information about how the client's personal needs are currently met, including an assessment of their strengths, needs and supports in areas such as:

a) Activities of daily living (ADL);

b) Whether or not his/her needs are currently being met and by whom;

c) Caregiver functioning, if applicable;

d) Ability to manage finances;

e) Ability to manage personal affairs;

f) Ability to make and understand medical decisions; and,

g) Assessment of decision-making capacity.

4.3.5 Physical/Medical Health

The Adult Service worker will 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:

a) Observed/reported physical conditions of the client;

b) Primary care physician;

c) Diagnosed health conditions;

d) Current medications;

e) Durable medical equipment/supplies used; and,

f) Nutritional status including special dietary needs, if applicable.

4.3.6 Mental/Emotional Health

The Adult Service worker will document information about the client's current and past mental health. 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:

a) Current treatment status;

b) Current mental health provider, if applicable;

c) Mental health services currently receiving;

d) Medication prescribed for treatment of a mental health condition;

e) Prescribing/treating professional;

f) Observed/reported mental health/behavioral conditions; and,

g) Mental health treatment history.

4.3.7 Financial Information

The Adult Service worker will 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 Adult Family Care services since the payment calculation and much of the individual agreement between the Department, the client and the provider is created by FACTS based on this information.

Included are areas such as:

a) Financial resources - type, amount and frequency;

b) Other resources available to the client (non-financial);

c) Assets available to the client (cannot exceed a maximum of $2,000 to be eligible for AFC supplemental payment);

d) Outstanding debt owed by the client;

e) Extraordinary expenses;

f) Health insurance coverage;

g) Life insurance coverage;

h) Pre-need burial agreement in effect;

i) Court ordered obligation for child support/alimony;

j) Information about the client's ability to manage their own finances; and,

k) Educational/vocational information.

4.3.8 Education and Vocational Training

The Adult Service worker will document information about the educational/vocational training the client has received or is currently receiving. This should include information such as:

a) Last grade completed;

b) Field of study;

c) History of college attendance/graduation;

d) History of special licensure/training; and,

e) Current educational/training needs.

4.3.9 Employment Information

The Adult Service worker will document information about the client's past and present employment, including but not limited to sheltered employment. Information should include:

a) Current employment status;

b) Current employer/type of employment;

c) Prior employment history; and,

d) Current employment needs.

4.3.10 Military Information

The Adult Service worker will document information about the client's military history, if applicable. Information should include:

a) Branch of service;

b) Type of discharge received;

c) Date of discharge;

d) Service related disability, if applicable; and,

e) Veteran's eligibility for benefits (contact local veteran representative).

4.3.11 Legal Information

The Adult Service worker will 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:

a) Assessment of the client's decision-making capacity by the social worker;

b) Information about legal determination of competence, if applicable;

c) Information about efforts to have the client's decision-making capacity formally evaluated; and,

d) Identification of specific individuals who assist the client with decision-making.

4.3 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. Areas identified as problematic

in the initial assessment process are to be addressed on the service plan.

4.4 Criteria for Selection of AFC Clients

It is important for the Adult Service worker to complete a thorough assessment of the client in order to determine if Adult Family 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:

1. In need of supportive living in order to remain in or return to a community living setting;
2. 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);
3. 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 AFC provider and/or other professional;
4. Be continent at time of admission or if incontinent, the provider must be willing to accept the client in their home;
5. 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 Family Care and able to benefit from placement;
6. Able, or have a legally appointed representative who is able, to understand what Adult Family Care is and expresses a desire for this type of placement;
7. Willing to contribute to their cost of care to the extent possible;
8. Unable to live alone as a result of physical or mental incapacity;
9. No other suitable living arrangements are available; and,
10. Free from communicable disease that would endanger the health of others.

Note: If a client requires an assistive medical support, such as oxygen, this would not necessarily disqualify the individual from participation in the Adult Family Care program. The worker would have to consult with the homefinder and evaluate these situations carefully to determine the client's ability to meet their own needs and the provider's willingness to accept this type of placement.

In addition, they must **NOT:**

1. Be in need of assisted living care, nursing home care or highly structured [institutional] care;
2. Be in need of acute medical or psychiatric care;
3. Be intoxicated by alcohol or drugs; and,
4. Be a danger to themselves or others (dangerous means a person who currently exhibits or has a history of aggressive behavior that can or is likely to result in Infliction of injury or damage to other persons or property).

SECTION 5

CASE MANAGEMENT

5.1 Case Management Activities

Once a client has been opened as a recipient of Adult Family Care services, various case management activities must occur.

These include tasks such as:

1. Advising the client of their approval to receive Adult Family Care services;
2. Location and selection of an appropriate provider;
3. Arranging pre-placement visits with the potential Adult Family Care provider when appropriate;
4. Arranging placement of the client in the Adult Family Care home;
5. Furnish the provider with information about the client/client needs' necessary for the provider to meet the client's needs (basic demographic info, medical/treatment information, current medications, decision-maker relationships in effect, funeral/burial information, emergency contact(s), etc.). The Client Information report in FACTS may be used for this purpose;
6. Arrange for moving the client and their personal belongings to the Adult Family Care home;
7. Arrange for completion of the client's medical evaluation if this has not been completed prior to placement;
8. Explain the payment process to both the client and the provider;
9. Complete all documentation in FACTS necessary to generate the Payment Agreement;
10. Review the completed Payment Agreement with the client and the provider and secure all necessary signatures;

    Note: Client's income must be verified at least yearly or as changes occur.

11. Review the Resident Agreement for Participation with the client and secure the required signatures on an annual basis;
12. Assessment of client's clothing needs and arrange for placement clothing allowance if needed;
13. In conjunction with the client, the provider and other appropriate parties, develop the Service Plan;
14. When the client becomes sixty-four (64) years and nine (9) months of age,

send the Medicare Part D Letter to the client that an application must be made for Medicare Part A, B and D prior to the client's sixty-fifth (65th) birthday. This letter is available in the Reports Section in FACTS and is titled Medicare Part D Letter;

15. A FREDI report titled Medicare Part D is available for the worker/supervisor to alert them of new cases opened during the month and also ongoing cases with clients that will be sixty-four (64) years and nine (9) months of age during the current month. This report must be accessed monthly, so appropriate follow-up can be completed to insure that all clients that are eligible for enrollment are enrolled in Medicare Part A, B and D, as well as appropriate applications made through Income Maintenance for SLIMB, QMB and QI-1. Also, an application for Extra Help through Social Security must be made. If DHHR has been appointed as guardian, the applications for Medicare Parts A, B and D, SLIMB, QMB and QI-1 may need to be made by the Guardian;
16. Arrange for additional services for the client and/or provider as appropriate; and,
17. Review and monitor the case as required, making modifications and changes as indicated.

Medicare Part D will cover the majority of medications; therefore, when the client becomes eligible for Medicare, the Special Medical authorization **MUST** not be issued for any prescriptions/doctor's visits that are covered by Medicare Part A, B or D, or any other resource. When the client becomes eligible for Medicare, regardless of whether they are receiving it or not, the Special Medical Card can only be issued for prescriptions and limited doctor's visits that are not covered by Medicare Part D.

Eligibility for Medicare is based on the client reaching age sixty-five (65) or receiving Social Security Disability benefits for two (2) years. When the client reaches sixty-four (64) years and nine (9) months of age, a Medicare Part D Letter must be sent to the client or their legal representative if that client is in a DHHR supplemented residential placement.

If DHHR is serving as the client's guardian, a letter does not need to be sent. However, the worker, as Guardian, must ensure that all necessary applications/enrollments are made on the client's behalf within thirty (30) days after the client is sixty-four (64) years and nine (9) months of age. This includes enrolling in Medicare Part A and B and selecting an appropriate plan under Medicare Part D that provides the best coverage for the client's individual medication needs. In addition, the worker must apply for Extra Help through the Social Security office. Also, an application for QMB, SLIMB and/or QI-1 must be made through Income Maintenance for assistance in payment of the Medicare premium.

QMB, SLIMB and QI-1 are programs through Income Maintenance that pay for Medicare Premiums. It is extremely important that workers make sure clients apply

or someone applies on their behalf for these programs through Income Maintenance. The worker, as guardian, must ensure that these applications are made on the client's behalf prior to the client reaching age sixty-five (65).

Extra Help is a program that provides financial assistance to individuals with limited income in paying for Medicare Part D. If an individual qualifies, they will receive assistance in paying the premium and/or co-pays for their prescription drugs. Therefore, it is extremely important that workers make sure clients apply or someone applies on their behalf for the Extra Help. This application must be made through the Social Security office. The worker as Guardian must ensure that these applications are made on the client's behalf prior to the client reaching age sixty-five (65).

If the client does not have a legal representative or anyone that will make the necessary applications/enrollments on their behalf and it appears the client lacks capacity to do this, a petition for guardianship may be considered. If it is determined that guardianship will be pursued, the Guardianship petition should be filed prior to the client reaching sixty-four (64) years and nine (9) months to ensure that the client will receive necessary medical coverage through Medicare Part D when they become sixty-five (65) years of age. If DHHR is appointed guardian, the necessary applications/enrollments outlined above must be made by the worker immediately after being appointed as guardian. If another individual is appointed guardian, that individual is responsible for making the necessary applications/enrollments.

If the client appears to have capacity, the worker must follow-up within thirty (30) days from the date the client reaches sixty-four (64) years and nine (9) months of age to ascertain that all necessary application/enrollments outlined above have been initiated. If the worker learns of any problems with the applications/enrollment process, these must be resolved immediately.

Once the client becomes sixty-five (65) years of age, the Special Medical authorization will not cover any prescriptions or medical services that are covered under Medicare Part D.

Note: DHHR may only make applications/enrollments on a client's behalf for the above mentioned benefits when DHHR is serving as guardian. If DHHR serves as Health Care Surrogate, DHHR cannot make the above mentioned applications on the client's behalf; however, if it appears the client lacks capacity to make these applications and no one else is willing or able to make these applications, a guardianship petition may be considered.

5.2 Placement

When placement of an adult in an Adult Family Care home is being considered, it is important to consider both the needs of the client and the characteristics of the Adult Family 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 Family 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. The worker is to work in collaboration with the Adult Family Care Homefinder to identify potential homes.

WV Code §16-5D-6 states that no public official or employee may place any person in, or recommend that any person be placed in, or directly or indirectly cause any person to be placed in, any assisted living residence, as defined in section two of this article, which is being operated without a valid license from the secretary. Therefore, DHHR cannot place or cannot authorize, recommend or facilitate placement in an unlicensed Assisted Living Facility or any other home that is unlicensed, or a legally unlicensed home. Adult Family Care is a certified provider by the DHHR homefinder. Even though AFC homes are not licensed, but certified, placement can only be made in AFC homes that are certified by the DHHR homefinder.

When placing a client in an Adult Family Care home a supplemental payment by DHHR will NOT be made if there is any source available that will pay for the client's cost of care up to the current state rate. DHHR will supplement the cost of care as a last resort. (Refer to Determination of Rate of Payment for additional information).

