PLEASE NOTE:

This sample Care Coordination Training Guide is for reference only.

If you intend to take Care Coordination training, you will receive a copy of the current month/year training guide from your instructors. Your testing will be based on the text that you are given. Your text may contain additional updated information based on when you take training.

DISCLAIMER:

The information contained in this training was current at the time it was written. It is not intended to be all inclusive, grant rights, impose obligations, or function as a stand-alone document. Although every reasonable effort has been made to assure the accuracy of the information in this document, the ultimate responsibility for compliance lies with the provider of services. The State of Alaska, Department of Health and Social Services, Division of Senior and Disabilities Services employees and staff make no representation, warranty or guarantee that this compilation of information is error-free and/or comprehensive and will bear no responsibility or liability for the results or consequences of the use of this curriculum.

SENIOR AND DISABILITIES SERVICES

BEGINNING CARE COORDINATION CLASSROOM TRAINING GUIDE

2016 | Operations and Training Unit

STATE of ALASKA
Department of Health and Social Services

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Welcome!

We're glad you've chosen to study Senior and Disabilities Service Care Coordination. This guide is designed to provide you with basic information and procedures. It is not intended to solely qualify you as a Care Coordinator. The qualifications needed to become a Care Coordinator are set forth in Unit 5: Certification. Even with the basic qualifications, for a new Care Coordinator, best practice is to spend a lot of time with a mentor. You may consider contacting a local Care Coordinator to see about mentorship possibilities. You may also choose to join your local Care Coordination Network association.

The practices described in this training are current as of the date on this guide. The SDS training team includes the latest known updates. Please check the SDS website for changes http://dhss.alaska.gov/dsds/Pages/default.aspx . Training materials will be updated to reflect changes as they progress. Join the e-alert system. SDS emails updates for all its' programs to providers: http://list.state.ak.us/soalists/SDS-E-News/jl.htm

About Critical Incident Report (CIR) Training

Please note: This training provides an introduction to Critical Incident Reporting. You must either enroll in a separate SDS webinar for Critical Incident Reporting to receive a certificate of attendance for Critical Incident Report Training, or participate in Critical Incident Report training facilitated by your employer agency. You may register for an SDS lead Critical Incident Report training webinar through the SDS webpage under Provider Training. SDS requires Critical Incident Report Training prior to Certification and verification again at Recertification.

About the Quizzes and Exam

You will participate in quizzes during class/webinar sessions. We will send you a final exam by email after the last class. SDS trainers evaluate your engagement with the learning group and topics during classes/webinar sessions. The quizzes we give during class are interactive and we may ask you to answer as a group exercise. You must complete the final exam on your own and send it back to us as a PDF attachment to an email. You need to work with the pdf document we send. (We will not accept hand written exam answers). Your exam must contain your original wording for narrative passages. Your final grade is a result of class and topic engagement, and passing the final exam. You may email your completed final exam to the SDS Training inbox hss.dsdstraining@alaska.gov . Alternatively, you may fax it to the training fax: 907-269-8164. **If you fax your exam you must send an email to let us know you faxed it.**

You must score at least 80% in order to pass the Beginning Care Coordination classroom/webinar curriculum. Upon successful completion, we give you credit for the training, and we email you a Certificate of Attendance, which you must include in your packet for Certification or Re-Certification for the service of Care Coordination. ***Keep a copy of your Certificate of Completion.***

If you have questions about training please email the training inbox at hss.dsdstraining@alaska.gov, or call the training unit at 907-269-3666, or 1-800-770-1672.

Kara Thrasher-Livingston
Training Specialist II
907-269-3685

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Training Specialist I
907-269-3734

Finding a Mentor

A beginning Care Coordinator should try to find a mentor- an experienced Care Coordinator who can share his or her knowledge and experience with you. Training can bring you technical information and updates. You will learn mostly by doing the work. A "trainee" who is not certified and enrolled cannot create and authorize documents; they cannot conduct visits with clients alone or sign any documentation until the trainee is Certified by SDS. A trainee can become familiar with the daily work of a Care Coordinator, practice interacting with people and work with the processes and sample documents through the process of shadowing.

You may wish to connect with a local Care Coordinator Association to find a mentor. Alaska Care Coordination Network http://www.alaskaccn.com/index.html is a good place to start. They have contacts in various regions of the State. Sometimes new Care Coordinators work in an agency with experienced Care Coordinators and there is a training plan.

When you find a mentor, here are some basic mentorship questions you may consider asking:

- What expectations does my mentor have?
- What are my expectations for the outcome of the mentoring experience?
- Will there be a learning plan, and what are the basic attributes of this? (for example, how often will we meet ?)
- How will I know I am making progress?

UNIT 1

Terms and Definitions

Senior and Disabilities Services Webpage

Mission & Service Principles

What is a Waiver?

Six Assurances to CMS

Quick Reference Common Acronyms:

ABPCA	Agency Based Personal Care Agency
ADL	Activities of Daily Living
AFDC	Aid to Families with Dependent Children
ANP	Advanced Nurse Practitioner
AS	Alaska Statute
CAT	Consumer Assessment Tool
CC	Care Coordinator
CCAN	Care Coordination Authorization Number (no longer used)
CCMC	Children with Complex Medical Conditions
CDPCA	Consumer Directed Personal Care Agency
CFR	Code of Federal Regulations
CHOICE	Community and Home Options to Institutional Care for Everyone (no longer used)
CMS	Center for Medicare and Medicaid Services
CPAP	Continuous Positive Air Pressure
DD	Developmentally Disabled, or Developmental Disability
DDN	Developmental Disability Nursing or Nurse (specialty of Nursing)
DHCS	Division of Health Care Services
DHSS	Department of Health and Social Services
DPA	Division of Public Assistance
DSDS, also SDS	Division of Senior and Disabilities Services
DSM-IV-TR	Diagnostic and Statistical Manual
EM	Environmental Modifications
HCB	Home and Community Based
I.H.S.	Indian Health Services
IADL	Instrumental Activities of Daily Living
IAT	Intensive Active Treatment
ICAP	Inventory for Client and Agency Planning
ICF	Intermediate Care Facility
IDD	Intellectual/Developmental Disability (equivalent to MR/DD
IEP	Individualized Education Program
IFSP	Individualized Family Service Plan
LOC	Level of Care
MR/DD	Mental Retardation/Developmentally Disabled, Now ID/DD
NFLOC	Nursing Facility Level of Care
OA/APD	Older Alaskan/Adults with Physical Disabilities
OCS	Office of Children's Services
OT	Occupational Therapy
PA	Physician's Assistant
PA	Prior Authorization
PCA	Personal Care Assistant
PCAT	Personal Care Assessment Tool (no longer used)
POC	Plan of Care
PT	Physical Therapy
QA	Quality Assurance
QI	Quality Improvement
RDA	Recommended Daily Allowance
SNF	Skilled Nursing Facility
SSI	Supplemental Security Income
ST	Speech Therapy
STAR	Short Term Assistance and Referral
TEFRA	Tax Equity and Fiscal Responsibility Act

More Common Terms and Definitions

AAC: Alaska Administrative Code
ACS: Affiliated Computer Services: former Medicaid fiscal agent for the State of Alaska. Service providers submit Medicaid bills to the fiscal agent for processing and payment. As of April 1, 2012 **Xerox** is the fiscal agent for AK Medicaid.
ADS: Adult Day Services: programs providing adults with various social and some health-oriented services in a supervised outpatient group setting
ADRC: Aging and Disability Resource Center, information and referral service
Alaska 211: Dial 211 for general information and resources for publicly funded assistance
ALH: Assisted Living Home: Helps adults who are frail and/or cognitively impaired maintain independence and dignity by providing assistance with activities of daily living. May include self-care and social skill maintenance and enhancement. This is done in a licensed residential home, with 24- hour supervision and assistance. It provides activities and services designed to: 1) minimize the need to move; 2) accommodate individual residents' changing needs and preferences; 3) maximize residents' autonomy, privacy, independence and safety; and 4) encourage family and community involvement.
ALI: Alaskans Living Independently Waiver (formerly Older Alaskans OA and Adults with Physical Disability APD Waivers)
A&G: Administrative and General
ACoA: Alaska Commission on Aging
ADAPT: America's Disabled for Attendant Programs Today
ADL: Activities of Daily Living: walking, eating, dressing, bathing, toileting and transferring
ADRD: Alzheimer's Disease and Related Disorders
AL: Assisted Living
ALL: Assisted Living Licensing. The process of meeting safety and service standards to become eligible to operate an assisted living home. ALL is now within DHCS (Division of Health Care Services)
ALI: Alaskans Living Independently- new term for OA and APD waivers
ALB: Alaska Longevity Bonus
ANP: Advanced Nurse Practitioner
APDD: Adults with Physical and Developmental Disabilities Waiver
APS: Adult Protective Services
AS: Alaska Statutes
Care Coordination Services: Assists clients in gaining access to natural supports, community services and Medicaid waiver services. Care coordinators are responsible for initiating and overseeing the planning process, as well as the ongoing monitoring and annual review of a recipient's eligibility and plan of care. **Certification:** The process of becoming approved to provide services that are reimbursable by Medicaid. Certification is obtained by application to DHSS or SDS, depending on the clients served.
CHOICE Program: Original term for Alaska's Waiver system: *Community and Home Options to Institutional Care for Everyone.* A Medicaid waiver program offering alternatives to people who otherwise would have to be in a nursing home. Now known as the **HCB (Home and Community Based) Medicaid Waiver**.
CCMC: Children with Complex Medical Conditions Waiver
CMS: Centers for Medicare and Medicaid Services. Formerly HCFA-Health Care Financing Administration. Federal oversight for all State Waiver programs.
CNA: Certified Nurse's Assistant
CON: Certificate of Need
COSI: Cost Sheet Interface. A database containing *CHOICE Program* clients' service and cost data. Used to generate prior authorization requests. Now used only by SDS staff.
DD: Developmental Disability
DHSS: Department of Health and Social Services
DHCS: Division of Health Care Services, Department of Health and Social Services. DHCS is responsible for administering the State Medicaid program. http://dhss.alaska.gov/dhcs/Pages/default.aspx
DME: Durable Medical Equipment

DPA: Division of Public Assistance, State of Alaska, Department of Health and Social Services. The Division of Public Assistance determines financial eligibility for Medicaid according to federal and state rules.
DSM: Direct Secure Messaging
DSS: Division of Senior Services, State of Alaska, Department of Administration
EIS: Eligibility Information System
EM or EMOD: Environmental Modification
EMT: Emergency Medical Technician
Enrollment: After certification is obtained from DHSS or SDS, the Alaska Medicaid Provider. Enrollment is done through Xerox, Alaska's fiscal agent for Medicaid, formerly known as **ACS- Affiliated Computer Services.** www.medicaidalaska.com Enrolled providers bill for services provided to Medicaid clients.
EPSDT: Early and Periodic Screening Diagnostic Treatment
FFP: Federal Financial Participation
GR: General Relief. A state-funded public assistance program for vulnerable adults. General relief can pay for assisted living home services.
HCB: Home and Community Based
HCFA: Health Care Financing Administration. Now, renamed as the Centers for Medicare and Medicaid Services (CMS), federal oversight of State Medicaid and Medicare programs.
IADL: Instrumental Activities of Daily Living such as doing laundry, cleaning of living areas, food preparation, managing money and conducting business affairs, using public transportation, writing letters, obtaining appointments, using the telephone, and engaging in recreational, leisure or social activities.
ICF/MR: Intermediate Care Facility for the Mentally Retarded, **now known as ICF/IID (Intellectual Disability)**
IDD: Intellectual and Developmental Disability
IDD Waiver: Intellectual and Developmental Disabilities Waiver
I&R: Information and Referral
ILC: Independent Living Center
LOC: Level of Care
LTC: Long Term Care. A spectrum of health and social service programs designed to provide personal care assistance over an extended period of time. These include services in the home, assisted living and skilled nursing facilities.
LTCO: Long Term Care Ombudsman
MDS: Minimum Data Set
Medicaid: A federal and state financed health benefits program that is available to children, families, adult with disabilities, elders and pregnant women whose incomes and resources do not exceed specific guidelines. **Medicare:** A federally-funded health insurance program available to U.S. citizens 65 and older and certain disabled people, regardless of income or individual circumstances.
MIRP: Material Improvement Review Process
MHTA: Mental Health Trust Authority
MMIS: Medicaid Management Information System
MOA: Memorandum of Agreement
NF: Nursing Facility
NOCM: Nursing Oversight and Care Management
PA: Prior Authorization
SPDN: Specialized Private Duty Nursing
PNA: Personal Needs Allowance
POA: Power of Attorney
POC: Plan of Care
SED: Severely and Emotionally Disturbed
SILC: State Independent Living Council
SME: Specialized Medical Equipment
SSA: Social Security Administration
SSI: Supplemental Security Income
XEROX: Alaska's fiscal agent for Medicaid