5.2.1 Selection of the Provider

Following the established local protocol, the homefinder will work in collaboration with the Adult Service worker to identify suitable homes for clients needing placement. The successful placement of a client in an Adult Family 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 Adult Service worker must evaluate the client in the following areas:

a) Current physical health status and medical history;

b) Current mental/emotional/cognitive status and history;

c) Current medications and ability to self-administer medication;

d) Individual or special needs as viewed by the client, the physician, and the social worker;

e) The client's expressed wishes regarding his/her living arrangements;

f) Family, friends and community ties, who and where these are located and assistance they are willing to provide to the client;

g) Family experiences of the client such as the kind of home life he/she had and attitude toward any remaining family;

h) Educational and employment history;

i) Religious preferences, interests, hobbies, likes and dislikes, and personal habits;

j) Household possessions or pets and plans for what will be done with these;

k) Physical appearance and personal characteristics (i.e., neat/untidy,

withdrawn/outgoing);

l) Behavior problems that are currently present or that have been present in the past;

m) Problems with any prior placement;

n) Unusual habits that could be problematic for a provider; and,

o) Financial resources such as income, medical insurance and assets.

5.2.2 Placement of Clients Being Discharged From a State Institution

Individuals who have resided in a state operated facility for an extended period of time will face some unique challenges as they adjust to an Adult Family Care setting. In order to ensure a smooth adjustment, it is important for the AFC provider to be aware, not only of the client's needs, but also of the prior routine and personal habits to which the client has become accustomed. A gradual transition from the familiar routine to a new setting and new routines will make for a smoother and more successful transition to Adult Family Care.

Because of these unique considerations, clients who are being discharged from a state operated facility for placement in an Adult Family Care Home must meet certain additional requirements before placement will be arranged. Specifically, the discharging facility must arrange for the completion of 1) a thorough current medical history and 2) a thorough social history. These reports are to be completed by a representative of the discharging facility who is familiar with the client's daily habits and activities while they have been placed in the facility. Upon completion, the reports must be submitted to the Department along with a request for placement in an Adult Family Care setting.

In no instance shall a client who has been institutionalized in a mental health facility on an involuntary commitment be fully discharged from the institutional setting to placement in an Adult Family Care home. Clients who are coming from this type of placement in a mental health facility are required to be released from the mental health facility on convalescent status and placed on a provisional basis in the AFC home. This provisional placement may last for a period of up to six (6) months. The purpose of the provisional placement with this population is to ensure a smooth transition from the institutional setting to the community and to facilitate return of the client to the institution in the event of a failed placement without requiring another hearing before the Mental Hygiene Commissioner. Upon completion of a successful provisional placement the client may be fully discharged from the mental health facility and permanently placed in the AFC home.

5.2.3 Trial Visit - General

A trial visit between the client and the prospective Adult Family Care provider should be arranged whenever placement is being considered, prior to making permanent arrangements. This provides the Adult Service worker, the potential provider and the client the opportunity to evaluate the client-provider match and the client's suitability

for placement in and Adult Family Care setting. Whenever the client is being discharged from an institutional setting to an Adult Family Care home, a trial visit is required. In this situation, the client is not to be fully discharged from the institutional setting until they are stabilized in the AFC setting. (See section titled Trial Visit - Clients from Another County or Institutional Setting for detailed information).

The Adult Social worker is responsible for the following tasks in preparation for the trial visit:

a) Furnish a summary of the client, his/her needs, and other required information to the provider with whom the trial visit is being arranged;

b) Consult with the receiving county to arrange/coordinate the trial visit, if applicable;

c) Arrange transportation of the client to the prospective Adult Family Care home;

d) Arrange an adequate supply of medication for the client during the visit; and,

e) Arrange for payment of the Adult Family Care provider for the trial visit.

Following the trial visit the Adult Service worker is to confer with the client and the provider individually to determine whether or not the placement is suitable. Results of the trial visit must be documented in FACTS. If both the client and the provider agree to making the placement permanent, all documentation and case activity must be completed in FACTS by the Adult Service worker.

If the Adult Family Care home being considered for placement is in another county, the worker must work in cooperation with staff in the county where the home is located to arrange the trial visit and must keep them informed as to the outcome of the visit. If it is determined that the client will be placed in the Adult Family Care home, staff in the sending county must work in conjunction with staff in the receiving county to arrange for transfer of the case. Upon completion and approval by the sending county supervisor, the case may be transferred to the appropriate supervisor in the receiving county. The case may then be assigned to an Adult Service worker for ongoing case work activity. (See Transfer of AFC Cases for detailed information about the case transfer process).

5.2.4 Trial Visit - Clients From Another County or Institutional Setting

If the client is coming from another county or is being discharged from an institutional setting, the sending county/discharge planner must provide the Adult Service worker in the receiving county with a written, detailed summary of the client's characteristics and needs, prior to arranging a trial visit. This summary must include the following information, at a minimum:

a) Client identifying information;

b) Description of client's current functioning;

c) Areas of need;

d) Description of support/assistance required;

e) Strengths and limitations;

f) Medical and psychological history;

g) Current medical/psychological needs;

h) Explanation of why placement is being sought; and,

i) Other relevant information.

For clients currently receiving Adult Services from the Department, the completed Comprehensive Assessment in FACTS may be used to meet this requirement.

For clients who are being discharged from an institutional setting, it is essential that the Adult Service worker receive thorough and accurate information regarding the client, his/her functioning and their needs. Upon receipt of this information, the Adult Service worker must discuss the client and their needs with the prospective provider. In doing so, the Adult Service worker is to prepare the provider for accepting the client for the trial visit and possible placement. In addition, clients who are coming from a state operated mental health facility are required to be released from the mental health facility on convalescent status and placed on a provisional basis in the AFC home. This provisional placement may last for up to a period of six (6) months. The purpose of the provisional placement with this population is to ensure a smooth transition from the institutional setting to the community and to facilitate return of the client to the institution in the event of a failed placement without requiring another hearing before the Mental Hygiene Commissioner. Upon completion of a successful provisional placement the client may be fully discharged from the mental health facility and permanently placed in the AFC home. In no instance shall an institutionalized client be fully discharged from the institutional setting on the date of initial placement in an Adult Family Care home.

5.2.5 Client Medical Evaluation

Whenever possible, the client must have a current medical evaluation completed by their regular physician prior to placement in an Adult Family Care home (information cannot be no more than three (3) months old). If completion prior to placement is not possible, the Adult Service worker must arrange for this evaluation to be completed within five (5) working days following placement. Completion of this form serves two (2) purposes. It documents the current health status of the client and it verifies 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 Adult Service 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 Adult Service 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 (paper) record and the location of this evaluation noted in FACTS Document Tracking. The AFC Client Medical Evaluation is available as a DDE and may be accessed through the Reports area of FACTS.

The Client Medical Evaluation is to be used to meet the requirement for completion of an annual medical evaluation. The Adult Service worker and the provider are to use this form to insure that the client receives appropriate medical care.

Any medical condition/service identified that requires additional follow-up is to be addressed on the Service Plan.

Note: Generally placement of individuals with a communicable disease will not be approved for placement in Adult Family Care unless a written statement from the physician is obtained verifying the client is not currently contagious. If this individual is placed, the Adult Service worker must furnish the provider with written instructions/information about the appropriate care (i.e., Universal Precautions).

5.2.6 Ongoing Medical Care for AFC Clients

All clients placed in an Adult Family 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.

Any documentation received by the provider regarding medical care provided is to be filed in the client's record maintained by the provider.

5.2.7 Placement When No Supplemental Payment Made by Department

There may be situations when an individual is in need of the level of care available in an Adult Family Care setting but his/her financial resources exceed the determined cost of care. These types of placements will be handled as private pay arrangements and the payment arrangements are to be made by the individual or his/her family. Approval by the Department, however, must be obtained by the provider prior to finalizing these placement arrangements. In situations where the individual is not capable of making these arrangements independently and has no relative or interested party who can or will make the arrangements on his/her behalf a referral for Representative Payee or Conservator may be necessary. In private pay arrangements, the Department shall not be responsible for any portion of the payment. The provider and the client or the client's representative will be responsible for determining payment arrangements. Clients who are placed in Adult Family Care as a private pay placement are not eligible for special medical authorization to cover medical expenses for which they may have no coverage, unless certain conditions are met. (Refer to the Special Medical Authorization section of this policy for detailed information).

Clients who are placed in Adult Family Care as private pay placements are not

eligible to receive an Initial Clothing Allowance or an ongoing clothing allowance. The provider is not eligible to receive payment for non-emergency medical transportation to secure medical services unless the resident being transported has a Medicaid card. Providers are not eligible to receive reimbursement from the Department for respite care provided for private pay placements; and, if no services are being provided by the Department, the Adult Services case is not to be opened.

A resident residing in an approved Adult Family Care home may be eligible to receive Food Stamps whether or not the Department is making a supplemental payment for his/her placement. The homefinder may inform the client and provider about possible benefits that may be available at the time placement is being approved by the Department. The business arrangement between the private pay client and the provider concerning payment is not the Department's responsibility. It must be made clear to the provider at the time of placement that the payment arrangements for private pay clients is a private arrangement and the Department will not provide payment to the provider in the event the client or his/her representative fails to make payment as agreed. A Request to Receive Adult Residential case type must not be completed in FACTS for private pay individuals, except for those that are requesting issuance of the Special Medical Card as a private pay individual. An Assessment must be completed to determine if the private pay individual meets the requirements for issuance of the Special Medical Card. If the Department is serving as guardian or Health Care Surrogate for a private pay individual that meets the eligibility requirements for issuance of the Special Medical Card, the Assessment may be shown as an Incomplete Assessment and connected to the Guardianship or Health Care Surrogate case. Then, on the Summary Screen, the primary case type must be changed to Adult Residential and the secondary case type shown as either Guardianship or Health Care Surrogate. A new Service Plan may need to be completed to reflect additional services that are being provided.

If the client meets the eligibility requirements for issuance of a Special Medical Card as a private pay client and DHHR is not serving as Health Care Surrogate or Guardian, a case must be opened up and all case management activities must be completed, (i.e., Comprehensive Assessment, Service Plan and face to face contact with the client every three (3) months, at a minimum).

Note: Private Pay clients that are eligible for issuance of the Special Medical Card are not eligible to receive an initial or supplemental clothing allowance, nor are the providers eligible to receive reimbursement from DHHR for respite care.

Placement in an Adult Family Care home can be authorized by DHHR when serving as Guardian, but not by DHHR when serving as Health Care Surrogate.

5.2.8 Required Notification of Placement

When placement of the adult in the Adult Family Care home is completed, the Adult Service worker must send/ensure notification of the placement to certain parties. Specifically, if the adult is receiving any services through Office of Family Support (i.e., Food Stamps, Medicaid, Emergency Assistance, etc.), written notification is to

be provided advising them of the placement. This notification is to be done following the established local office protocol 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 Adult Service 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 Adult Service worker sends this notification, the Interagency Referral Form is to be used.

5.2.9 Initial Placement Period

During the first several weeks following placement, the client and provider will need regular guidance and support from the Adult Service worker to ensure a smooth adjustment. The Adult Service 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. At a minimum, the Adult Service worker must conduct a visit within one (1) week following placement. Thereafter for the first six (6) months, visits are to be conducted on a regular basis. The frequency of visits should be determined by the level of support and contact needed by the client and provider in order to facilitate a smooth adjustment and, to resolve any problems that arise in a timely manner. Depending on the individual needs, this visitation may be conducted weekly, bi-weekly, or monthly. Contact during the first six (6) months must be made at least once (1) every month. Each visit is to include a face-to-face contact with the client. Each contact is to be documented in FACTS as soon as possible.