About our Web Page: Senior and Disability Services: Explore all sections of the website.
http://dhss.alaska.gov/dsds/Pages/default.aspx

Health and Social Services > Senior and Disabilities Services

Duane Mayes
Director

Deb Etheridge
Deputy Director

SDS Newsletter -July 2015
Staff Spotlight - Recognitions

About Us

- Our Mission
- Contact Us

Reporting

- **Making a Report of Harm**
- **Report Medicaid Fraud**
- **Recipient Change of Status**
- **Contact SDS**

Provider Training

- SDS Training Resources
- Training Schedules and Registration

Recruitment

- Careers at Health and Social Services

Information

Welcome to Senior and Disabilities Services

Our mission is to promote health, well being and safety for individuals with disabilities, seniors and vulnerable adults by facilitating access to quality services and supports that foster independence, personal choice and dignity.

By federal requirement, an advisory group providing input and guidance to the state and public regarding Medicaid 1915(i) option and 1915(k) Community First Choice option for Home and Community-Based Services (HCBS) benefits has been established. Find out more:

Headlines

2015_____

- **VIDEO:** Director Duane Mayes gives a presentation on the 1915i and 1915k options for Alaska.
- 12/11 Home health care service owner of Good Faith Services gets 3 years for Medicaid fraud
- REVISED TRANSITION PLAN for Home and Community-Based Services Settings
- 10/26 It's time to compare and choose 2016 Medicare Part D plans during open enrollment
- 8/19 The Alaska State Plan for Senior Services, FY2016–FY2019 is now available online!
- 6/18 Fraud Charges Brought Against 40 Individuals by the Alaska Department of Law and U.S. Attorney's Office
- 6/2 SDS Issues Policy Memo Prohibiting Recipient Solicitation
- 5/6 Good Faith PCA and Two Recipients Receive Jail Time for Fraudulently Billing Medicaid
- 4/8 HCBS Provider Sentenced for Medical Assistance Fraud
- 1/26 State of Alaska CMS Regulation Transition Plan

Go to SDS News Archives

Senior and Disabilities Services
- Home
- Our Mission
- Contact Us
- Centralized Reporting

Units
- Adult Protective Services (APS)
- Intellectual & Developmental Disabilities (IDD) Waiver
- Nursing Facility Level of Care (NFLOC) Waiver
- Grant Services
- Personal Care Assistance (PCA)
- Policy & Program Development
- Provider Certification & Compliance
- Quality Assurance (QA)
- Research & Analysis
- Operations, Training, Transportation & Hearings

Programs and Offices
- Aging and Disability Resource Centers
- General Relief Program
- Home and Community Based Senior Grants
- Medicare Information Office
- Nursing Facility Transition Program
- Nutrition, Transportation, and Support Services Grants
- Rural Long-Term Care Development
- Traumatic and Acquired Brain Injury Program

Providers
- Search for a provider
- Care Coordination Quick List (pdf)
- Care Coordination Quick List (excel)
- Search for Public Notices
- Provider Certification Information
- Provider Resources and Quick Reference
- Skilled Nursing Facilities
- SDS Policy Memo: Prohibition of Recipient Solicitation

Of Interest
- Automated Service Plan
- Alaska Medication Education
- Direct Secure Messaging
- Approved Program Forms
- Reports & Publications
- Medicaid Waiver Brochure
- AK HCBW Applications
- Waiver Regulations (Effective July 1, 2015)
- Conditions of Participation (COPS)(Effective July 1, 2015)
- PCA Regulations 7AAC 125.010
- Contractors Wanted for Home Accessibility Modifications
- Telehealth
- Waiver, SME, PCA Payment Rates & Cost Survey
- E-Alert Listings
- SIGN UP for E-Alerts
- SDS Newsletters

***MISSION*:**
Senior and Disabilities Services promotes health, well-being and safety for individuals with disabilities, seniors and vulnerable adults by facilitating access to quality services and supports that foster independence, personal choice and dignity.

***VISION*:**
Choice, safety, independence and dignity in home and community-based living

***SERVICE PRINCIPLES*:**
Senior and Disabilities Services is person-centered and incorporates this value into the following service principles:

- We and our partners are responsible and accountable for the efficient and effective management of services.
- We and our partners foster an environment of fairness, equality, integrity and honesty.
- Individuals have a right to choice and self- determination and are treated with respect, dignity and compassion.
- Individuals have knowledge of and access to community services.
- Individuals are safe and served in the least restrictive manner.
- Quality services promote independence and incorporate each individual's culture and value system.
- Quality services are designed and delivered to build communities where all members are included, respected and valued.
- Quality services are delivered through collaboration and community partnerships.
- Quality services are provided by competent, trained caregivers who are chosen by individuals and their families.

Think of the Service Principles as Core Values by which we do services in the State of Alaska.
All providers (a Care Coordinator is also referred to as a "provider" of Medicaid service) can refer to the Service Principles as overarching guiding principles.

How do people know about possible services in their community?

People can access information and referral through the Aging and Disability Resource Centers

Alaska's ADRCs connect seniors, people with disabilities, and caregivers with long-term services and supports of their choice. The ADRC network serves Alaskans statewide, regardless of age or income level, through regional sites.

1-877-6AK-ADRC (1- 877-625-2372)

All potential Waiver Recipients should contact the ADRC for possible additional assistance

What is a Waiver?

Two of the most important pieces of legislation that affect the lives of those we serve:

- The **Americans with Disabilities Act** (ADA) which gives civil rights and protections to individuals with disabilities.

- The **Olmstead Act**, issued in July 1999, requires states to administer services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities."
  -This Act established community care options for people with long term Medicaid

Learn more about the CMS Community Living Initiative:
http://www.cms.hhs.gov/CommunityServices/10_CommunityLivingInitiative.asp#TopOfPage
Learn more about The Olmstead Decision:
http://www.accessiblesociety.org/topics/ada/olmsteadoverview.htm

Each state must develop a system of support for people who meet financial eligibility for Medicaid, *and have met the level of necessity for care such as that customarily provided in a skilled nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities,* who wish to receive support in their own home and/or community.

The Home and Community Based Waiver **=** ***a choice*** to receive home and community based care rather than care in a nursing facility or an institution

Centers for Medicare and Medicaid Services (CMS) http://www.cms.gov/ oversees all states' participation in the Home and Community Based Waiver, and partially reimburses the state for services implemented in that state.

Federal Authority: Section 1915c of the Social Security Act permits a state to "waive" certain Medicaid requirements in order to provide an array of home and community based services that promote community living for Medicaid beneficiaries and thereby, avoid institutionalization.

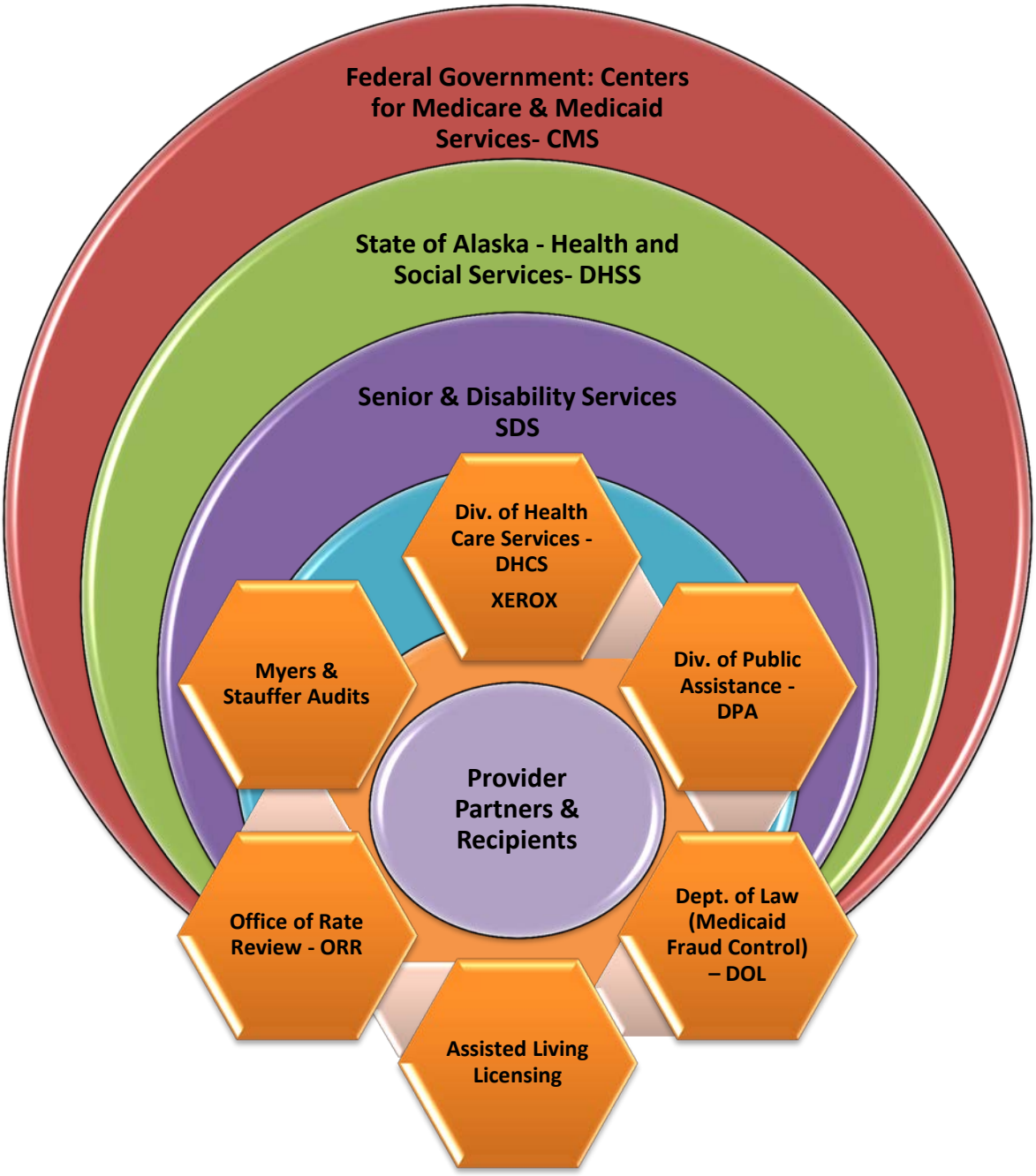
Waiver services complement those offered through other funding sources including families and community supports. Family and community supports are accessed before and along with Waiver services.

People can also choose ***NOT*** to have the Home and Community Based Waiver at all!

State of Alaska Regulations for the Home and Community Based Waiver:
Chapter 130 Medicaid Coverage; Home and Community-Based Waiver Services, Nursing Facility and ICF/MR Level of Care 7AAC 130.200-7 AAC 130.319
For Care Coordination:
7 AAC 130.238 Certification of care coordinators
7 AAC 130.240 Care Coordination Services
7 AAC 105.200-7 AAC.105.290 Provider Enrollment, Rights and Responsibilities 7 AAC 105.400-7 AAC 105.490 Provider Sanctions and Remedies

Providers and recipients are at the center of DHSS, State of Alaska

Each state designs its' Waiver program to fit the needs of the people who access the waiver for supports. Because of this, all states, including Alaska, need to provide several basic Assurances to CMS. Assurances are the outcomes of the Medicaid and State plan programs. SDS reports these results to CMS. Assurances form the regulation context for the work care coordinators do.



The State of Alaska, Senior and Disabilities Services, offers 4 waivers:

ALI: Alaskans Living Independently

People 21 and over who experience physical disability or functional needs associated with aging.

Nursing Facility Level of Care

APDD: Adults with Physical and Developmental Disabilities

People 21 and over who experience both physical and developmental disabilities.

Nursing Facility Level of Care

CCMC: Children with Complex Medical Conditions

Children and young adults birth to age 22.

Nursing Facility Level of Care

IDD: Intellectual and Developmental Disabilities

People of all ages who experience developmental or intellectual disabilities.

Intermediate Care Facility for Individuals with Intellectual or Developmental Disabilities- Level of Care

Six Assurances the State make to Centers for Medicare & Medicaid Federal Authority

Home and Community Based Waiver (1915c)

Level of Care (LOC):
Waiver applicants who may need services are provided an individual LOC evaluation. A SDS Nurse Assessor or Qualified Intellectual Disabilities Professional will schedule an assessment with the applicant. The LOC of enrolled recipients is re-evaluated at least annually or as specified in the approved waiver.

Level of Care is determined by the assessment units at SDS.

Service Plan (Plan of Care or POC):
Recipients have choice between waiver services and institutional care and between/among waiver services and providers.
Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.
The Service plan addresses all the recipients assessed needs, including health and safety risk factors, and personal goals, either by the provision of waiver services or through other means.
The state monitors service plan development in accordance with its policies and procedures.
Service plans are updated/revised at least annually or when warranted by changes in waiver recipient needs.

All Plans are reviewed annually by SDS and approved or denied based on this and other criteria.

Qualified Providers:
The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.
The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

Provider Certification and Compliance at SDS ensures that HCBW providers are in compliance

Health and Welfare:
On an ongoing basis the state identifies, addresses and seeks to prevent instances of: Abuse, Neglect, and Exploitation (including financial exploitation) of vulnerable individuals.

Adult Protective Services, and Office of Children's Services, help to support the Health and Welfare Assurance, and Alaska Statute 47.24.010

Administrative Authority:
The State of Alaska DHSS – SDS as the Medicaid agent retains ultimate authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-State agencies and contracted entities.

Financial Accountability:
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the waiver.

Senior and Disabilities Services (SDS) is part of the Department of Health and Social Services (DHSS), State of Alaska. Office of Rate Review (ORR) works with Medicaid Provider Rates of reimbursement.

UNIT 2

Medicaid Provider Participation
Care Coordinator Certification
Provider Disenrollment and Decertification

These Home and Community Based Waiver Services (HCBWS) are certified by Senior and Disabilities Services

Waiver Service	APDD	ALI	CCMC	IDD
Nursing Oversight and Care Management	NA	NA		
Care Coordination				
Chore				
Adult Day			NA	NA
Residential Supported Living			NA	NA
Day Habilitation		NA		
Residential Habilitation				
Family Home Habilitation		NA		
Supported Living Habilitation		NA		
Group Home Habilitation		NA		
In-home Support Habilitation		NA		
Supported Employment		NA		
Intensive Active Treatment		NA		
Respite Care				
Family-directed Respite Care	NA	NA		
Transportation				
Meal				
Congregate Meals				
Home-delivered Meals				
Environmental Modification				

NA indicates services unavailable for the waiver specified in that column.

Note:

**Although Specialized Private Duty Nursing is a Waiver service. This service is certified and enrolled through*

7 AAC 110.520. Private-duty nursing agency enrollment requirements

**Specialized Medical equipment is a Waiver service. This service is certified and enrolled through*

7 AAC 105.200. Eligible Medicaid providers (3)(C)

What standards are all providers required to meet?

SDS has established standards to ensure that services are delivered by individuals with the requisite skills and competencies to meet the needs of the waiver population and to ensure that services are performed in a safe and effective manner. The SDS standards are specified in the Home and *Community-based Waiver Services regulations* and in the *Provider Conditions of Participation* and each of the HBW Services *Conditions of Participation*. In addition, providers must comply with other regulations including:

- Medicaid regulations
- *HIPAA (Health Insurance Portability and Accountability Act of 1996)*
- HIPAA Title II Administrative Simplification and Compliance Act
- Civil Rights Act of 1964
- Section 504 of the Rehabilitations Act of 1973
- Age Discrimination Act of 1975
- Americans with Disabilities Act of 1990

Medicaid Provider Participation

Becoming a Medicaid provider through certification and enrollment means that the agency administrator and any agency representatives acknowledge understanding and will abide by:

Medicaid Program; Scope and Authorization of Service. (7 AAC 105.100 - 7 AAC 105.130)

This series describes the purpose and scope of the Medicaid program, which encompasses all forms of providers, including Care Coordination. All approved Medicaid services are best thought of as "medically necessary", including Care Coordination, and all other HCB Waiver services.

All publicly funded services, such as Medicaid, must show financial accountability and program integrity. The state/partner provider relationship needs to produce the outcome that is expected by people served, who have communicated their directive to legislation. This is why providers certify and enroll, and participate in cost studies and audits.

Provider Enrollment, Rights, and Responsibilities. (7 AAC 105.200 - 7 AAC 105.290)

This series defines the enrollment process and the responsibilities of the provider. Providers should know that they are potentially subject to sanction up to and including paying back for reimbursement for services that are not justified, or withholding payment until improvement is made under a specified action plan, and potential decertification and disenrollment. The series describes the appeal process for providers. As part of continuous quality improvement, SDS and DHSS may conduct audits of provider records, practices and sites, as necessary.

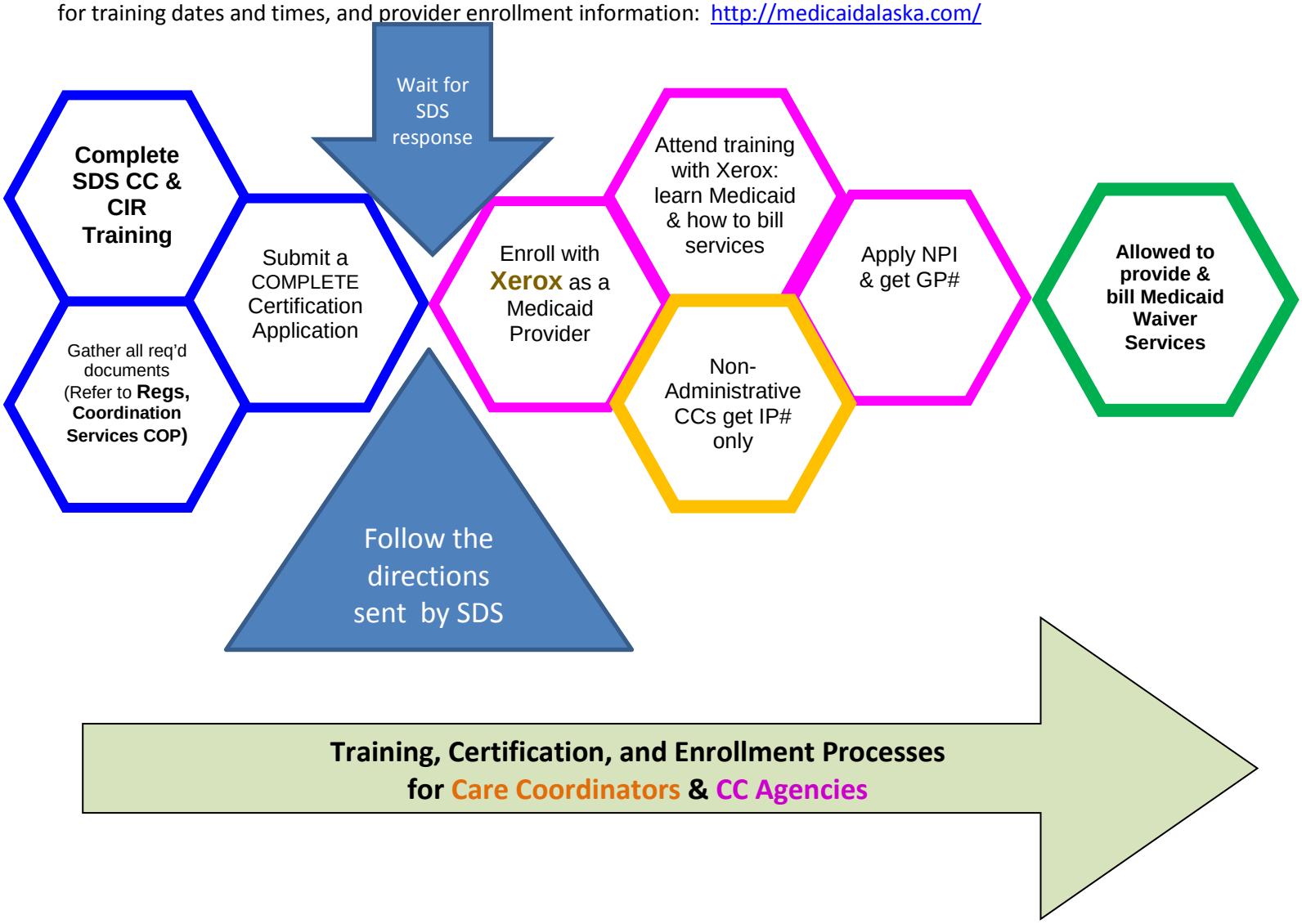
Provider Sanctions and Remedies. (7 AAC 105.400 - 7 AAC 105.490)

These regulations describe the role and responsibilities of the provider, which are acknowledged through the certification and enrollment processes. The series describes the sanction process including conditions under which a sanction may be imposed.

Care Coordinator and Agency Certification

Senior and Disabilities Services (SDS) requires Certification of all Home and Community Based service providers, including Care Coordination Services, and individual Care Coordinators, as part of 42 CFR 441.302 State Assurances, Health and Welfare and Qualified Providers Assurances to Centers for Medicare & Medicaid Services (CMS).

All Home and Community Based Waiver services are Medicaid services. In order to be able to bill for these services, service providers must not only certify with SDS, they must also enroll as a State of Alaska Medicaid provider. This is done by attending training with Xerox, the fiscal agent for the State of Alaska, Department of Health & Social Services, and enrolling as a Medicaid provider. See Xerox's Alaska Medical Assistance website for training dates and times, and provider enrollment information: http://medicaidalaska.com/



Regulations (Waiver Regs, COPs, Rate Chart): http://dhss.alaska.gov/dsds/Pages/regulationpackage.aspx
SDS Certification Application packet: http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx
Xerox (Provider Training Schedule): http://www.medicaidalaska.com/providers/training/providerTraining.shtml
Xerox (Enrollment): http://www.medicaidalaska.com/providers/Enrollment.shtml
Apply online National Provider Identifier (NPI): https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart

Certification Requirements, Standards, and Process

Each agency that provides Care Coordination MUST have a Certified Care Coordinator Administrator.