5.2.10 Resident Agreement for Participation

At the time of placement a Resident Agreement for Participation must be completed. In order to complete this document the Adult Service worker must review the terms of participation with the client. To participate in the Adult Family Care program, the client must be willing to agree to the terms set forth and to signify his/her agreement by his/her signature. If the client has a legally appointed representative, this individual must sign on the client's behalf. After obtaining the signature of the client or his/her representative, the Adult Service worker is to sign on behalf of the Department. A copy of the signed document is to be provided to the client and/or their representative. The completed document is then to be filed in the client's case record and its' location recorded in Document Tracking in FACTS.

Note: The Resident Agreement for Participation is available as a DDE in FACTS and may be accessed through the Reports area.

5.2.11 If the AFC Placement Fails

It is essential that the Adult Service 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 Adult Service 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 Adult Service worker has provided or arranged for all appropriate assistance, the arrangement remains unworkable, the Adult Service worker will attempt to arrange for placement of the client with another provider who is better able to address the client's needs.

As part of the process of arranging the new placement, if possible, the Adult Service worker should include a trial visit with the prospective new provider. If a successful match is found and the client is placed with another DHHR subsidized residential provider, the Adult Service worker must monitor the new placement carefully. While it is important to maintain regular contact with both the provider and client during the weeks immediately following any placement, this is especially important when the placement has occurred as a result of a failed placement in another setting. Regular contact with the client and provider will ensure the support and opportunity necessary to promptly identify problems, should these occur, and seek appropriate resolution.

5.2.12 Complaints Against the Provider

The homefinder will follow-up on all complaints about the provider and respite provider related to compliance with program standards. When a complaint is received against an Adult Family Care provider or respite provider relating to non-compliance with program standards or regulations, a I & R Intake must to be entered in FACTS. If allegations of abuse/neglect are received, these must be entered in FACTS as an APS referral and investigated by the APS worker.

5.2.13 Payment by the Bureau for Children and Families

Providers of Adult Family Care services may receive reimbursement from the Department in one (1) of two (2) 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 Family Care setting. **When determining the amount of payments, the provider does not get paid for the last day of placement.**

a) If an overpayment is received by the provider regardless of whether it is the Adult Service worker, homefinder or provider error, the Adult Service worker/homefinder must notify the provider in writing of the overpayment amount and the month(s) the overpayment(s) covers;

b) If the overpayment is client specific, the Adult Service worker must pursue repayment;

c) If the overpayment is provider specific, the repayment must be pursued by the homefinder. The provider must negotiate an agreement with the Adult Service worker and or homefinder to repay either, in a lump sum payment or monthly payments; and,

d) The time frame for the repayment will usually be within thirty (30) days; however, the homefinder/Adult Service worker may grant additional time.

After all reasonable attempts, if the provider does not agree to repay or defaults on monthly payments that has been negotiated by the Adult Service worker, the Adult Service worker must contact the homefinder to consider Corrective Action. If the homefinder negotiated the repayment agreement, the homefinder must consider Corrective Action.

5.2.14 Determination of Rate of Payment

Determination of the supplemental payment due to an Adult Family Care provider is done automatically by FACTS and is based on a variety of information entered in the system by the Adult Service worker. Key areas used in calculating the rate of payment include employment information including sheltered employment, income and asset information, date client entered placement, and debts and expense information. Complete and accurate documentation in each of these areas is essential in determining the supplemental payment. This calculation must be completed before the Payment Agreement can be created.

In addition to the client's income, if there is a payment made from any other source on behalf of the client, this amount must be applied toward the client's cost of care to reduce or eliminate the supplemental amount paid by DHHR. If the supplemental payment made by DHHR is eliminated, the case must be closed.

5.2.15 Resource Deductions

In unique situations the client may be allowed to redirect a portion of his/her monthly resources rather than using these to pay for his/her care. These should not typically be for routine requests, but rather for necessary expenditures that are extraordinary. (i.e., irrevocable pre-need burial plan IF this was in effect for a long period of time prior to placement in AFC and the total amount of the pre-need burial does not exceed $5,000.00. In addition, the client must have paid at least 50% of the total cost of the pre-need burial); OTC/Non-Medicaid covered medications that are needed on a regular basis; conservator charge (the usual fee is 5% of the total monthly income of the client). Life insurance policies must not be considered for a resource deduction.

If the only financial responsibility of the conservator is the disbursement of the monthly income of the client (with no assets involved), the Adult Service worker must explore the possibility of the provider becoming the Representative Payee and document these efforts in the Contact screen in FACTS. If the provider is willing to become the Representative Payee a petition must be filed for removal of the

Conservator. If the court approves removal of the Conservator, a new contract must be done in FACTS to remove the resource deduction.

Granting of a resource deduction may be considered only when the following criteria are met:

a) Client has a special need (if a medical need - must be documented by their physician);

b) All potential resources must be thoroughly explored and documented (i.e., includes, but are not limited to, community/civic organizations, family members, churches, Medicare Part D, drug company assistance programs, samples from physicians, mental health agencies, health right clinics, etc.

c) There are no potential resources to meet this need.

After a thorough search, if alternate resources are not available, the Adult Service worker may consider requesting a resource deduction. If this is a onetime expense, the Adult Service worker may also consider doing a Demand Payment. To request a resource deduction, the Adult Service worker must complete the required information on the Debt/Expense screen in FACTS. Whenever a resource deduction is being requested, the amount of deduction to be allowed, and the reason(s) the resource deduction is being requested must be documented. Completion of the debt/expense information is required as part of the process to create a Payment Agreement. When completed, the Adult Service worker must submit this along with other information required to create a Payment Agreement to the supervisor for approval. When the Payment Agreement is completed with a resource deduction request, the contract becomes a two-tiered approval.

Upon receipt, the supervisor must review all applicable screens prior to approving the Payment Agreement. (See Payment Agreement for detailed information about creating the Payment Agreement). Following approval by the supervisor, the request will be forward in FACTS to the appropriate person for the final disposition. The payment agreement cannot be generated by FACTS until the required approval(s) are done. The Adult Service worker must obtain receipts or verification of each month's deduction to verify that the approved resource deduction amount is being applied to the approved allowable expense. This should be done, at a minimum, at each review. If the resource deduction is not being applied to the approved expense, the resource deduction must be discontinued and reimbursement recouped for each month the resource deduction was not used for the allowable expense.

Note: It is not necessary to grant a resource deduction for the full "monthly payment amount of the debt or expense". If an alternate source is located that will pay part, but, not all of the monthly amount, the Adult Service worker will indicate the amount on the contract that is to be considered as a resource deduction (i.e., total debt amount is $100.00, and $40.00 of this will be paid by a civic organization, then $60.00 is the amount to be requested as a resource deduction).

5.2.16 Personal Expense Allowance

The Personal Expense Allowance is the amount a client, placed in an Adult Family Care home, is permitted to retain from the total income they receive in order to meet their personal expenses. The amount of the Personal Expense Allowance is established by the Bureau for Children and Families and may be adjusted periodically. All clients placed by the Department in an Adult Family Care home shall receive the full Personal Expense Allowance amount each month or have this amount readily available for their use.

The client may use his/her Personal Expense Allowance to purchase any item(s) they choose so long as the purchases do not conflict with established house rules or regulations applicable to operation as an Adult Family Care home. The allowance must be available to the client and used as he/she desires. The Personal Expense Allowance shall NOT be used to obtain basic necessities such as food, clothing, shelter costs, medication, transportation, or medical care unless it is the desire of the client to do so.

Examples of items that may be purchased with the personal expense allowance, if the client so desires, include:

a) Tobacco products;

b) Hair styling/permanents;

c) Hair spray, cologne, aftershave;

d) Extra clothing;

e) Jewelry;

f) Radio or television;

g) Games, books and other recreational items of interest to the client;

h) Postage stamps and stationary;

i) Cosmetics;

j) Pre-need burial trust fund; and,

k) Hair care above and beyond the basic care that must be provided to maintain cleanliness and neatness of the client's hair.

Items that are the responsibility of the provider to furnish and that ARE NOT to be paid for with the client's personal expense allowance:

a) Basic personal hygiene articles (toothbrush, toothpaste, soap, deodorant, towels, washcloths, etc.);

b) Regular hair cut (applies to all clients, male and female);

c) The provider is responsible to supplement basic clothing, if the clothing allowance does not meet this need (i.e., undergarments, all

appropriate clothing for normal everyday use, etc.); and,

d) Basic recreational needs.

If certain prescribed medications are determined, by a physician, to be the sole drug the client can take, and that drug is not eligible for reimbursement by Medicaid, the Adult Service worker must seek alternate resources to pay for this medication. Examples of alternate resources include Medicare Part D waiver process, drug company program assistance programs, samples from physicians, mental health agencies, health right clinics, etc. These efforts must be documented in the Contact screen in FACTS. After a thorough search, if alternate resources are not available, the Adult Service worker may consider requesting a resource deduction to allow the client to retain a portion of their income to pay for this medication rather than using their Personal Expense Allowance for this purpose. (See Case Management-Payments-Resource Deductions for detailed information). If a resource deduction is requested, the amount of the deduction and the reason it is to be granted must be documented in FACTS. In addition, the Adult Service worker must obtain a statement from the client's physician stating why this particular medication is needed. Approval for this or any resource deduction is a two-tier approval. This means that the supervisor must first approve the resource deduction. If supervisory approval is granted, the request will then be forwarded by FACTS to the appropriate person for approval. Both levels of approval must be granted before the resource deduction may be included in calculating the payment for the client's care.

Note: If the client has a court appointed legal representative, the legal representative has the ultimate decision making authority regarding the use of the Personal Expense Allowance, however, the funds must be used for the client's benefit and the client should be permitted and encouraged to be involved in decisions about how the funds are to be used.

5.2.17 Sheltered Workshop Income

Adults who have been placed in a residential setting by the Department who receive income for Sheltered Workshop Employment are entitled to keep a portion of their income from this source. The adult is permitted to keep up to $65.00 of income earned from this source. Individuals who receive $65.00 or less per month from this source are entitled to keep the full amount earned while those who earn more than $65.00 from this source are permitted to keep $65.00 and the balance is to be applied to their monthly payment to their residential care provider.

Sheltered Workshop Employment income is included in the determining the amount of payment due from the Department and from the client. Since the amount of Sheltered Workshop income will vary monthly, a new Payment Agreement must be developed each month. The Adult Service worker must complete documentation in FACTS indicating Sheltered Workshop wages as the income type. Thereafter, on a monthly basis the Adult Service worker must verify and update the amount of income received from this source. The amount entered is to be the full amount of monthly earnings from this source for the preceding month. FACTS will calculate payment

amounts and disregard the appropriate amount up to the maximum allowed $65.00.

5.3 Payment Agreement

Immediately following placement of a client in an Adult Family Care home, an agreement outlining the terms of payment to the provider must be completed. In no instance may completion of the Payment Agreement exceed ten (10) working days following placement of the client in the Adult Family Care home. Once created and signed by all parties, this document is a legally binding agreement between the client, the provider and the Department. It identifies all parties to the agreement and sets forth the terms and the amount of payment due to the provider and payable by the client and/or the Department. It also identifies the date on which the agreement becomes effective. Payment by the Department to the Adult Family Care provider will be an automatic payment and will be based on the amounts set forth in the Payment Agreement as the Department's responsibility.