The Agency may also have additional Care Coordinators who work for the agency. They must also meet the individual Care Coordinator Standards.

Some agencies have only one Care Coordinator who is both the administrative CC and the working CC.

A Care Coordinator must submit sufficient evidence that they meet the Medicaid certification standards before SDS will certify them for each specific type of Waiver.

Care Coordination Services
Conditions of Participation

Care Coordination Services - Program Administrator Standards

(from the Care Coordination COPs)

a. The provider must designate a care coordination services program administrator who is responsible for the day-to-day management of the program including the following:
   i. orientation, training, and supervision of care coordinators;
   ii. implementation of policies and procedures;
   iii. intake processing and evaluation of new admissions to the services;
   iv. participation in the development of plans of care in collaboration with other providers of services;
   v. ongoing review of the delivery of services, including
      (A) monitoring the amount, duration, and scope of services to assure delivery as outlined in the plan of care;
      (B) assessing whether the services assist the recipients to attain the goals outlined in plans of care; and
      (C) evaluating the quality of care rendered;
   vi. development and implementation of corrective action plans for identified problems or deficiencies in delivery of care coordination services; and
   vii. submission of required reports to Senior and Disabilities Services, including critical incident reports.

b. The provider may use a term other than program administrator for this position, e.g., program director, program manager, or program supervisor.

c. The program administrator must be at least 21 years of age, and qualified through experience and education in a human services field or setting.
   i. Required experience:
      (A) one year of full-time or equivalent part-time experience working with human services recipients and their families, programs and grants administered by Senior and Disabilities Services, and providers of program and grant services; and
      (B) one year (which may be concurrent) of full-time or equivalent part-time experience, as a supervisor of two or more staff who worked full-time or equivalent part-time in a human services field or setting, in a position with responsibility for planning, development, and management or operation of programs involving service delivery, fiscal management, needs assessment, program evaluation, and similar tasks.
   ii. Required education and additional experience or alternatives to formal education:
      (A) Bachelor of Arts or Bachelor of Science degree from an accredited college or university in social work, psychology, rehabilitation, nursing or a closely related human services field, in addition to the required one year of experience as a supervisor; or

(B) Associate of Arts degree from an accredited college or university in psychology, rehabilitation, nursing or a closely related human services field, and two years of full-time or equivalent part-time experience working with human services recipients, in addition to the required one year of experience as a supervisor; or
(C) four years of full-time or equivalent part-time experience working with human services recipients in social work, psychology, rehabilitation, nursing, or a closely related human services field or setting, in addition to the required one year of experience as a supervisor; or
(D) certification as a rural community health aide or practitioner, and one year of full-time or equivalent part-time experience working with human services recipients, in addition to the required one year of experience as a supervisor.

d. In addition to meeting education and experience requirements, the administrator must possess the knowledge base and skills necessary to carry out the care coordination services program.
   i. The administrator knowledge base must include:
      (A) the medical, behavioral, habilitative, and rehabilitative conditions and requirements of the population to be served; and
      (B) the applicable laws and policies related to Senior and Disabilities Services programs.
   ii. The administrator skill set must include:
      (A) the ability to evaluate, and to develop a plan of care to meet, the needs of the population to be served; and
      (B) the ability to supervise professional and support services staff.

Care Coordinator Standards

Care coordinators shall be at least 18 years of age, and qualified through experience and education in a human services field or setting.

a. Required education and additional experience or alternatives to formal education.
   i. Bachelor of Arts , Bachelor of Science, or Associate of Arts degree from an accredited college or university in social work, psychology, rehabilitation, nursing or a closely related human services field, and one year of full-time, or equivalent part-time experience working with human services recipients; or
   ii. two years of course credits from an accredited college or university in social work, psychology, rehabilitation, nursing or a closely related human services field, and one year of full-time, or equivalent part-time experience working with human services recipients; or
   iii. three years of full-time or equivalent part-time experience working with human services recipients in social work, psychology, rehabilitation, nursing, or a closely related human services field or setting; or
   iv. certification as a rural community health aide or practitioner and one year of full-time or equivalent part-time experience working with human services recipients.

b. In addition to meeting education and experience requirements, care coordinators must possess, or develop before providing program services, the knowledge base and skills necessary to carry out the care coordination process.
   i. The care coordination knowledge base must include:
      (A) the medical, behavioral, habilitative, and rehabilitative conditions and requirements of the population to be served by the care coordinator;
      (B) the laws and policies related to Senior and Disabilities Services programs;
      (C) the terminology commonly used in human services fields or settings;
      (D) the elements of the care coordination process; and
      (E) the resources available to meet the needs of recipients.
   ii. The care coordination skill set must include:
      (A) the ability to evaluate, and to develop a plan of care to meet, the needs of the population to be served;
      (B) the ability to organize, evaluate, and present information orally and in writing; and
      (C) the ability to work with professional and support staff.

Training

1. An individual who seeks certification to provide care coordination services
   a. must enroll in the Senior and Disabilities Services Basic Care Coordination and Critical Incident Reporting training
   b. demonstrate comprehension of course content through examination (if applicable); and
   c. provide proof of successful completion of the course when submitting an application for certification.

2. A certified care coordinator
   a. must enroll in at least one Senior and Disabilities Services care coordination training course during the individual's one or two year period of certification; and
   b. provide proof of successful completion of that course when submitting an application for recertification.

You should always refer to the *Waiver Regulations 7 AAC 130.200 – 7 AAC 130.319*, *Provider Conditions of Participation*, and *Care Coordination Services Conditions of Participation*. Care Coordinators and providers must comply with the regulations, and the COPs to give you guidelines in helping you to completing your certification application.

Care Coordination application process:

For quick reference, use this checklist when you are ready to submit a Certification Application packet:

Individual Care Coordinator within the Agency (First Time Application)	Care Coordination Agency (First Time Application)
◯ Care Coordinator Certification Application (CERT-02)	◯ Provider Certification Application (CERT-01)
◯ Disclosure of Business and Familial Relationships Form (CERT-20)	◯ Provider Certification Application Worker Assurances - w/o employees (CERT-03)
◯ Beginning Care Coordination Training Certificate	◯ Service Declaration: CC Services (CERT-06)
◯ Critical Incident Reporting Training Certificate	◯ Notice of Appointment: Program Administrator Form (CERT-04)
◯ Applicant's Resume	◯ State of Alaska Business License
◯ Documentation showing applicant's Educational Qualifications- if using (Refer to Care Coordination Services COP)	◯ Certificate of Insurance
The Care Coordinator Certification Application and the Disclosure of Business and Familial Relationships can be found at: http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx	◯ Organization Chart or Personnel List if applicable
	◯ Operations Manual
	◯ Core Employee Policies

Guidance on the CC Certification Application Forms

Detailed instructions and certification forms about home and community-based waiver services may be found at the links below. **Or on the SDS webpage**

Instructions for Provider Certification

- HCBS Waiver Certification FAQ's
- HCBS Waiver Certification Application Guidance

Individual CCs are <u>certified separately</u> from the agency

Note: Business Resources for Care Coordination Agency Applicants If you need information about how to set up a business, how to write an employee manual or other business related practices, you can view a list of resources here: http://dhss.alaska.gov/dsds/Documents/pca/Provider_Certification_Resources.pdf

- You may email a completed certification packet to Provider Certification and Compliance.
  - dsdscertification@alaska.gov

Background Check Program

Once your application has been received and determined complete, you will be contacted (e-mailed) and given instructions on how to complete your background check.
All Care Coordinators must obtain at least a provisional clearance and be affiliated with a provider agency through the New Alaska Background Check Program prior to working with recipients and/or their protected health information. All individuals (staff, volunteers, adults who live in the licensed residential settings) who work in the SDS programs at provider agencies or in community settings, or have access to people in services, must pass the background check. This includes people who only have access to records such as timesheets or other documents generated through giving services.

To apply for certification, you must obtain and pass a background check per AS 47.05.300– 47.05.390

All providers must participate in the Alaska Background Check program. The Alaska Background Check Program (BCP) provides centralized background check support for programs that provide for the health, safety, and welfare of persons who are served by the programs administered by the Department of Health and Social Services (DH&SS). Programs subject to the licensing and certification authority of DH&SS or are eligible to receive payments, in whole or in part, from the department are subject to the statutory requirements of: AS 47.05.300–47.05.390.

The BCP conducts a state check and a national background check. All employees and volunteers regardless of their role in the agency must be cleared to work by the background check as well as all people who will contact vulnerable individuals before working with recipients and/or their protected health information. Each agency must check for each employee, it is not possible to bring background check results from a previous place of employment and supply them to a new place of employment.

Fingerprints are good for 6 years; background check is variable depending on factors such as, if an individual is charged with a barrier crime, etc. Note: Fingerprints are good for 6 years, not background check itself.

Example: A Care Coordinator is dually affiliated, receives clearance to be affiliated with new agency, but fingerprints expire soon thereafter; still needs to update fingerprints to maintain a valid clearance.

Contact information for the Background Check program:

Division of Health Care Services Certification and
Licensing Section Background Check Program
4601 Business Park Blvd, Building K
Anchorage, AK 99503
(907) 334-4475
Fax (907) 269-3488
BCUnit@alaska.gov

Enrollment with XEROX

In order to bill for Medicaid services, provider agencies must certify with SDS, **AND** they must enroll as a State of Alaska Medicaid provider. This is done by attending training with Xerox, the fiscal agent for Alaska Medicaid and enrolling as a Medicaid provider. See their website for training dates and times, and provider enrollment information: http://medicaidalaska.com/

Training is available to help you fill out the **enrollment application**. You can access introductory training about the enrollment process at https://enroll.medicaidalaska.com/ProviderEnrollment/Help/PEP101/
To access the Medicaid Enrollment Learning Portal please click on https://learn.medicaidalaska.com/

Individual Care Coordinators are assigned a provider ID# (this is still CM# on many SDS forms). The Agency they work with is assigned a Provider Group ID# (this is still CMG# on many SDS forms).

HCB Waiver Service of Care Coordination can only be provided and billed by a certified and enrolled Care Coordinator.

Note: There are 2 processes involved in becoming a care coordinator.
1st apply for certification. Save time by submitting a COMPLETE application which follows all requirements found in the certification application.
2nd After you receive your letter of certification with SDS and your enrollment form, you must then apply for enrollment with Xerox (Alaska Medicaid). You will receive your provider numbers from Xerox.

Renewing Certification

Recertification is required after the first year of approval, and again every two years thereafter. Both care coordination agencies and individual care coordinators must recertify, and are required to renew their certification no later than 60 days before the expiration date of the current certification period. Recertification of the agency and the individual care coordinator may happen at different times. SDS sends notice to recertify 90 days before the certification expires.

The Care Coordinator Administrator will collect the following information and submit it to SDS -Provider Certification & Compliance Unit. This information is required for all recertifying care coordinators.

For quick reference, use this checklist for submitting a **Renewal** Application:

Individual Care Coordinator	Care Coordination Agency
◯ Care Coordinator Certification Renewal Application (Will be provided to you)	◯ Provider Certification Renewal Application (CERT-01)
◯ Updated Disclosure of Business and Familial Relationships Form (CERT-20)	◯ Provider Certification Application Worker Assurances - w/o employees (CERT-03)
◯ Care Coordinator training certificate within prior certification period	◯ Renewal Service Declaration: CC Services (CERT-06)
	◯ State of Alaska Business License
	◯ Certificate of Insurance
	◯ Organization Chart or Personnel List if applicable
	◯ **Quality Improvement Report**

Updating your Care Coordination training:
Your training and certification dates are not the usually the same. Your training will expire before your certification so you must track this on your own. SDS sends a regular monthly report that shows both your training expiration and certification expiration date.

After completion of Beginning Care Coordination training courses you may choose how to renew your training requirement. SDS trainers offer a qualifying training monthly (either Beg. CC, Applied CC or Professional Development Seminar) or you may choose to request the self-study course for SDS Care Coordination.

Please visit the SDS Training Schedules & Registration page for the most current offerings.

Senior and Disabilities Services

Alaska Home and Community Based Waiver
Care Coordinator Training Options

Are you certified now?

Not yet, or starting over?

STEP ONE:
Required class -
Basic Concepts of Care Coordination
Presented by Alaska Training Cooperative
go to http://www.ttclms.org/ to register of
email Kimber@alaskachd.org

THEN COMPLETE ONE OF THE FOLLOWING
Beginning Care Coordination (BCC)
formats

- Self-Paced
- E-book and exam, complete within the month
- BCC Exam score 80% or higher

or

Face to face 3 day class

- Attend all three
- BCC f2f Exam score 80% or higher

or

Webinar series
6 sessions, 2 hrs. each

- Attend all webinars
- Complete assignment
- BCC Web Exam score 80% or higher

Yes, one year or more!

Applied Care Coordination (ACC)
Face to face 2 day class

- Attend both days
- ACC Exam score 80% or higher

or

Webinar series (4 sessions, 3 hrs. each)

- Attend all webinars
- Complete assignment
- ACC Web Exam score 80% or higher

Or choose
Beginning Care Coordination *instead:*
Self-Paced

- E-book and exam, complete within the month
- BCC Exam score 80% or higher

or

Face to face 3 day class

- Attend all three
- BCC f2f Exam score 80% or higher

or

Webinar series
6 sessions, 2 hrs. each

- Attend all webinars
- Complete assignment
- BCC Web Exam score 80% or higher

Yes, two years or more!

Professional Development Seminar (PDS)
Face to face 1 day class

- Attend 1 day class
- Complete PDS activity or assignment

or

Webinar series (2 sessions, 3 hrs. each)

- Attend all webinars
- Complete PDS activity or assignment

Or choose
Applied Care Coordination (ACC) *instead:*
Face to face 2 day class

- Attend both days
- ACC Exam score 80% or higher

or

Webinar series (4 sessions, 3 hrs. each)

- Attend all webinars
- Complete assignment
- ACC Web Exam score 80% or higher

Or choose
Beginning Care Coordination *instead:*
Self-Paced

- E-book and exam, complete within the month
- BCC Exam score 80% or higher

or

Face to face 3 day class

- Attend all webinars
- BCC f2f Exam score 80% or higher

or

Webinar series
6 sessions, 2 hrs. each

- Attend all webinars
- Complete assignment
- BCC Web Exam score 80% or higher

Questions? Email hss.dsdstraining@alaska.gov
To see class descriptions and register,
go to http://dhss.alaska.gov/dsds/Pages/ops/senior-disabilities-servicetraining.aspx

Certification hints: **Keep a copy of everything!**

1. Contact SDS PCC Unit with questions on certification
2. Submit a COMPLETED Certification Application dsdscertification@alaska.gov
3. Follow the instruction letter from SDS

Suspension or Denial of Certification Application, Decertification, and Appeal

SDS discovers noncompliance through audits, site reviews, investigations, program reviews, and monitoring.
SDS can take immediate custody of a provider's records if there is reason to believe they are at risk of alteration.

A care coordinator/provider's certification application or renewal may be suspended, denied, or their current certification may be revoked for any of the following reasons:

- the care coordinator/provider failed to submit a complete application;
- the care coordinator/provider's certification, license, or enrollment related to Medicaid or Medicare was denied, revoked, or rescinded;
- the care coordinator/provider's name appears on any state or federal exclusion list related to health services;
- SDS has documentation indicates that the care coordinator/provider is unable or unwilling to meet the certification requirements or any other Medicaid requirement under;
- the care coordinator/provider creates a risk to the health, safety, or welfare of a recipient
- the care coordinator/provider does not operate honestly, responsibly, and maintain Medicaid program integrity

The care coordinator/provider may file an appeal if they do not agree with the decision made by SDS about the denial and decertification.

Note:
Refer to these regulations:
7 AAC 130.220 Provider Certification
7 AAC 130.238 Certification of Care Coordinators
7 AAC 105 – 7 AAC 165 Medicaid Coverage and Payment Regulations
7 AAC 105.400-490 Provider Sanctions and Remedies

What happens when a Care Coordinator wants to discontinue his or her certification and enrollment?

The Care Coordinator is responsible to send Senior and Disabilities Services, Certification Unit, written notice of the intent to de-certify. An email is acceptable. The Certification Unit will reply to the email or other written notification with a confirmation. The individual Care Coordinator (and his/her administrator as applicable) will then notify Xerox, enrollment unit, about the intent to dis-enroll. Both notifications should contain the agency's name, the name of the Care Coordinator, the Care Coordinator's Administrator, a statement stating the intent to decertify and dis-enroll, and the target date of de- certification and disenrollment.

Use SDS Approved Form Cert-44 Change of Status - Care Coordinator or Program Administrator

Can a Care Coordination agency be sold or transferred?

An individual Care Coordination or agency certification and enrollment themselves cannot be sold or transferred. If a Care Coordination agency (business) will be sold, the Care Coordinators and Care Coordinator administrator working under the business will need to apply and be approved for certification and enrollment before any billing for Care Coordination can take place. All information regarding recipients is confidential. All recipients need to be given choice of Care Coordinator. Recipients will not be transferred to the new staff automatically. Follow the Transfer of Care Coordination process, and ensure that recipients choose a new Care Coordinator (regardless of the agency in which their chosen Care Coordinator works.) Best practice- Contact Quality Assurance at SDS at least 6 months prior to starting the process of selling an agency business. Quality Assurance can offer technical assistance for this transition.

UNIT 3

Care Coordinator Responsibilities

CC Conditions of Participation

Case Notes

What does a Care Coordinator do?

Care Coordinators assist individuals who are eligible to receive waiver services or who already do, in gaining access to needed waiver and other state plan services, as well as needed medical, social, and other services, regardless of the funding source for the services to which access is gained. Care Coordinators may also assist people to access grant funded services.

You are responsible for supporting the best possible health and safety of the people you are serving through statutory, regulatory, and policy requirements. You are responsible for carrying out the service of Care Coordination according to regulations found in Title 7, Health and Social Services, Part 8, Medicaid Coverage and Payment, 7 AAC 105 through 7 AAC 165, and all referenced Alaska Statutes.

You will initiate and maintain any licensure and/or education/training requirements associated with the Care Coordination you are providing even if these requirements are not overseen by Senior and Disabilities Services (for example, a nursing license). You are responsible for correct Medicaid billing and record keeping practices. You will also renew your certification and enrollment as a provider as required by Senior and Disabilities Services and Division of Health Care Services.

7 AAC 130.240. Care coordination services outlines the duties of Care Coordination. Upon being selected by an individual, the Care Coordinator will learn more about the person's desires and goals for services. The Care Coordinator will informally assess the person's needs, and create a plan of care to address those most outstanding. This plan will include agencies which can best serve the person according to his/her plan. The Care Coordinator will visit the individual. Although the regulation states that one visit in person and one electronic visit is the minimum, visits are often done more than once a month- depending on the person's needs- to make sure that he or she is satisfied, receiving services, and to see that the person enjoys the best possible health and safety. In cases where the individual resides in a rural/remote location and Care Coordination visits may be done quarterly on approval from SDS.

The Care Coordinator (from the regulation): 7 AAC 130.240(b)(2)(A):
Remains in contact with the recipient or the recipient's representative in a manner and with a frequency appropriate to the needs and the communication abilities of the recipient, but at a minimum makes two contacts each month with the recipient or the recipient's representative; one if the two contacts must be an in-person visit with the recipient, unless the department waiver the visit requirement under (d) of this section.

(d) refers to the application for approval to visit a client once per quarter if the client and care coordinator live in a remote community or location and the cost to visit the client is greater than reimbursement to the care coordinator; providing the client has stable health and resources to allow quarterly visits.

When visiting the care coordinator will:

(i) monitor service delivery at least once per calendar quarter; and

(ii) develop the annual plan of care; the annual plan of care may be developed during one of the quarterly visits; and after each visit with the recipient, completes and retains, as documentation of each visit, a recipient contact report in accordance with the department's *Care Coordination Conditions of Participation*, adopted by reference in 7 AAC 160.900.

When we think of Care Coordination we often think of the activities of visiting the person and writing the plan of care. However there is more that we will do for our monthly "unit" of service.

The department will pay a care coordinator, beginning with the first month that the recipient is enrolled under 7 AAC 130.219 and has a plan of care approved under 7 AAC 130.217, for the following ongoing care coordination services provided in accordance with (b) of this section:

(1) routine monitoring and support;
(2) monitoring quality of care;
(3) evaluating the need for specific home and community-based waiver services;
(4) reviewing and revising the plan of care under 7 AAC 130.217;
(5) coordinating multiple services and providers;
(6) assisting the recipient to apply for reassessment under 7 AAC 130.213;
(7) assisting the recipient in case terminations.

The Care Coordinator protects the individual's choice, between and amongst service providers. The Care Coordinator discloses to the recipient (and to the department during the certification process) any close familial or business relationship with a home and community based provider. Familial and business relationships are defined in the regulation.

CCs are responsible for ongoing monitoring of services and providers, including connecting with providers to make sure services are being delivered. CCs verify regularly that there is progression or movement towards the person's goals.

Provide Ongoing CC Services

Some basic best practices for Care Coordination visits:

a. Consult with the person to determine best times of day and day of the week for visits. Consider that you may be doing visits outside of the 9-5 weekday workday as some of your clients and/or their legal representatives will be working during those times.
b . A good length of time for a visit can be considered to be one hour. This allows for time to observe and interact in the environment whether it is at home or at a service provider. You may also interact with your clients' informal (non-waiver) supports and other providers, for example medical providers or school or day care personnel.
c. Care Coordinators may at times need to help the person know about or make choices about his/her direct service staff. Regulations limit who may be a paid provider, to protect against conflict of interest.
d. During any given month CCs may spend differing amount of times addressing individual client's needs. Therefore a CC caseload must not exceed that CC's abilities to service the entire client base.
e. Twice a month contacts with the **recipients** are required in regulation. If your client does not communicate via phone or email, the CC may still visit/see the recipient two times a month. If your client does not communicate by phone or email you may visit/contact the legal representative for the required "second contact". Monthly contact with the legal rep, service providers, and others will overall the other duties of Care Coordination.

Avoid planning to SOLELY meet regulatory minimums for the duties of Care Coordination. The individual's needs are likely to change. Each person has preferences that work for them.

The move to CFCM: Conflict Free "Case Management"

CMS has issued a Final Rule effective March 17th , 2015. Case management (for Alaska this means Care Coordination) must be conflict free by July 1 2016. This means that Care Coordinators can work for agencies either as a sole provider or with other providers, who are providing only care coordination (not other HCBW services or PCS). SDS and our partners are in the transition phase to CFCM. You can learn more about the transition on the main website, in the headlines section. Make sure you are signed up for e-alerts to get the latest information. Click here to learn more: http://dhss.alaska.gov/dsds/Pages/default.aspx

Ethics and Boundaries: Some Basic Best Practices

Much of what a Care Coordinator does relies on an ethical approach to the work. It is helpful to consider best practices in the area of ethical responsibilities. People entering services and receiving services are naturally vulnerable. They rely on the Care Coordinator to help them navigate a system of services on which they depend. This puts the Care Coordinator in a position of power and authority. The person you serve may understand you as the one with all the answers. It is important to put the person and his or her needs in front of all the work you do in planning and working with systems and providers.