Note: Whenever the Department is making a supplemental payment, the amount set forth in the Payment Agreement is PAYMENT IN FULL. The client shall not be assessed additional charges, payable by the client or others for the care furnished by the AFC provider.

5.3.1 Creation of the Payment Agreement

The Payment Agreement is created by FACTS based on a variety of information entered in FACTS by the Adult Service worker. Specifically, information from the following areas of FACTS is used in creating the Payment Agreement:

a) Financial;

b) Debt/expenses; and,

c) Employment.

Therefore, it is essential that documentation in these areas is complete and accurate prior to creation of the Payment Agreement.

Based on information entered in these areas of FACTS, the appropriate amounts will be entered on the Payment Agreement when the document is printed. Upon completion of all documentation, the Adult Service worker must submit the Payment Agreement to the supervisor for review and approval. Prior to granting approval, the supervisor must review all the areas indicated above.

Once the supervisor approves the Payment Agreement, the Adult Service worker must print the Agreement. The Adult Service worker must then check the printed document for accuracy. Finally, the Adult Service worker must review the Payment Agreement with the client and the provider and obtain the necessary signatures. The signed copy of the Payment Agreement is to be filed in the paper record with a notation made in Document Tracking.

Note: The Payment Agreement is available as a DDE in the Reports area of FACTS. The per diem rate entered in the Payment Agreement, are based on the following

formula: monthly rate x 12 months / 365 days = daily rate. Payment is made for the date of placement but payment IS NOT made for the date of discharge.

5.3.2 Payment For Individuals With No Available Income

a) No Income

If a client who is being placed in an Adult Family Care home has no income, all potential financial resources must be explored by the Adult Service worker. When appropriate, this will involve preparation of referral(s) to other agencies such as the Social Security Administration or Veterans Administration.

If the client has no income, the Payment Agreement developed between the Adult Service worker, provider and the client will reflect that the Department will reimburse the provider for the full cost of care. In addition, payment will be included in the provider's reimbursement for the client's Personal Expense Allowance, which the provider is then responsible to make available for the client's use. If, at some point, the client begins to receive income, the Adult Service worker must develop a new Payment Agreement with the provider and client reflecting the client's resources and the amount of payment he/she will be responsible for.

b) Income Not Available

If a client who is being placed in an Adult Family Care home has income that is not presently available to him/her, the Adult Service worker must determine how the client might gain access to their resources and what other potential resources the client might be eligible for. This may involve working closely with individual(s) who are assisting the client in making their personal and financial decisions. If there are resources and the individual assisting the client in making their financial decisions is not using the client's income for their care, the worker must request a change in Payee or petition for a Conservator.

If the client has income but it is not available for their use at the time of placement, the Payment Agreement developed between the Adult Service worker, provider and the client will reflect that the Department will reimburse the provider for the full cost of care. In addition, payment will be included in the provider's reimbursement for the client's Personal Expense Allowance, which the provider is then responsible to make available for the client's use. At the point the client's income becomes available for their use, the Adult Service worker must develop a new Payment Agreement with the provider and client reflecting the client's resources and the amount of payment he/she will be responsible for. In addition, the Department may request reimbursement for payment made on the resident's behalf.

5.3.3 Review of the Payment Agreement

The Payment Agreement must be reviewed every twelve (12) months. In addition, whenever there is a change in the client's financial situation, the Payment Agreement must be updated. A new Payment Agreement must be completed any time there is a change in the resources available to the client to contribute to their cost of care.

5.4 Bed Hold

It is recognized that there will be times when it is necessary for the client to be absent from the Adult Family Care home. In certain circumstances payments to the provider may continue uninterrupted. These include absences from the home due to client inpatient hospitalization, provider respite and client social activities.

Specific time frames apply to each. There may be instances where an extension of established time frames may be required. In this event, the Adult Service worker must request a Policy Exception. It must be done through FACTS and must include thorough documentation and justification for the extension of the bed hold.

5.4.1 Medical

A bed may be held for a resident for up to fourteen (14) days per episode when it is necessary for the client to be absent from the facility for inpatient hospitalization/treatment. Payment at the established rate will continue for up to fourteen (14) days, or until such time as it is determined that the client will not be returning to the home, not to exceed the fourteen (14) day limit. Payment by the Department and/or the client will continue in accordance with the terms of the Payment Agreement in effect. If it is determined that the resident will not be returning to the facility, the Adult Service worker must end date the Payment Agreement with the date it was determined that the client will not be returning to the home and advise the provider.

In order to grant a bed hold for medical treatment purposes, ALL the following criteria must be met:

a) The provider must notify the Department of the adult's need for out of home medical treatment (in advance whenever possible, the next working day whenever out of home medical care is required on an emergency basis);

b) The adult for whom payment is being continued was placed in the AFC home by the Department and the Department is currently making a supplemental payment for their care;

c) The adult's absence from the AFC Home is to be temporary and short-term, not to exceed fourteen (14) days per episode;

d) The resident is expected to continue to be appropriate for placement in an Adult Family Care home upon discharge from treatment/hospital;

e) The resident will be returning to Adult Family Care upon discharge; and,

f) Respite.

An Adult Family Care provider is entitled to use up to seven (7) days of respite care per calendar year. During the seven (7) days the Adult Family Care provider will continue to receive the regular Adult Family Care payment uninterrupted. (See

Section on Respite Care under Case Management and Demand Payments for additional details).

5.4.2 Social

Providers are to encourage residents to engage in appropriate social and recreational activities. Examples include; natural family visitation, natural family vacations, special camps, overnight field trips, etc. A client may be absent from the facility for these types of events for up to fourteen (14) days per calendar year. During the resident's absence, the Adult Family Care home will continue to receive payments uninterrupted.

In order to grant a bed hold for social purposes, ALL the following criteria must be met:

a) The activity must be scheduled in advance and reflected in the client's Service Plan;

b) The adult for whom payment is being continued was placed in the Adult Family Care home by the Department and the Department is currently making a supplemental payment for their care;

c) The adult's absence from the Adult Family Care home is to be temporary and short-term, not to exceed fourteen (14) days per calendar year; and,

d) The resident will be returning to the Adult Family Care home.

All overnight absences for this purpose must be approved in advance by the local DHHR staff.

5.5 Automatic Payments

The primary method used to make payment to AFC providers will be the automatic payment process. Specifically, payment to the provider for the care of each individual placed in their home is automatically created by FACTS and mailed to the provider on a monthly basis. The amount of payment the provider will receive is based on information entered in FACTS regarding the provider and the client. Payment is made for the date of placement but payment IS NOT made for the date of discharge. Information that is taken into consideration by FACTS in generating the monthly automatic payment is as follows:

1. Type of placement;
2. Client's personal expense allowance;
3. Client's benefit income;
4. Client's employment income;
5. Client's sheltered workshop income;
6. Client's assets; and,

7. Client's monthly expenses (in certain circumstances - debt expenses).

Based on all these various pieces of information, FACTS will calculate the total rate of the monthly payment due to the provider.

In order to assure that monthly payments to the provider are accurate and received by the provider without delay, it is essential that the Adult Service worker enter the required information in a timely manner. Payment information and supervisory approval must be completed by noon on the fourth (4th) working day of the month in order to prevent inaccurate or delayed automatic payment. Payment information that is not entered and approved by noon of the fourth (4th) working day of the month will require the Adult Service worker to request a Demand Payment for the purpose of doing a payment adjustment/correction.

After the total rate of payment is determined by FACTS, the Adult Service worker can create the Payment Agreement. The Payment Agreement will reflect several amounts related to the payment the provider is to receive. These include:

1. The total monthly rate of payment due to the provider for a full month of care;
2. The total daily rate due to the provider for a partial month's care;
3. The portion of the monthly payment which is to be paid by the client for a full month of care;
4. The portion of the daily rate that is to be paid by the client for a partial month's care;
5. The portion of the monthly payment, if any, which is to be paid by the Department for a full month of care;
6. The portion of the daily rate, if any, that is to be paid by the Department for a partial month's care; and,
7. The amount of the personal expense allowance.

After the Payment Agreement is created based on the information entered in FACTS, the Adult Service worker must carefully review the printed document for completeness and accuracy. (See Payment Agreement for more detailed information).

Finally, prior to noon on the fourth (4th) working day of each month the Adult Service 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 Adult Service worker must make the necessary changes prior to the fourth (4th) working day of the month. If no errors are detected, the Adult Service worker must verify the payment shown.

Note: Effective July, 2003, the payment to the AFC provider was changed to a flat rate. Previously, variable rates were paid to AFC providers based upon the level of care assessment. The Level of Care Evaluation is no longer required.

5.6 Demand Payments

Most costs associated with the care of an adult placed in an Adult Family 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 Family Care home by the Department or for specific expenses incurred by the Adult Family Care home provider that are not client specific.

The need for a Demand Payment of any type must be determined jointly by the client's Adult Service worker, the Adult Service worker's supervisor and homefinder and/or Adult Services Consultant (if applicable) and the provider prior to any cost being incurred and cost associated with the client 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 a second party. If the Demand Payment requires a two-tiered approval in FACTS, the appropriate individual(s) responsible for approving/denying the two-tiered payment must be contacted for approval/denial prior to any cost being incurred, preferably by e-mail.

In addition, **all potential resources must be thoroughly explored before requesting a Demand Payment.** Examples include, but are not limited to, family members, community/civic organizations, churches, drug company programs, assistance programs, samples from physicians, mental health agencies, health right clinics, etc. Efforts to locate alternate resources must be documented in FACTS.

Payments that are made on behalf of a specific client (i.e., co-pays, durable medical, etc.) are to be entered by the client's Adult Service worker. Payments to the provider that are not client specific (i.e., training incentive payment) are to be entered by the homefinder. Payment is made for the date of placement but payment **IS NOT** made for the date of discharge.

In order to generate Demand Payments for clients placed in Adult Family Care, the vendor must submit a W-9 and be set up in FACTS as a provider. The worker must provide the Financial Unit with the original W-9, as well as name, tax address and telephone number so the provider can be opened in FACTS. After the provider is opened in FACTS, the provider must be entered on the Service Log in FACTS for the appropriate service and month. The worker must make a copy of the W-9 and file it in the provider's paper record and document the W-9 in Document Tracking.

Once the worker has obtained the appropriate prior approval(s) and it is determined that the Demand Payment will be used, the worker will complete the Demand Payment screen in FACTS. Those payment types that require a two-tiered approval are marked with an (*) in the list below. When one (1) of these types is to be used approvals must be obtained before services are provided. This approval must be requested by completion of the Demand Payment screens in FACTS. In addition, the Adult Service worker must document justification/explanation for payment in FACTS

in the Comments Text Box on the Demand Payment screen. (See documentation requirements for the specific Demand Payment type being requested.) The Demand Payment will not be generated by FACTS and sent to the provider until the required approval(s) is done.

5.6.1 Demand Payment Types

Those payment types that require a two-tiered approval are marked with an (*) in the list below. When one (1) of these types is to be used approvals must be obtained before services are provided. This approval must be requested by completion of the Demand Payment screens in FACTS. In addition, the Adult Service worker **must** document justification/explanation for payment in FACTS in the Comments Text Box on the Demand Payment screen. (See Documentation Requirements for the specific Demand Payment type being requested.) 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:

a) Respite care;

b) Trial visit (only when client does not have resources to pay this cost);

c) Payment adjustment (to correct underpayment to provider);

d) Specialized AFC payment (applies only to existing AFC providers of this type);

e) Clothing allowance;

f) Educational expenses for special education students;

g) *Durable medical equipment and supplies;

h) Annual client medical evaluation;

i) *Non-Medicaid and non Medicare Part D covered services (prescriptions only);

j) *Food supplements;

k) *Over-the-counter (OTC) drugs/DESI drugs or prescriptions not covered by insurance/Medicaid;

l) Co-payment on prescription medications;

m) Provider training incentive payment (not client specific);

n) Annual provider medical report (not client specific);

o) *$1,000 incentive payment to provider for their efforts in client's return home; and,

p) *Other Demand Payments.

Demand Payments are done on a weekly basis, based on information entered in

FACTS by the Adult Service worker. Information that is required in order for FACTS to generate Demand Payments include:

a) Information identifying the provider to be paid;

b) Client for whom the request is being made, if applicable;

c) Invoice date;

d) Service month;

e) Amount to be paid;

f) Payment type; and,

g) Explanation of why the payment is necessary.

When a Demand Payment is needed, the Adult Service 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 a second (2nd) party is also required in addition to the supervisory approval.

Finally, after the required approval(s) is granted, the Adult Service 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).

5.6.2 Respite Care

An Adult Family Care provider is entitled to use up to seven (7) days of respite care per calendar year. A calendar year is to be from January 1st through December 31st. During these seven (7) days, the Adult Family Care provider will continue to receive the regular AFC payment uninterrupted. Respite care can be arranged to provide temporary care to elderly or disabled adults in order to offer short term relief to regular Adult Family Care providers. The purpose is to allow these full-time providers to have planned times for vacations or other activities and to provide emergency care in the event of illness of the provider or a provider's family member. Although providers are encouraged to take their residents with them on vacations, it is also recognized that sometimes families may need to spend some time by themselves. **Clients are not to be placed in with an unapproved respite provider. Household members cannot be paid for providing respite care.**

a) <u>Determining the need/planning for paid respite care</u>

All paid respite is to be planned and approved by the Adult Service worker in advance, with the exception of respite which is needed as a result of an emergency involving the provider or a member of the provider's household. When respite is needed in an emergency, verbal approval of the Adult Service worker must be obtained prior to placement of the client with an approved respite provider. The need for paid respite is to be documented in the Service Plan and is not to exceed seven (7) days per calendar year per client for whom DHHR is making a supplemental

payment. Respite care arrangements must be part of the Service Plan and all contacts regarding the arrangements are to be documented.

Prior to payment for respite care, the respite provider must submit a written signed/dated statement or invoice, verifying dates respite care was provided and the client's name(s) that care was provided to, with the name of the respite provider and the regular AFC provider's name. Upon receipt of this written invoice/statement, the Adult Service worker is to request a Demand Payment for the appropriate amount. In the event respite care would continue beyond the allowed seven (7) days, the Adult Service worker is to discontinue respite payment for the client to the respite provider The per diem rate paid to the respite provider will be based on the per diem rate for the regular AFC provider. Payment beyond the annual seven (7) days is the Adult Family Care provider's responsibility.

5.6.3 Trial Visit

If a client who is currently an active Adult Services client is planning to move to another home or a different type of setting, a trial placement is recommended to assure a good match between the prospective provider and the client. If an overnight stay is planned as part of a trial visit, the Department may reimburse the prospective provider.

If the client is being discharged from an institutional setting or coming from the community and is not an active Adult Services client at the time of the trial visit, the client must be encouraged to use his/her resources to make payment to the prospective provider. If it is determined that the client does not have resources to pay the provider for the trial visit, the Adult Service worker is to request that payment to the provider be made by the Department as a Demand Payment.

Reimbursement made by the Department for a trial visit is to be at the current daily rate for the type of provider involved in the trial visit. (See Case Management - Payment for additional information).

Note: Trial visits are not to exceed more than seven (7) days unless a Policy Waiver is sought by the Adult Service worker and granted by the supervisor or approved administrator.

5.6.4 Payment Adjustment

This Demand Payment type is to be used for the purpose of correcting an under payment to an Adult Family Care provider. An under payment may occur when the Adult Service 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. When the Adult Service worker is calculating the amount of payment adjustment, the provider is not paid for the last day of placement if the client is leaving current placement.

5.6.5 Specialized AFC Payment

This Demand Payment type **applies only to payments made to existing** Specialized **Adult Family Care providers in Lewis County.** The rate of payment to this type of provider is different from the payment rate for regular Adult Family Care providers. The rate of payment for this type of provider is different from the rate of payment for a regular AFC home therefore this Demand Payment type is to be used to reimburse Specialized AFC providers for the balance of payment due each month.

5.6.6 Clothing Allowance

Clients who are placed in residential settings by the Department are to have adequate clothing. A clothing allowance is available for adults who are placed in a residential setting by the Department and for whom the Department is making a supplemental payment. The clothing allowance is available at the time of placement and on six (6) month intervals throughout the placement.

Requirements related to the use a clothing allowance include the following:

a) Must be based on the client's need for clothing;

b) The Department must be making a supplemental payment to the provider for the client's care;

c) Initial Placement Allowance cannot exceed $100 (life time, one time only);

d) Re-placement allowance cannot exceed $75 during a six (6) month period; and,

e) Need for placement or re-placement clothing must be planned in advance of purchase by the provider and the Adult Service worker.

To receive reimbursement by the Department, the residential service provider must submit an itemized invoice for the clothing purchased. (See section titled Clothing Allowance Eligibility, for detailed information).

5.6.7 Educational Expenses for Special Education Students

Adults who are enrolled in Special Education programming may incur costs associated with their educational program. In order for the Department to reimburse the provider for these costs, the adult must be enrolled on a full-time basis in an educational program. In addition, the costs for which reimbursement is requested must not be reimbursable by any other source and must be related to enhancing or completing their educational program (i.e., of costs that may be reimbursable include graduation fees and special fees for school trips/functions.

5.6.8 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 Family Care home by the Department and for whom the Department is making a supplemental payment. Reimbursement by the Department may only be considered after it has been

determined by the Adult Service 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:

a) Be prescribed by the adult's physician;

b) Meet an identified need on the adult's Service Plan;

c) Be necessary to prevent the need for a higher level of care;

d) Be a one (1) time only expense rather than a reoccurring cost;

e) Not exceed the current Medicaid rate; and,

f) No other resources are available.

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 Adult Service 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 Adult Service worker must forward the request to the supervisor for approval. This Demand Payment type requires a two-tiered approval. After approval by the supervisor, FACTS will forward the request to the appropriate person for the final disposition. The Demand Payment will not be generated by FACTS and sent to the provider until the required approval(s) is done (i.e., wheelchair, hospital bed, commode seats, colostomy supplies, etc.).

5.6.9 Annual Client Medical Evaluation

Each client placed by the Department in an Adult Family Care home must receive an annual physical examination. The Adult Family Care provider is to arrange for this examination to be completed. Upon completion of this examination, the provider may submit the receipt to the Department to request reimbursement. The Adult Service worker must then prepare a request for reimbursement for the client medical evaluation. Upon completion of the Demand Payment request, the Adult Service worker must forward the request to the supervisor for approval.

5.6.10 Non-Medicaid Covered Services

Clients placed in Adult Family 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 Adult Service 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:

a) Be recommended/authorized by the adult's medical/mental health professional;

b) Have been deemed necessary by the adult's medical/mental health

professional (written statement of need required);

c) Meet an identified need on the adult's Service Plan; and,

d) 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 Adult Service 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 Adult Service worker must forward the request to the supervisor for approval. This Demand Payment type requires a two-tiered approval. Upon approval by the supervisor FACTS will forward the request to the appropriate person for the final disposition. The Demand Payment will not be generated by FACTS and sent to the provider until the required approval(s) is done.

5.6.11 Food Supplements

In unique situations, food supplements may be required by an adult placed by the Department in an Adult Family 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 Adult Service 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:

a) Be prescribed by the adult's physician or deemed medically necessary by the adult's physician (written statement of need required);

b) Meet an identified need on the adult's Service Plan; and,

c) 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 Adult Service 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 previously mentioned.

Upon completion of the Demand Payment request, the Adult Service worker must forward the request to the supervisor for approval. This Demand Payment type requires a two-tiered approval. Upon approval by the supervisor FACTS will forward the request to the appropriate person for the final disposition. The Demand Payment will not be generated by FACTS and sent to the provider until the required approval(s) is done.

5.6.12 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 Family Care home that are not covered by Medicaid or other insurance. These include items such as over-the-counter medications (OTC), 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 Adult Service 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:

a) Be prescribed/ordered by the adult's physician or deemed medically necessary by the adult's physician (written statement of need required);

b) Meet an identified need on the adult's Service Plan; and,

c) 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 medication after it has been purchased. The Adult Service 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 Adult Service worker must forward the request to the supervisor for approval. This Demand Payment type requires a two-tiered approval. Upon approval by the supervisor FACTS will forward the request to the appropriate person for the final disposition. The Demand Payment will not be generated by FACTS and sent to the provider until the required approval(s) is done.

5.6.13 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 Family Care home by the Department and for whom the Department is making a supplemental payment. Reimbursement by the Department may only be considered after it has been determined by the Adult Service 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:

a) Be prescribed by the adult's physician;

b) Have been deemed medically necessary by the adult's physician;

c) Meet an identified need on the adult's Service Plan; and,

d) 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 within 6 (six) months after they have been purchased. The Adult Service 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 Adult Service worker must forward the request to the supervisor for approval.

5.6.14 Provider Training Incentive Payment

Adult Family Care providers who are currently receiving a supplemental payment for a client(s) placed in their home by the Department 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 Family 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 Adult Service worker may then prepare a request for a Demand Payment in the amount of $25.00. Upon completion of the Demand Payment request, the Adult Service worker must forward the request to the supervisor for approval.

Note: The training allowance cannot be prorated. If a full six (6) hours of training is not completed within the quarter, the provider is not eligible for this payment. In addition, hours earned during one (1) quarter may not be carried over to any subsequent quarter.

5.6.15 Annual Provider Medical Report

After an Adult Family Care home becomes an approved provider, the person(s) in the household who are primarily responsible for furnishing care to the clients placed in the home is required to have a medical evaluation completed every three (3) years, unless the homefinder request one prior to that. 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 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.

5.6.16 $1,000 Incentive Payment

The intent of this incentive payment is to reward a provider who has been primarily responsible for a client improving to the point that they no longer required residential care services and consequently can return to their own home to live. This payment is not intended to provide additional compensation for providers who have provided short term care to clients with short term needs.