In Alaska it is understood that many communities are small and people often must have multiple roles in the community. Because of this, there should be a way for the person you are serving to understand his or her informed choices in cases when there are dual roles to support the person. If you have a dual role with the person you are serving, it is best practice to consider answering the following questions:

How is the individual protected from conflict of interest?
How will I clarify my role when serving the person as a Care Coordinator?
How will I record the person's choice the above plan so the person and the supportive team can refer to it if necessary?

Conflict of interest: Sometimes it is easiest to understand conflict of interest as a dual relationship. This is when we have more than one role in our interactions with the person. For example, as a Care Coordinator for the person, we should avoid offering other goods and services to the person when we stand to gain financially from the sale or referral. The reason is that the person may have a difficult time saying "no" because of our influence as their Care Coordinator. We may encounter situations in which the person becomes dissatisfied and may blame the Care Coordinator for a choice they were not happy with later. Having clear roles and boundaries protects both the person and the Care Coordinator.

Sometimes we face challenges that are difficult to identify in the course of our service to people. We bring a spirit of helping to the work, but we should avoid the following in order to stay ethically responsible.

Putting our own stories and ideas for solutions first: It may be easy to state that we know about the best solution to meet the persons' needs. We may wish to help the person avoid going through the perceived hardship we envision when he or she voices his or her own solution. If we apply supports and solutions without listening to the person we are not helping them to participate in finding solutions. The person may not engage with solutions and find them intrusive- which is counterproductive to the purpose of supports. Waiver services should support as much independence as possible, including when extensive supports are necessary.

Exploiting dependency: People rely on Care Coordinators for navigation to supports and services on which they depend. It may become difficult to move towards independence when we think of people by their needs first. It's important to avoid keeping a person in a dependent position (dependent on services, or on the Care Coordinator) long after the dependency is useful to the person.

When someone shows you who they are, believe them the first time.
~Maya Angelou

The purpose of ongoing Care Coordination is not only to comply with regulatory requirements, but it will help with early identification of potential problems. This can help protect health and safety and avoid subsequent more restrictive services or interventions.

(Summers, N. *Fundamentals of Care Management Practice,* 4E. 2012. Wadsworth, a part of Cengage Learning, Inc. by permission, www.cengage.com/permissions)

Subtracting from people's self-esteem, or sense of self-worth: It may be difficult to know how to communicate with the person we are serving. Sometimes we are having a bad or hectic day and we may be unintentionally rude or short with the person. Because of our position of authority, people may interpret this as being somehow their fault. We always want to put the people we serve first, for example by using person-first language. We want to interact with an attitude of warmth and genuineness. The people we serve come to us because they need assistance. Each person has an individual story. Along with the disabilities and needs for care people experience, we can expect to interact with people who come from different cultures, economic levels, and philosophies of life. We can expect to spend some time learning more about how each person communicates in order to be able to put him or her at the center of the plan of care. Having an attitude of respect for all is a healthy, strength-filled way to approach the work of Care Coordination.

Not knowing our own limitations: Care Coordination requires significant skills not only as outlined in the certification process, but in working with people and specific community resources. It is ethically responsible to know one's limitations and to ask for help when we see that the situation at hand requires additional expertise. It is ethically responsible to increase one's knowledge base through professional development. As a new Care Coordinator it is helpful to obtain a mentorship with an experienced Care Coordinator. You may consider joining a local or statewide Care Coordinator provider association. There are many training resources available, including but not limited to the University of Alaska (human services), the SDS training team, and the Trust Training Cooperative.

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Do you know the difference between education and experience? Education is when you read the fine print. Experience is what you get when you don't.

~Pete Seeger

Care Coordinators …

are Mandatory Reporters

In accordance with **Section 47.24.010 of the Alaska Statutes**, CC's must make a report to Adult Protective Services or the Office of Children's Services whenever there is cause to believe that a vulnerable person has suffered abuse, abandonment, exploitation, neglect, or self-neglect. All reports must be made within 24 hours of discovery.

Adult Protective Services helps to prevent or stop harm from occurring to vulnerable adults. Alaska law requires that protective services not interfere with the elderly or disabled adults who are capable of caring for themselves.

Alaska law defines vulnerable adults as adults 18 years of age or older, not just the elderly. Vulnerable adults have a physical or mental impairment or condition that prevents them from protecting themselves or from seeking help from someone else.

The harm they suffer may result from abandonment, abuse, exploitation, neglect or self-neglect. The following are examples of things to report:

ABANDONMENT is the desertion of a vulnerable adult by a caregiver.
ABUSE is the intentional or reckless non-accidental, non-therapeutic infliction of pain, injury, mental distress, or sexual assault.
EXPLOITATION is the unjust or improper use of another person or their resources for one's own benefit.
NEGLECT is the intentional failure of a caregiver to provide essential services.
SELF-NEGLECT is the act or omission by a vulnerable adult that results, or could result, in the deprivation of essential services necessary to maintain minimal mental, emotional, or physical health and safety. **UNDUE INFLUENCE** is when a person of trust uses their influence to exploit a vulnerable adult.

Adult Protective Services implements supportive services for the person such as:

- Information and Referral
- Investigation of Reports
- Protective Placement
- Guardianship or Conservatorship Counseling
- Linking Clients to Community Resources
- Training and designation of local community resources

Please see APS website at http://dhss.alaska.gov/dsds/Pages/aps/default.aspx

A Report of Harm Form is included in the Attachments. You may also call SDS at **(907) 269-3666 or (800) 478-9996** during business hours to fill out a report by phone. Ask to talk with Adult Protective Services and an intake staff will assist you.

To report harm of a child, call Office of Children's Services Child Abuse Hotline: 1-800-478-4444

View the Office of Children's Services website: http://www.hss.state.ak.us/ocs/

Must disclose business and familial relationships with all other HCB Waiver providers

In order to protect against conflict of interest, Care Coordinators will disclose business and familial relationships with other Home and Community Based Waiver providers. This occurs through the certification process, in which the Care Coordinator indicates this information to Senior and Disabilities services. When working with the ALI and APDD waivers, the Care Coordinator explains this to the applicant/recipient. Evidence of this is shown on the Waiver Application for ALI/APDD/CCMC as seen on http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx . Please note that this form, when used for CCMC, is used only for renewal applications. From the application form:

> **"7 AAC 130.217 and 7 AAC 130.240 protect you from conflict of interest by putting definitions around who can serve you as Care Coordinator. Has your Care Coordinator informed you of any employment or family relationship to a certified provider agency (per 7 AAC 130.217 (1)(A) ?**
> ***Applicant please initial"***
> **Yes _____ No_____(no known relationships)**

This is how the person indicates that they were informed by the CC of familial/business relationships to a certified provider, so the person understands that he/she has choice between and amongst providers. "Yes" means the applicant/recipient has been informed of the CC familial/business relationships with HCBW providers. "No" means the applicant/recipient has been informed that the CC has no familial/business relationship with HCBW providers (ie: there is no familial/business relationship with HCBW providers presently.)

Obtain Releases of Information when working with PHI- protected health information

Always obtain signed release of information forms when you are assembling waiver intake materials, or renewal packets. People always retain the right to release the use of their protected health information (PHI) and may revoke it at any time.

PHI can be understood as any identifier which would associate a person with a diagnosis, service plan, financial status, or treatment program. Because of this, all information about the person you serve, including his or her name, is private health information. In working between providers and SDS, all information regarding the person is based on medical necessity (the Waiver program) so all information is considered PHI.

The Care Coordinator must have written release of information from the person for these communications. On the release form, the person will indicate specifically what information is to be released, to whom (what entity) and for how long. A person must annually choose to continue HCB Waiver services therefore the ROIs associated with waiver services expire in 1 year.

The release of information form also has a revocation section allowing the person to revoke their consent to release information at any time. The Care Coordinator should be aware of the revocation part and assist the person to use it to revoke consent of private information sharing. For example, if a client leaves one Care Coordinator to be served by the next- the former Care Coordinator should ask the client to revoke consent to share PHI. Then the new Care Coordinator can be fully responsible for sharing necessary information with providers. The former Care Coordinator can then redirect subsequent inquiries to the new Care Coordinator.

- Utilize the **DHSS Approved Release of Information Form**
  - For the person to authorize you the CC to release their information to SDS
  - For the primary Dr. to confirm with SDS any diagnosis
- **One Releaser** of information can go to **multiple Receivers**
- The form is considered incomplete without the revoke section as the 2nd page (back side)

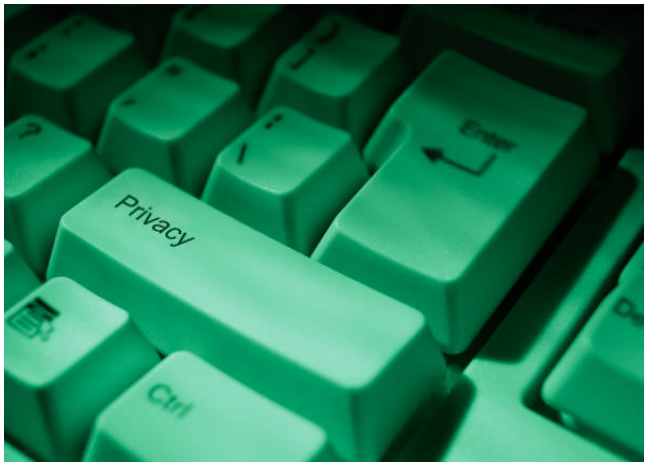
Follow the Health Insurance Portability and Accountability Act (HIPAA) requirements

The Health Insurance Portability and Accountability Act (HIPAA) generally requires covered entities to receive authorization from an individual before using or making disclosures to others about protected health information (PHI). An authorization is required if a use or disclosure of PHI is for purposes that are unrelated to treatment, payment, health care operations, unless disclosure is otherwise required or permitted by HIPAA (for instance it is a requirement of law).

You can learn more about HIPAA through the agency enrollment process and here:
http://dhss.alaska.gov/fms/its/Pages/Hipaa.aspx

Establishing a Direct Secure Messaging account:

HIPAA also covers all electronic transactions. Agencies must ensure that electronic billing and transmission of documents, such as attachments to an email, or a fax, are received only by the intended party. For electronic attachments to email, SDS uses DSM, Direct Secure Messaging. **All providers who routinely communicate with DHSS, including SDS and DPA will need to request a DSM account through the Alaska eHealth Network** (AeHN) at 1-866-966-9030 or email info@ak-ehealth.org. This service has an annual charge of $9 per year at the time of this publication. Providers must use some form of file encryption to comply with HIPAA.



Fill out and submit Critical Incident Reports

In accordance with the Critical Incident Reporting and Management regulation 7 AAC 130.224, CC's make Critical Incident Reports to SDS Quality Assurance following the instructions in the policy. All reports must be made within 24 hours of discovery.

You must attend a separate webinar to fulfill training requirements for Critical Incident Reporting. Please register for this training through the SDS Webpage under Provider Training.

Care Coordinators convene a planning team for all waiver types:

Convene a planning team to contribute to the Plan of Care. The Care Coordinator can receive feedback and practical information about services through the planning team meeting. Meetings may be conducted in person, by electronic mail, telephone or videoconference.

The planning team must consist of at least:

- the recipient,
- the recipient's representative if applicable,
- a representative of each certified provider who will be providing services in the plan of care.

Exceptions to the planning team are: the Specialized Medical equipment provider, the Transportation provider, and the Environmental Modifications provider. These providers do not have to be on the planning team however, they are required to sign the POC.

Report Medicaid Fraud

Contact Quality Assurance to report concerns about known or suspected misuse or abuse of Medicaid services. Email hss.dsdsqa@alaska.gov or call 907-269-3666, or toll free 800-478-9996, or fax Quality Assurance at 907-269-3690.

The Alaska Medicaid Fraud Control Unit (MFCU) has been part of the Attorney General's Office since January 1992. The unit is located in Anchorage and has statewide jurisdiction. It has the responsibility for investigating and prosecuting Medicaid fraud and the abuse, neglect or financial exploitation of patients in any facility that accepts Medicaid funds.

Although the vast majority of health care providers are honest and dedicated to providing the highest quality health care to their patients, Medicaid provider fraud costs American taxpayers hundreds of millions of dollars annually and threatens the integrity of the Medicaid program. Nationally, it is estimated that fraud, waste and abuse account for about 10 percent of the payments made by Medicaid. If the national trends hold true for the State of Alaska, this percentage equates to millions of Medicaid dollars annually, resulting in a substantial reduction in moneys available to provide necessary medical services to needy Alaskans.

Service is reimbursable when:

- Provided by certified and enrolled agency
- Provided to Medicaid recipient
- Medicaid recipient has met eligibility for the service
- Approved in service plan
- Prior Authorized
- Delivered by qualified/trained service staff
- Documented properly by service staff
- Billing created with correct code/process within 1 yr of delivery
- Service note/billing handled properly (HIPAA)

In general, fraud occurs when a provider submits a claim for payment to Medicaid when the provider knows, or should know, they are not entitled to the payment. While health care fraud can take many forms, the most common involves billing for services not performed or billing for more expensive services than those actually provided. Medicaid patients may not suspect fraud, as they are seldom made aware of the procedures or dollar amounts billed to Medicaid. An unscrupulous provider can generate a fraudulent Medicaid payment simply by filing a false claim with an eligible recipient's identification number and a valid procedure code.

Message Hotline to Report Medicaid Fraud 1-907-269-6279

Examples Of Fraud Schemes In Health Care:

- Billing for services not rendered
- Billing for higher level of services than actually performed
- Billing for more services than actually performed
- Charging higher rates for services to Medicaid than others
- Coding billings to get more reimbursement
- Providing and billing for unnecessary services
- Misrepresenting an unallowable service in a Medicaid billing
- Falsely diagnosing so Medicaid will pay for more services

If you suspect Medicaid health care fraud or patient abuse, do your part to protect the integrity of the Medicaid program and the public resources that fund it!

Alaska Medicaid Fraud Control Unit
Office of Special Prosecutions and Appeals
310 K Street, Suite 300
Anchorage, AK 99501
email: medfraud@alaska.gov

Medicaid Fraud Control Unit Hotline
907-269-6279
fax 907-269-6202

Crimestoppers Hotline at 1-907-561-7867

Provide timely information regarding changes in recipient basic information:

Use the Recipient Change of Status, All Programs form located at http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx to report changes of status. You may type in the form but then must print it out and either email or fax it in. Email addresses are located on the form for the correct unit. Change of Status forms are not reports of harm or critical incidents.

- Changes of Status include:
  - Change of recipient address/phone number,
  - Legal representative/custody,
  - Name changes/adoption,
  - Admission/discharge from hospital/long term care

Care Coordination Services Conditions of Participation

Care coordination services are provided for every recipient. Care coordinators assist individuals to gain access to waiver and other state plan services, as well as medical, social, educational, and other services with funding sources other than Medicaid. For recipients, care coordinators manage the process of planning for services, developing a plan of care, on-going monitoring of services, and renewing the plan of care annually. Throughout the year, care coordinators remain in contact with recipients in a manner, and with a frequency, appropriate to the needs of the recipients.

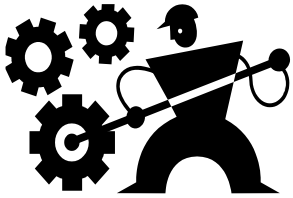
The provider who chooses to offer care coordination services must be certified as a provider of care coordination services under 7 AAC 130.220 (b)(2), meet with the requirements of 7 AAC 130.240, and operate in compliance with the Provider Conditions of Participation and the following standards.

I. Program Administration through training- *(see unit 4)*

II. Program operations

A. **Quality management**.

1. Plan of care tracking system.
   a. The provider must develop a system to monitor plan of care development and implementation to ensure that plans of care for recipients
      i. are complete and submitted within required timeframes;
      ii. address all needs identified in the recipient's assessment;
      iii. include the personal goals of the recipient; and
      iv. address recipient health, safety, and welfare.



   b. The provider must develop and implement
      i. a protocol for analysis, annually at a minimum, of the data collected through its tracking system;
      ii. a procedure for correcting problems uncovered by the analysis;
      iii. a process for summarizing the annual analysis and corrective actions for inclusion in a report to be submitted to Senior and Disabilities Services with the provider's application for recertification or to be made available upon request.
   c. At a minimum, the provider must determine whether
      i. services meet the needs of the recipients;
      ii. services are effectively coordinated among the various providers;
      iii. recipients and their informal supports are encouraged to participate in the care coordination process;
      iv. recipients are afforded the right to make choices regarding their care; and
      v. services are integrated with informal care and supports.

The CC is the filter for services; all services must be prior authorized by SDS and requested through the CC on POC or Amendment

B. Backup care coordinator.

1. The provider must designate, for each care coordinator, another certified and enrolled care coordinator to serve as backup when the primary care coordinator will not be available to provide services.
2. The backup care coordinator may provide services to no more than the number of recipients, including that of the primary care coordinator's usual case load, for which service coordination and response to any recipient needs can be managed effectively.
3. The provider must inform each recipient, affected by the end of the provider's association with a care coordinator employee, of the name and contact information for a care coordinator who will serve as backup until the recipient chooses another care coordinator to provide services.

C. Billing for services.

1. The provider may not submit a claim for reimbursement for care coordination services until the services have been rendered.
2. Claims for monthly care coordination services for recipients may not be submitted until the first day of the month following the month in which services were rendered.

D. Ending care coordinator associations with the provider agency.

1. The provider agency must notify, in writing, each recipient affected by the end of the provider's association with a care coordinator employee.
2. The written notice must include
   a. a statement indicating the care coordinator is ending employment with the agency;
   b. the name of the hiring agency, if the care coordinator has accepted employment at another agency;
   c. the name of the backup care coordinator who will ensure services are provided without interruption until other arrangements for care coordination services are made; and
   d. a statement that the recipient has the right to choose to receive care coordination services from any certified provider, and that the provider agency will facilitate the transfer process if he/she chooses another provider.

III. Recipient relationships.

A. **Conflicts of interest**.

1. The care coordinator must
   a. afford to the recipient the right to choose to receive services from any certified provider;
   b. inform the recipient, documenting the occasion in writing of any employment relationship or any other relationship with other provider personnel or owners who could be selected by the recipient to provide services; and
   c. facilitate the transfer process when the recipient chooses to receive care coordination services from another care coordinator.
2. The care coordinator may not
   a. solicit as clients any recipients known to be receiving services from another care coordinator or provider agency;
   b. after deciding to leave a provider agency for employment at another agency, attempt to influence any recipient to retain him/her as care coordinator or to initiate the process of transferring any recipient to the hiring agency for care coordination services; or
   c. offer, promote, or sell products or non-program services to, or engage in any commercial transaction with, recipients, their families, or their representatives.
3. The provider must develop a process for resolution of conflicts that might arise between the care coordinator and the recipient, family, or informal supports, regarding needs, goals, or appropriate services.

B. Recipient contacts.

1. For each contact, the care coordinator must
   a. use a method of communication appropriate for the communication abilities of the recipient or the recipient's representative to ensure the content of the contact and any plans for further action are understood by each party to the conversation ;
   b. ensure the contact is of sufficient duration that the requirements for on-going care coordination under 7 AAC 130.240 (c) are met;
   c. address the following topics, at a minimum, with the recipient or the recipient's representative:
      i. whether services have been delivered in the scope, duration, and frequency described in the plan of care;
      ii. whether the delivery of services was acceptable in terms of safety and respect for the recipient; and
      iii. whether adjustments to the plan of care or to arrangements with providers might be needed because of changes in the recipient's health or other circumstances; and
   d. document the content of each contact with the recipient or recipient's representative, and the method used to make that contact meaningful in terms of monitoring the health, safety, and welfare of the recipient, and the adequacy of provider services.
2. The care coordinator must meet in-person with the recipient at least once in each service environment during the plan year.
3. The care coordinator must obtain the signature of the recipient or the recipient's representative for the record of each in-person contact; however, if the recipient is unable or unwilling to sign the record, the care coordinator
   a. must indicate the cause of the inability or unwillingness to sign, and
   b. may request other providers who are present at the time to sign the record.

IV. The care coordination process.

A. **Care coordination goals.**

The provider must operate its care coordination services program for the following purposes:

1. to foster the greatest amount of independence for the recipient;
2. to enable the recipient to remain in the most appropriate environment in the home or community;
3. to build and strengthen family and community supports;
4. to treat recipients with dignity and respect in the provision of services;
5. to secure for recipients appropriate, comprehensive, and coordinated services that will promote rehabilitation and maintenance of current abilities;
6. to serve as a link to increase access to community-based services; and
7. to improve the availability and quality of services.

B. Plan of care development.

1. Recipient orientation. The care coordinator must
   a. orient the recipient, the recipient's family, and informal supports to the care coordination process;
   b. provide information about service options for medical, social, educational, employment, and other services;
   c. affirm the recipient's right to choose to receive services from any qualified provider; and
   d. offer assistance in identifying potential providers for the recipient.
2. Planning team. The care coordinator must identify, and consult with each member of, a planning team for the purposes of
   a. developing an individualized, person-centered plan of care that identifies problems and strengths, and focuses on understanding needs in the context of the recipient's strengths; and
   b. providing an opportunity for the recipient and family
      i. to express outcomes they wish to achieve,
      ii. to request services that meet identified needs, and
      iii. to explain how they would prefer that the services to be delivered.

Care Coordinators convene the planning team for all waiver types:
You will receive feedback and practical information about services through the planning team meetings. Meetings may be conducted in person, by electronic mail, tele- or video- conference. The planning team must consist of at least: the recipient, the recipient's representative if applicable, and a representative of each certified provider who will be providing services in the plan of care. Exceptions to the planning team are: the **Specialized Medical Equipment** provider, the **Transportation** provider, and the **Environmental Modifications** provider. These providers do not have to attend the planning team meetings. However they still agree to serve in the POC by writing on a separately attached document.

3. Integrated program of services. The planning team must
   a. incorporate the findings of the most recent evaluation or assessment in the plan of care;
   b. recommend services that support and enhance, but do not replace unless necessary, care and support provided by family and other informal supports;
   c. develop an integrated program, including
      i, individually-designed activities, experiences, services, or therapies needed to achieve goals and objectives or identified, expected outcomes; and
      ii. supports that will assist the recipient to become gainfully employed in the general workforce in an integrated workplace; and
   d. write a plan of care that meets program requirements, and that specifies the responsibilities of the care coordinator, the recipient, and the recipient's informal and formal supports.

4. The care coordinator must deliver
   a. copies of the plan of care to each provider of services (except for providers of chore services, meal services specialized medical equipment, transportation services, and environmental modification services) included in the plan of care; and
   b. pertinent sections of the plan of care to providers of chore services and meal services, including at a minimum:
      i. Section I Plan of Care Information and Identification,
      ii. Section IV Summary of Services content applicable to the provider, and
      iii. Section X Signatures.

C. **Plan of care implementation**.

The care coordinator must

1. arrange for the services and supports outlined in the plan of care, and coordinate the delivery of the services on behalf of the recipient;
2. support the recipient's independence by encouraging the recipient, family, and informal supports to be responsible for care to the greatest extent possible; and
3. teach the recipient and family how to evaluate the quality and appropriateness of services.