In order to qualify for this payment, a provider must be nominated by the Adult Service worker. In order for a provider to be considered for nomination to receive this incentive payment, all the following criteria must be met:

a) The client must have been income eligible and the provider having received a monthly supplemental payment from the Department for the service they rendered (private pay clients are not to be considered);

b) The provider must have provided full time care to the client for a minimum of twelve (12) consecutive months;

c) A Multi-disciplinary team, such as a Community Planning Team (CPT) used with guardianship cases, must have been involved in the establishment of the goal of independent living and the development/monitoring of the Service Plan that was implemented;

d) Independent living must have been the planned objective on the client's Service Plan and progress toward the achievement of this goal should be well documented in the six (6) month Case Review. 1) The provider must have been assigned, as part of the Service Plan, key/measurable tasks toward the achievement of the client's goal of independent living. 2) The Adult Service worker must be able to demonstrate the client's return to the level of independence was primarily due to the efforts of the provider;

e) An after Care Plan must be in place to identify the tasks to be accomplished, and by whom, during the six (6) month period the client is living in their own home; and once the client has returned to their home, they must remain there independently for at least six (6)

months before the bonus can be given;

Close communication between the local staff and the Bureau for Children and Families is encouraged throughout this very involved procedure. When a client is first identified as a possible candidate for independent living, the Adult Service worker will need to consult with their supervisor. If it is agreed that the provider is a potential nominee, the Adult Service worker is to notify the Bureau for Children and Families of their intention to proceed. An appropriate Service Plan must be developed with the goal of independent living and the specific tasks assigned to the provider in accomplishing this goal clearly identified. Regular monitoring of the progress being made by the client toward the achievement of the established goal of independent living is to be documented by the Adult Service worker. Upon completion of the six (6) month Case Review, an update regarding the status of progress must be forwarded to the Bureau for Children and Families.

If supportive services are required once the client goes home, an after Care Plan must be developed to identify what services are to be provided and who will be responsible for the provision of those services. The Adult Service worker must continue to provide Case Management services for at least six (6) months after the client's return home. Follow-up during this period of time must include, at a minimum, monthly monitoring visits. If more frequent monitoring is required, this should be evaluated carefully as it may be an indication that the case may not be stable and the client may need to return to a more supportive type of setting.

Note: The client's placement is to be end dated upon discharge from the Adult Family Care home to their own residence. However, the case is to remain open as an Adult Residential case in FACTS during the six (6) month after care period so contacts and progress can be documented and the incentive payment generated when applicable.

If, at the end of the six (6) month after care period the client is able to continue to live independently, the worker must prepare a request for payment of the $1000.00 provider bonus. Upon completion, the request must be submitted to the supervisor for approval. At a minimum, the request must include the following:

a) The date the client went into placement with the provider; and,

b) Adequate documentation/justification to support the provider's eligibility to receive the bonus, based upon each of the criteria listed above.

If the supervisor concurs with the worker's recommendation that the provider is eligible to receive this special compensation, the request is then to be forwarded, to the Adult Services Unit of the Bureau for Children and Families for consideration and approval. Once approval of both the supervisor and the Bureau for Children and Families has been obtained, a Demand Payment may be issued by the Department. In addition to the payment, the local office is encouraged to send a letter of commendation to the provider being recognizing them for their efforts.

5.6.17 Other Demand Payment - Not Specified

In certain situations the cost of obtaining needed supplies or services may be reimbursed for the provider or for adults who have been placed in an Adult Family Care home by the Department and for whom the Department is making a supplemental payment. Reimbursement by the Department may only be considered after it has been determined by the Adult Service 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. This Demand Payment type requires a two-tiered approval. Upon approval by the supervisor FACTS will forward the request to the appropriate person for the final disposition. The Demand Payment will not be generated by FACTS and sent to the provider until the required approval(s) is done.

The Department may only be considered after it has been determined by the Adult Service worker that there is no other personal or community resource that can meet this need. In addition, the other Demand Payment for which payment is requested must:

a) Be prescribed by the adult's physician;

b) Meet an identified need on the adult's Service Plan;

c) Be necessary to prevent the need for a higher level of care;

d) Be a one (1) time only expense rather than a reoccurring cost;

e) Not exceed the current Medicaid rate; and,

f) No other resources are available.

5.7 Special Medical Authorization

Most clients who are placed in an Adult Family Care will be eligible for Medicaid or some other type of medical insurance to cover the cost of needed medical care. If a client currently receives Medicaid, the Special Medical authorization must **not** be issued. The coverage for Medicaid and the Special Medical authorization are identical. If the client does not have coverage for necessary medical care, the Adult Service worker must thoroughly explore all potential options for securing appropriate medical coverage. Examples include, but are not limited to, community/civic organizations, family members, churches, Medicare Part D, drug company assistance programs, samples from physicians, mental health agencies, health right clinics, etc. 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 to pay for specific medical expenses. The Special Medical authorization will **not** cover any prescriptions that are covered under Medicare Part D, regardless of whether the client is enrolled in Medicare Part D or not.

To be eligible for Medicare Part D the individual must be receiving either Medicare Part A or B. To be eligible for either Medicare Part A or B, the individual must be sixty-five (65) years of age OR, if under sixty-five (65) years of age, the individual

must be receiving disability Social Security benefits and must have been receiving disability Social Security benefits for two (2) years.

Regardless of the reason(s) resources are not available, use of the Special Medical authorization may only be used to meet an emergent need or to prevent an emergency from occurring. When this is the case, the Adult Service worker may request use of the Special Medical authorization to cover the cost of certain medical care or services. The Special Medical authorization may only be issued for a period of up to six (6) months. At the end of the approved eligibility period if continuation of services is necessary, a new authorization must be requested.

The lack of resources may include the following:

a) The client does not have funds to pay for medical care;

b) No other resources are available, such as family, friends, community/civic organizations, etc.;

c) Is not eligible for any type of medical coverage; and,

d) Is eligible for medical coverage but benefits are not currently available (recent application - not yet approved for coverage), with the exclusion of Medicare Part D.

Note: In a situation where a client needs services from more than one (1) vendor (i.e. an office visit with a physician and prescriptions from a pharmacy) a separate Special Medical authorization request will be required for each vendor, with the appropriate eligibility period for each authorization.

5.7.1 Special Medical Authorization Criteria

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

a) The client is currently a resident in an Adult Family Care home;

b) The client was placed by the Department or was placed by another party but the placement was approved by the Department;

c) The treatment, service, or certain supplies for which authorization is being requested is deemed medically necessary by the client's physician;

d) The medical treatment, service or certain supplies are needed to remedy an emergency medical situation or to prevent a medical emergency from developing; and,

e) The Department is making a supplemental payment to the Adult Family Care home (except for private pay clients that have approval of a Policy Exception for the Special Medical Card).

The Special Medical authorization may be used to cover certain medical costs however; all Medicaid eligible services are not necessarily covered by this authorization. The Special Medical Card **will not cover** any prescription that is not on the Medicaid Drug Formulary. In addition if the client is in a category that should be eligible for Medicare Part D, **the Special Medical Card will not cover any prescription costs that are covered by Medicare Part D.** Therefore the Special Medical Card must not be issued for individuals in this category. The Special Medical authorization is to be used to provide for medical care needed to treat an emergency or to prevent a medical emergency from occurring (limited to prescriptions and limited doctor visits).

5.7.2 Examples of Costs that are Typically Covered:

a) Medication (must be prescribed by a physician);

b) Limited doctor visits;

c) Pads/Chux only - 150/month;

d) Adult disposable briefs only - 200/month; and,

e) Combination of pads and adult disposable briefs - 250/month.

Note: Workers must get a physicians prescription for payment. The WVMI Medicaid DMI form is to be completed and sent for payment to be made for Pads/Chux and briefs.

5.7.3 Examples of Costs that are NOT Covered (not all inclusive):

a) Hospitalization;

b) Nursing home placement;

c) Psychiatric treatment;

d) Behavioral health day treatment;

e) Dental work;

f) Glasses;

g) Outpatient surgery; and,

h) Diagnostic testing.

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 (i.e., hospitalization **IS NOT** covered by the Special Medical authorization; nor is Case Management services at behavioral health centers).

5.7.4 Required Procedures

If a client, who has been placed in an Adult Family 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 services, Special Medical authorization may be requested to cover the cost. To request Special Medical authorization, the Adult Service worker must complete the Special Medical screen in FACTS. This request must be approved before a Special Medical authorization 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 Adult Family Care home placement at the time of the request.

If the Department is making a supplemental payment for the Adult Family Care home 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 AFC placement at the time of the request, the approval for use of a Special Medical authorization requires a Policy Exception and approval by the supervisor and a second party.

5.7.5 When requesting a Special Medical Authorization the Following Information Must be Documented in FACTS:

a) Client's goal related to providing the requested services on the Service Plan;

b) Explanation of how provision of the requested services will prevent movement of the client to a higher level of care;

c) List the specific service(s) payment is being requested for and associated cost (cannot exceed current Medicaid rate);

d) Statement of verification that all potential resources have been explored and the amount of resources that will be paid through another source (if any) or that there are no other resources available to meet the cost;

e) Anticipated duration of request;

f) Name of provider;

g) Income amount and source;

h) Amount of supplemental payment being made by the Department; and,

i) Any other relevant information.

In addition to the above information, **private pay clients** must be paying the current state rate and must not have any resources to pay for the medical need (this must be explored thoroughly and documented). **A Policy Exception must be requested and approved by the local supervisor, as well as the second tier approval before the Special Medical Card can be issued.** If a private pay client has any excess income after paying current state rate to the Adult Family Care home, minus the Personal Needs Allowance **this amount must be applied towards the cost of the medical need before using the Special Medical Card.** The Adult Service

worker must verify and document each month that all excess income has been applied towards the cost of the medical need and that the client is not using the excess income for unapproved items. A Policy Exception is required prior to the excess income being used for something other than medical needs.

Much of the required documentation should be recorded on various screens within FACTS (i.e., medications should be recorded in the Medical screens, income should be documented in 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.

5.7.6 Approved

The Adult Service worker must print the Special Medical authorization and review the printed document to ensure that all information is complete and accurate. The Adult Service worker must then furnish the vendor who will be providing the service with this authorization. The Adult Service worker will file a copy of the Special Medical authorization in the client's paper file and/or the case File Cabinet in FACTS. The information about this authorization will be forwarded electronically from FACTS to the Bureau for Medical Services (generally will occur within five (5) days following the approval, because of this delay, the vendor will not be able to immediately call to verify authorization with the Bureau for Medical Services, the written authorization printed by the Adult Service worker is to provide verification of the approval). If at any time during the approval period, the authorized services are no longer required, the Adult Service worker must send written notification to the vendor advising them to discontinue provision of the authorized services.

5.7.7 Denied

The Adult Service 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: Clozaril, or an equivalent is covered by Medicare Part D. If the client is not eligible for Medicare Part D, Medicaid covers this for recipients of Medicaid. If the client is not currently receiving Medicaid and is not eligible for Medicare Part D, an application for Medicaid must be made through Income Maintenance as a potential resource. There is a Special Pharmacy Program for individuals who cannot meet a Medicaid spend down and who meet certain other criteria.

5.8 Clothing Allowance Eligibility

The purpose of providing a clothing allowance is to insure that all clients placed by the Department of Health and Human Resources and for whom the Department is making a supplemental vendor payment, have adequate clothing while in placement. Private pay clients that are receiving the Special Medical Card are not eligible for the clothing allowance. Provision of a clothing allowance is not to be considered an automatic payment. Rather, it is to be based upon the individual client's need for clothing. There are two (2) types of clothing allowance available for eligible adults: 1)

an Initial Placement Allowance and, 2) a re-placement clothing allowance. An assessment of the need for clothing is to be done by the Adult Service worker at the time of placement and again every six (6) months, during the case review process to determine if a clothing allowance will be needed.

5.8.1 Determination of Eligibility

Certain adults in residential settings are eligible to receive a clothing allowance. In order to be eligible for this allowance, the client must meet two (2) criteria. These are:

a) They must reside in a supervised care setting; and,

b) The Department must be making a supplemental payment to the residential placement provider for the client's care.

5.8.2 Initial Placement Allowance

In order to insure that the adult has sufficient and adequate clothing at the time of placement, an Initial Placement Clothing Allowance may be requested. Eligibility for the Initial Placement Allowance begins on the date of placement and ends on the day prior to the date of the six (6) month review or the date of discharge, whichever occurs first. A life time maximum of $100 is available for the Initial Placement Clothing Allowance. It is not necessary to use the entire amount permitted at one time, however, purchases do need to be completed prior to the six (6) month Case Review following placement. Any unspent portion of the client's Initial Clothing Allowance will be forfeited and may not be carried over to the following six (6) month period.

The Initial Placement Allowance is available at the first placement of the adult and is a onetime only allowance. If the client is discharged from the placement to home or another setting and is later admitted to the same or a different subsidized residential placement, the client is not eligible for an Initial Placement Clothing Allowance, but would be eligible for the Replacement Clothing Allowance. In the event the adult would move from one (1) placement setting to another, the adult is not again eligible for an Initial Placement Allowance. The discharging provider is to send the adult's clothing with them at the time of removal from their home. The Adult Service worker is to insure that this occurs and that the adult has adequate clothing when placed with the new provider. If clothing is needed, any balance remaining in the client's Replacement Clothing Allowance for the six (6) month period may be used to purchase needed clothing.

5.8.3 Replacement Clothing Allowance

In order to insure that the adult has sufficient and adequate clothing throughout their placement, a Replacement Clothing Allowance may be requested every six (6) months. Eligibility for a Replacement Clothing Allowance begins on the date of the scheduled six (6) month review and ends on the day preceding the date of the next scheduled six (6) month review or upon discharge, whichever occurs first. A maximum of $75 is available for each six (6) month period. The voucher can be spent

any time within that six (6) month time frame if the client is in need. It is not necessary to use the entire amount allowed at one time, however, purchases do need to be completed prior to the six (6) month Case Review. Any unspent portion of the client's Initial Clothing Allowance will be forfeited and may not be carried over to the following six (6) month period.

5.8.4 Required Procedures

To request an Initial or Replacement Clothing Allowance for an eligible client, the AFC provider or the client may contact the Adult Service worker or, the AFC provider, the client and the Adult Service worker may jointly identify this as a need during the placement or review process. When a clothing allowance is needed, the following must occur:

a) Reimbursement to the Adult Family Care Home provider:

The Adult Family Care home provider must purchase clothing. The adult should be encouraged to assist with selection and purchase of their clothing whenever possible. If the adult is unable to assist, the provider is to purchase the needed clothing for the adult, taking into consideration the adult's wishes and preferences; and, the Adult Family Care home provider must submit the itemized receipts to the Department's district office for approval and reimbursement.

b) Payment to the Vendor:

The Adult Service worker must issue a completed BA-67 to the vendor indicating the maximum amount for the purchase, either $100.00 if this is an Initial Clothing Voucher or $75.00 if this is a Replacement Clothing Voucher. The Adult Service worker should indicate on the form that the clothing is for either an adult female or adult male (this form is available in the Reports area of FACTS.) Upon completion by the vendor, the BA-67 is to be submitted to the Department's district office for approval and payment through FACTS. The Adult Service worker must do the following:

a) Verify the accuracy and completeness of the invoice/documentation (review to ascertain that the items listed are clothing items and that they are items suitable for the gender and size of the client);

b) Complete a Demand Payment request, selecting the "Clothing Allowance" payment type;

c) Forward the request to the supervisor for approval (payment will be processed upon supervisory approval);

d) Retain a copy of all receipts and/or BA-67 in the client's case record with documentation in FACTS as to the location of this documentation;

e) If a BA-67 has been used, after information to generate the Demand Payment has been entered into FACTS, mark the BA-67 (VOID) to prevent duplicate payment; and,

f) The voucher needs to match what was purchased for the client.

5.9 Service Planning

5.9.1 Introduction

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 Adult Service worker, the client, the AFC 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.

A new Service Plan must be completed at the six (6) month review, which involves completing both the Service Plan screen and the Summary Evaluation screen. The Service Plan is only a part of the review process. At the time the annual Comprehensive Assessment is completed, a new Service Plan must be completed. A new Comprehensive Assessment is due annually; however, the case must be reviewed every six (6) months. If there are changes in the client's circumstances prior to the next annual completion of the Comprehensive Assessment, these changes are to be documented on the Modification Tab of the Comprehensive Assessment.

The Service Plan can and should be modified as appropriate, any time there is a significant event or change in the client's circumstances that warrants a change in the Service Plan. The box on the Summary Screen Evaluation that says "Case Review Completed" must only be checked when the six (6) month Case Review is completed, not when the Service Plan is modified in between the six (6) month review period. (Refer to the section titled Case Review for additional information)**.**

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. The Comprehensive Assessment must be submitted along with the Service Plan whenever:

a) The Service Plan being submitted is the initial Service Plan; and

b) The annual Comprehensive Assessment has been completed.

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.

5.9.2 Inclusion of the Incapacitated Adult in Service Planning

Inclusion of incapacitated adults in the service planning process presents the Adult Service 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 Adult Service worker include the following:

a) 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;

b) When the client has an informal representative (i.e., 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;

c) When the client appears to lack decision-making capacity, but does not have a court appointed or informal representative, the Adult Service 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; and,

d) When a client appears to have decision-making capacity and could benefit from intervention but is resistant, it is appropriate for the Adult Service 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 Adult Service worker. Variations, however, may occur and could require consultation between the Adult Service worker and their supervisor to determine the most appropriate approach.

5.9.3 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.

5.9.4 Required Elements - General

The Service Plan must be completed as part of the assessment/review process. Based on the information gathered during the assessment/review, including but not limited to discussions with the client and the provider, the Adult Service 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:

a) Specific criteria which can be applied to measure accomplishment of the goals;

b) Specific, realistic goals for each area identified as a problem. This will include:

1. Identification of the person(s) for whom the goal is established;

2. Person(s)/agency responsible for carrying out the associated task(s), identification of services, and frequency/duration of services;

3. 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 i.e., Mary Jones will attend AA meetings at least once weekly). These tasks are typically short-term and should be monitored frequently; and,

4. 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.

5.9.5 Other Considerations for Service Planning

Other important considerations for the service planning process are:

a) The client's real and potential strengths;

b) Attitudes, influences and interpersonal relationships and their real or potential impact on implementation of the Service Plan; and,

c) Levels of motivation of both the client and the AFC provider.

Note: 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 Adult Service 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 AFC 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). The Service Plan is available in FACTS as a DDE and can be accessed through the Reports area.

5.9.6 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 the client and provider 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).

SECTION 6

CASE REVIEW

6.1 General Considerations

Evaluation and monitoring of the Adult Family Care case and the progress being made should be a dynamic process and ongoing throughout the life of the case. For AFC 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 Adult Service worker every six (6) months. Review must be completed more frequently if the client's circumstances, living situation, level of care, income, etc. should change prior to the six (6) month review date.

6.2 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; however, it is not the entire process. The Adult Service 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.

6.3 Time Frames

At a minimum, the Adult Service worker must have face-to-face contact with the client every three (3) months and a formalized Case Review must occur at least every six (6) months. 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 Adult Service worker can and should have regularly scheduled contact with the client and provider between the required reviews in order to monitor progress and identify and resolve potential problem areas promptly. These contacts by the Adult Service worker are to be face-to face contact with the client and provider in the client's usual living environment. The interview should be private with the client in the event the client has some issues/problems they feel uncomfortable in discussing in the presence of the provider. Also, the interview with the provider should be private. 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. All contacts are to be documented in FACTS as soon as possible of completion of the contact. Documentation is to be relevant and pertinent to completion of the Case Review.

6.4 Conducting the Review

A formal review of the case must be completed at least at six (6) months following

case opening and again at six (6) month intervals thereafter so long as the case remains open. Finally, the case is to be reviewed prior to case closure. Part of the review process consists of evaluating progress toward the goals identified in the current Service Plan. This requires the Adult Service worker to review the current Service Plan and have a face-to-face contact with the client and the AFC 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 Adult Service worker is to determine the following:

1. Summary of changes in the individual or family's circumstances;
2. Evaluate need for clothing allowance;
3. If applicable, collect receipts/bills for any co-pays within the past 6 (six) months which may be eligible for a reimbursement/payment via a Demand Payment;
4. Determine if the co-pays are eligible for reimbursement, and make a Demand Payment, if appropriate;
5. If applicable, assess the need for continued Special Medical and issue another Special Medical Card if the period of eligibility has expired;
6. Summary of significant case activity since the last review;
7. Assessment of the extent of progress made toward goal achievement;
8. Whether or not the identified goals continue to be appropriate and, if not, what changes and/or modifications are required;
9. Barriers to achieving the identified goals; and,
10. Other relevant factors.

Based on the results of the Case Review, a new Service Plan must be developed. (See Service Panning for detailed information).

6.5 Review of Personal Expense Allowance Use

As part of the regularly scheduled Case Review process, the Adult Service worker is to discuss and document in FACTS how the Personal Expense Allowance is being used with the client and the provider to ensure these funds are being used appropriately. (For items that can be purchased with the Personal Expense Allowance, please refer to the Personal Expense Allowance section of this policy). If the Adult Service worker believes that the Adult Family Care provider is negligent or exploitive with a client's Personal Expense Allowance, the Adult Service worker may require the provider to furnish an accounting of how the client's Personal Expense Allowance funds have been used. An appropriate referral will need to be made concerning the allegations. The Adult Service worker would also need to notify the AFC homefinder concerning the allegations. In the event the provider is not cooperative with this request or does not appear willing to correct any inappropriate

behavior or practice regarding the handling of the Personal Expense Allowance, consideration should be given to closing the home as an Adult Family Care provider. (See Adult Family Care - Request to Provide Services for detailed information).

6.6 Documentation of Review

At the conclusion of the review process the Adult Service 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 on the Review Evaluation Tab of the Service Plan. Goals that have not been end dated must be continued on the new Service Plan and can be modified as appropriate on the new Service Plan. Additional goals may be added as needed to the new Service Plan. The Summary Evaluation Screen must be completed and approved by the Adult Service worker before a new Service Plan can be completed in FACTS. The Adult Service worker must indicate on the Summary Evaluation Tab if this is a six (6) month review and if the case is going to continue or if the case is going to be closed. The Service Plan may be modified at any time; however, if the Service Plan is modified and this is not the scheduled six (6) month review, the Adult Service worker must not check the box that says “Case Review Completed”. This box is to be checked only when a new Service Plan is completed as a result of the regularly scheduled six (6) month review.

When a new Service Plan is completed, the Adult Service worker must submit this new Service Plan to the supervisor for approval. Once approved, the Adult Service 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 AFC 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. All contacts are to be documented in FACTS as soon as possible of completion of the contact. Documentation is to be relevant and pertinent to completion of the Case Review.

6.7 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 Adult Service worker. The provider is to establish a file for each individual placed in their home and maintain all information about the client in a confidential manner. Information that must be given to the provider by the Adult Service worker and maintained in the client file by the provider includes the following:

1. Identifying information about the client;
2. Information about significant others such as family members, friends, legal representatives, etc.;
3. Information about the client’s interests, hobbies and church affiliation;
4. Medical status including current medications, precautions, limitations;

5. Attending physician, hospital preference;
6. Advance directive(s) in force;
7. Information about client's burial wishes, plans and resources;
8. Copy of the signed Resident Agreement for Participation;
9. Copy of the current and all previous Payment Agreements; and,
10. Copy of the current Service Plan.

Note: Much of this information is contained in the Client Information report - an online report in FACTS. 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 Adult Service worker as well as information from other sources.

6.8 Confidentiality

6.8.1 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 provider information are contained in the Code of West Virginia. In addition, this provision requires DHHR to establish rules and regulations governing the custody, use, and preservation of the records, papers, files and communications concerning applicants and recipients of DHHR services. (For more information refer to Common Chapters).

6.8.2 When Confidential Information May be Released

All records of the Bureau for Children and Families concerning an Adult Services client/provider shall be kept confidential and may not be released, except as follows:

a) Records Maintained by the Department

1. 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.

2. 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 Adult Service worker/homefinder 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 Adult Service 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 state office of the Bureau for Children and Families 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/provider specific reports.

b) Records Maintained by the Provider

Records maintained by the provider are confidential and are to be maintained in a secure location. Information about the client shall only be released to other parties in order to provide needed services (i.e., medical information to medical providers, income information if eligibility is based on financial information, allergies/dietary needs to day treatment provider, etc.). If the client is discharged from the AFC home, the Client Record is to be returned to the client's Adult Service worker. The Adult Service worker is to review the record to determine what information is to be passed on to the new provider, if applicable. If the client does not move to another adult residential placement, the client information is to be filed in the client's paper record maintained by the Department.

c) 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/had involvement.

The various mechanisms that may be used are:

1. Subpoena;

2. Subpoena duces tecum; and,

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.

d) 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 Adult Service 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.

e) 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 Adult Service 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. 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.

6.9 Transfer of AFC Cases

There may be times when it becomes necessary for a client to transfer from one Adult Family Care home to another or from one county to another. When a case must be transferred, this is to be a planned effort with close coordination, between the sending worker/county and the receiving worker/county.

6.9.1 Timing of Transfers

It is recommended that case transfers be planned for the beginning or end of a month in order to minimize confusion related to payment. If this is not possible, the sending Adult Service worker must calculate the amount of payment due to the original provider from the client. If the client paid the provider the full monthly amount,

the Adult Service worker must request that the original provider reimburse a pro-rated amount for the remaining days of the month. This amount is then to be used by the client to pay the new provider upon placement. The client is responsible for paying the new provider in accordance with the new Payment Agreement. In addition, the original provider is to reimburse the client any portion of their Personal Expense Allowance that remains at the time of transfer to the new provider. The provider does not get paid for the last day of placement when the client is exiting placement.

6.9.2 Sending Worker/County Responsibilities:

When it is necessary to transfer an Adult Family 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):

a. 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;

b. The homefinder needs notified before placement occurs;

c. Provide a summary about the client's needs (i.e., reason for the transfer, problems in other settings, disturbing behaviors, family and financial resources, insurance coverage, and legal representative(s), if applicable);

d. Arrange for a trial visit(s) by the client to the proposed setting. Whenever possible this visit should be arranged at the convenience of the receiving county and the new provider;

e. Provide transportation for the client to the trial visit(s) and permanent placement, if placement is approved;

f. Inform and prepare the client, prior to the final move to the new residence, explaining where she/he is going, why she/he is going and what to expect upon arrival;

g. Arrange for a pro-rated portion of the client's financial resources to accompany him/her to the new residence, as well as adequate clothing and medication;

h. Complete all applicable case documentation prior to case transfer;

i. Immediately upon transfer of the client to the receiving county, send the updated client record to the receiving county;

j. Notify the DHHR Family Support staff, the Social Security Administration office, and all other appropriate agencies of the client's change of address; and,

k. Coordinate the move with the homefinder following the established protocol.

6.9.3 Receiving Worker/County Responsibilities

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

1. Be involved in preparing the new provider thoroughly for the client's arrival;
2. Notify the DHHR Family Support staff of the client's arrival when the transfer is complete;
3. Complete all applicable documentation;
4. Assist the client, and provider if applicable, with adjustment to the new arrangement;
5. Assist with arranging or initiating any needed community resources; and,
6. Complete a new Service Plan.

When an Adult Family Care case has been transferred, problems that arise during the first six (6) month period 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 Adult Service 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. During this six (6) month period, in the event problems cannot be resolved, the sending county must be willing to re-assume responsibility for the client upon the request of the receiving county.

If the Adult Service worker discovers the provider has moved, the Adult Service worker must notify the appropriate homefinder so that a home study can be completed in the new provider's home to determine if the provider will continue to be certified as an AFC provider or respite provider.

6.10 Exceptions to Policy

In some circumstances exceptions to policy may be requested. Exceptions will be granted on an individual case by case basis and only in situations where client circumstances are sufficiently unusual to justify the exception. However, such exceptions are to be requested ONLY after other methods and/or resources have been exhausted. In that event, requests must be submitted as a Policy Exception in

FACTS. The Policy Exception request is to be submitted by the Adult Service worker to the supervisor. Upon supervisory approval, the request will be forwarded to the appropriate individual final approval/denial. Policy Exception requests must include:

1. Explanation of why the exception is requested;
2. Alternate methods resources attempted;
3. Anticipated impact if the policy exception is not granted;
4. Efforts to resolve the situation;
5. Information supporting the request;
6. The time period for which the exception is being requested; and,
7. Other relevant information.

In an emergency situation, the request for a Policy Exception may be made to and approved by the Adult Services Consultant verbally. Once verbal approval is granted by the Consultant, the request for Policy Exception and all supporting information must be entered in FACTS within two (2) working days.

SECTION 7

CASE CLOSURE

7.1 Case Closure - General

The case must be closed when the client is no longer in Adult Residential placement and is not receiving any Adult Services or upon death of the client. When the request for case closure is received, (whether it is from the client, provider, or a collateral) this must be documented on the Contact screen. A final evaluation must be completed as part of the case review process prior to closure of the case, which is documented on the Summary Evaluation screen. The Adult Service worker must document the results of this assessment in FACTS, including the reason(s) case closure is being recommended. The Summary Evaluation screen is then submitted to the supervisor for approval of recommendation for case closure. In addition, the Summary screen must be completed and sent to the supervisor for approval. Upon supervisory approval, the case is to be closed. When the need for aftercare is identified, the worker and the client will work together to develop an aftercare plan, if requested by the client.

If the client is no longer in Adult Residential placement but is an active Health Care Surrogate or Guardianship case, the case must not be closed in FACTS. The primary case type must be changed to reflect either Health Care Surrogate or Guardianship Services and the secondary case type removed on the Summary screen in FACTS. If the case type is changed from Adult Residential to Health Care Surrogate or Guardianship because the client leaves placement, the Summary Evaluation screen must be completed and a new Service Plan completed reflecting the client's current circumstances.

Note: Before closing the case, verify that there are NO outstanding payments that are to be made on the client's behalf, such as clothing allowance payments or other Demand Payments. Closure of the case before all payments are generated may result in payment not being made as required.

7.2 Notification of Case Closure

If the case is closed for Adult Family 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** (previously SS-13) is to be used for this purpose. This form is available as a DDE in FACTS and may be accessed through the Reports area.

7.3 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 Service** (previously SS-13) 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.

SECTION 8

REPORTS

8.1 Adult Initial Assessment

The Adult Initial Assessment is completed in the intake phase of the case process. It is a compilation of elements from 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 Adult Service 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.

8.2 Comprehensive Assessment

The Comprehensive Assessment screen is completed in the case management phase of the case process; however, the Comprehensive Assessment Report is a compilation of elements from 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 Adult Service 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.

8.3 Client Medical Evaluation

Clients who are placed in Adult Family Care by the Department are required to have a medical evaluation completed during the placement process if one has not been 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 DDE form and may be accessed through the Report area of FACTS.

8.4 Payment Agreement

The Payment 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 in the Adult Family Care home. Within this document, the following are specified:

1. The payment amount due to the provider;
2. The portion of payment to be paid by the client; and,
3. The portion of the payment to be paid by the Department.

The agreement further identifies the monthly rate (for full month of placement) and the daily rate (for a partial month of placement). Finally, the agreement identifies the amount that is to be available to the client as Personal Expense Allowance and whether the client is to retain this amount from their funds or if the provider is to furnish this amount from their reimbursement by the Department. The Payment Agreement is created by FACTS based on information entered by the Adult Service worker. After all required documentation has been completed in FACTS, the Payment Agreement may be printed and required signatures obtained.

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 Adult Service 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 Payment Agreement, the Adult Service 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.

Note: The Adult Service worker must review the Payment Agreement carefully to insure the accuracy of the information. Particular attention should be paid to the facility type and payment amounts reflected on the document.

8.5 Resident Agreement for Participation

The Resident Agreement for Participation, which is completed during the case management phase of the case work process, is an agreement that the Adult Service worker completes with the client being placed in an Adult Family Care home that specifies certain requirements that the client agrees to abide by while in placement. This form should be updated annually. This form is available as a DDE and may be accessed through the Report area of FACTS. Finally, after printing the Resident Agreement for Participation, the Adult Service worker must secure the required signature, provide the client and provider 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.

8.6 Client Information Report

The form, which includes demographic and other information about the client, is to be used to furnish necessary information about the client to the Adult Family Care home provider at the time the client is placed in the home. The information on the report is pulled from various areas of the FACTS system. As a result, the Adult Service worker must ensure that all applicable documentation in FACTS is current at the time the form is printed so the information on the form is complete and accurate. It is available as a FACTS online report and may be accessed through the Report area of FACTS.

8.7 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 Adult Service 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 Adult Service 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.

8.8 Negative Action Letter (Previously used SS-13)

Any time a negative action is taken in an Adult Family 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** (previously SS-13) is to be used for this purpose. This form is available in FACTS as a DDE and may be added to the File Cabinet and Document Tracking by using the 'Save to FACTS' functionality. This functionality may be found in Microsoft Word under the 'Add – Ins' menu and then selecting 'Save to FACTS'; then FACTS will automatically add this document to the File Cabinet and the Document Tracking screen. If this automatic functionality is not used you may manually enter the report into the FACTS Document Tracking screen and saving a copy of the letter into the Investigation Filing Cabinet by using the import functionality.

8.9 Medicare Part D Letter

When the client is receiving the Special Medical Card and becomes sixty-four (64) years of age, the Medicare Part D Letter must be sent to the client or their legal representative notifying them that an application for Medicare Part A, B and D must be made prior to the client's sixty-fifth (65^{th}) birthday. Also, the letter notifies them that an application for QMB, SLIMB and QI-1 must be made through Income Maintenance, as well as Extra Help through Social Security. When the client becomes eligible for Medicare, **regardless of whether they are receiving it or not,** the Special Medical Card can only be issued for prescriptions and limited doctor's visits that are not covered by Medicare Part D.