D. Service monitoring.

1. The care coordinator must contact the recipient at least twice a month, and as frequently as necessary, to evaluate whether the following conditions are met.
   a. The services are furnished in accordance with the plan of care and in a timely manner.
   b. The services are delivered in a manner that protects the recipient's health, safety, and welfare.
   c. The services are adequate to meet the recipient's identified needs.
2. The care coordinator must evaluate whether changes in the needs or status of the recipient require adjustments to the plan of care or to arrangements with providers.

Amendment guidelines

A modification to the POC (amendment) is required to meet the recipient's needs because of a change of circumstances.

-an increase or decrease of approved units is needed related to the health, safety, and welfare of the recipient

-a change of providers is requested

-must be submitted within 10 business days of the change

3. The care coordinator must contact each provider of services for a recipient as needed to
   i. ensure coordination in the delivery of multiple services by all providers;
   ii. address problems in service provision or goal achievement;
   iii. consult regarding need to alter plans of care;
   iv. intervene to make providers more responsive to the recipient's needs; and
   v. verify service utilization in the amount, duration, and frequency specified in the plan of care.
4. The care coordinator must act to ensure substandard care is improved, or arrange for service delivery from other providers.
5. The care coordinator must notify, within one business day of learning of a recipient's death, termination of a service, or move to another residence, any provider affected by such change in recipient status.

As the Care Coordinator you arranged for the authorization of these services therefore it is your responsibility to notify the providers when they need to change

E. Care coordinator appointment and transfer.

1. The care coordinator must notify Senior and Disabilities Services, on a form provided by Senior and Disabilities Services, of
   a. the care coordinator's appointment when selected by a recipient to provide services; and
   b. the transfer of care coordination services to another care coordinator.

c. The care coordinator must send to the new care coordinator, within five working days of notice of appointment of that care coordinator, the following materials:
   d. current plan of care and amendments to the plan,
   e. most recent assessment,
   f. case note for the past 12 months, and
   g. additional documents or information necessary for a safe transition.

2. The former and the new care coordinators must cooperate to ensure that all services outlined in the recipient's plan of care continue during a transfer of care coordination services.
3. The newly appointed care coordinator must send a copy of the appointment form to all providers listed in the plan of care to notify them of the change in care coordination services.

V. Environmental modification projects

A. Environmental modification evaluation

1. The care coordinator must review the need for physical adaptations to the recipient's residence with the recipient and the home owner, and obtain preliminary permission from the home owner to proceed with the environmental modification project.
2. The care coordinator must verify that project can be accommodated within the funding limits set by 7 AAC 130.300 (c).

B. Request for cost estimates

1. The care coordinator must notify all certified and enrolled environmental modification service providers of the proposed project by electronic mail in a format provided by Senior and Disabilities Services.
2. The care coordinator's notification to environmental modification providers must include
   a. the care coordinator's name and contact information;
   b. the location of the proposed project, and a statement indicating providers may arrange with the care coordinator for on-site viewing of the area to be modified;
   c. the *Request for Cost Estimate* form or forms appropriate to the type of physical adaptation included in the environmental modification project;
   d. photographs of the area to be modified with sufficient detail for provider review; and
   e. notice of a time limit of at least 14 days for submission of estimates, unless different timeframe was approved by Senior and Disabilities Services.
3. The care coordinator may not disclose, except to Senior and Disabilities Services, financial information regarding the project or competing estimates, or the identity or number of providers expressing interest in the project.

C. Selection of the project provider

1. The care coordinator must
   a. review all *Request for Cost Estimate* forms received by the date specified for submission to determine
      i. which environmental modification provider submitted the lowest cost estimate for the project; and
      ii. whether that provider can complete the project in time to meet the recipient's needs; and b
      send to Senior and Disabilities Services

i. a Plan of Care that includes
   (A) a description of proposed physical adaptations with a photograph of the area to be modified, and any measurements, sketches, or other relevant representations, developed by the environmental modifications provider to show the project plan;
   (B) justification for the project based on the recipient's functional or clinical needs;
   (C) the name of the environmental modification provider recommended for the project;
   (D) if applicable, a *Waiver of Requirement for Provider Selection* form with an explanation regarding the need to select an environmental modification provider other than the one submitting the lowest cost estimate; and
   (E) the *Property Owner's Consent to Environmental Modification* form; and
ii. all *Request for Cost Estimate* forms received in regard to the project.

2. Upon written notice of approval by Senior and Disabilities Services, of selection of the environmental modification provider, the care coordinator must notify
   a. the provider selected of that provider's approval for the project; and
   b. any other providers that submitted estimates of that provider's selection.

D. Collaboration with interested parties

1. The care coordinator must advise the environmental modification provider of any recipient conditions or needs to ensure that the health, safety, and welfare of the recipient are protected throughout the project.
2. The care coordinator must review, with the environmental modification provider, any proposed changes for equivalent facilitation to ensure that the needs of the recipient will be met; the care coordinator may contact Senior and Disabilities Services regarding questions.
3. The care coordinator must work with the recipient, the home owner, and the environmental modification provider to resolve any disagreements regarding dissatisfaction with the project or with work performance; the care coordinator may contact Senior and Disabilities Services if unable to resolve any issues that remain after discussion with the parties.

Question:

Sometimes Care Coordinators need to answer questions for people served about who can and cannot be a paid provider for the person served in the HCB Waiver system. Who cannot be a paid direct service worker for that person, under which kinds of connections?

Any family member who has a duty to support the person under state law, including but not limited to a spouse, an adult parent of a minor child, a guardian and/or Power of Attorney; and anyone under the age of 18. For legal representatives or those with a duty to support, the only exception is when a judge grants the ability to be a paid provider in the legal documents that portray the relationship of responsibility. Also, individuals who have not passed the required background check will not become direct service worker.

Keep records of Care Coordination service

Maintain a written record (Case Note) of all applicant/recipient, service provider and informal support contacts. (There's an example in the attachments). This record includes entries for the type of contact (phone, in-person, and e-mail), the date of contact, the length of contact, and complete Case Notes on what occurred during the contact. This Case Note record is kept within the individual recipient file maintained by the Care Coordinator, under **7AAC 105.230 Requirements for Provider Records**, and as specified by the Alaska Division of Health Care Services (DHCS) in the Provider Billing manual provided by Xerox to all providers upon enrollment in Medicaid. The Care Coordinator provides copies of items in the recipient record set to the recipient and/or the recipient's legal representative(s) upon request.

Records need to be organized so they are easily accessed. Documents requested by state and federal agencies must meet the requirements of **7AAC 105.240 Request for Provider Records**

The Care Coordination Case Note

Care Coordinators should follow best practices for documentation. These are general guidelines that apply to the Care Coordinator service note or to service notes for individual supports. Service notes can be handwritten or digital.

You will be documenting visits (contacts) with the person, face to face, telephonically and by email. You will also be contacting legal representatives, family members, and other service providers (collateral contacts). Be sure that you have a release of information in order to talk with the collateral contact.

- Document every contact related to the client.
- Your notes should focus on the person.
- Your service notes will help you make sure that the supports given to the person stay current, even if you are working on amending the plan of care.

Your case note for visits with the person you are serving should contain these four elements:

1. The focus or purpose of your contact.
2. A short summary containing your observations about the person's behavior, appearance
    a. What did the person do while you were visiting?
    b. Was there anything significant about his or her way of communicating with you? Emotional state? Current health?
3. Any resolution (decision made to take action) that took place
4. The reason for next contact or follow-up that will occur if applicable

Additionally indicate where the face to face visit took place.

- For example you could state "home visit" for a visit at the person's home.
- "Site visit" would be a visit where you went to a service agency to evaluate services given to your client.
- It could be a visit to a community site which is not a waiver service
    - for example in school for a school age child
- A "phone" visit is exactly that- you or your client or legal representative called and you spoke on the phone.

SAMPLE CARE COORDINATION VISIT NOTE TEMPLATE

Medicaid #: _____Date:_____Time of Visit: _____
Location of Visit: _____Telephonic Visit: ☐
Current Status: Describe any changes in condition, medications, or circumstances since the last visit:

Review of Services: ***What services were provided and list any issues or changes:***

Services Provided	Comments/Issues/Need for Change
PCA Services	
Physician Visits	
Hospitalizations	

Additional Notes or Plans for Follow-up	**Present for Visit**	**Relationship**

Care Coordinator Name: (print clearly) _____ CM#:

Care Coordinator Signature _____ Date_____

Recipient Signature (face to face only) _____ Date_____

Tips for writing professional notes

Be clear and precise

Avoid being general and vague. Be specific about what you are conveying in your note. Think about what it "looks like" – your observation- when you are documenting potentially vague or nonspecific topics. Professional notes should avoid making assumptions about another person. Document emotional states and other potentially subjective information by writing "as evidenced by". For example, rather than stating "Alice was angry", the note could say "Alice was angry as evidenced by her frowning facial expression" or "Alice stated she was angry".

Be specific and objective about what may be generating the person's responses. For example, instead of writing "Fred was angry today" it could be written that "Fred expressed his frustration today about how long it took him waiting in line at the pharmacy."

Use language the people you serve can understand

Care coordinators are aware of acronyms and professional terminology related to the work. However this can seem overwhelming to those we serve. Avoid over using jargon in your notes. If you use acronyms spell them out the first time, then use the acronym afterward.

Document how you interacted with your client

Your interaction may contain valuable information for services or planning. Document your observations. Use quotation marks when you want to quote a person word for word. Place only the person's exact words in the quotation marks. Likewise, if paraphrasing what a person has said, do not use quotation marks. Avoid using quotation marks to simply highlight meaning.

Document what you found important about the contact

The Care Coordinator is able to informally assess people's needs for support and general health concerns. When you think the following aspects are important or significant in your contact, document them in the case note:

- Appearance
- Dress
- Facial expressions
- Mannerisms
- Responses to others or to activities
- Participation- with you or with services
- Attitude or mindset of the person- regarding you or services
- Any observed cognitive issues- new or ongoing
- Changes in health needs or level of support

Avoid contradictions

The case note should relate to previous notes. If there are changes in health or services, this must be documented. If the person experiences changes in level of support, whether for more supports or less, this must be documented. The notes should be able to be reviewed as a continuum without the sense of a gap in information where something was left out that may have impacted service level or general health and safety.

Portray strengths along with needs

Every person who experiences needs for support also brings some strengths, gifts and talents to their story. Your notes should reflect the person's positive gains or maintenance, and challenges or problems. Notes that exist solely as a collection of negatives can create an inappropriate legacy for the person, for example if he or she was to transfer to a new Care Coordinator- the written record would show only deficits without strengths. This can affect services offered (or not offered) to the person as time goes on.

Provide evidence of agreement

The person you are serving participates in the development and delivery of the services in the plan of care. He or she authorizes the plan with a signature (or that of the legal representative). Service providers may also agree on the plan via signature. You can show evidence of agreement with the plan further by documenting your interaction with the person at the visit as an extension of the plan. You can document with collateral contacts through your interaction at team meetings or other staffing concerning the person. The person or legal representative can sign the visit case note.

(Summers, N. *Fundamentals of Care Management Practice,* 4E. 2012. Wadsworth, a part of Cengage Learning, Inc. by permission. www.cengage.com/permissions)

Follow the records retention schedule for the Alaska Home and Community Based Waiver

Whether the person you serve is terminating services or not, you will need to keep all records of the case for seven years from the last date of service, which is the records retention schedule for HCB Waiver providers.

From 7 AAC 105.230:

> (e) A provider shall retain a recipient's records described in (b) - (d) of this section for which services have been billed to the department for at least seven years from the date the service is provided. The duty of the provider set out in this subsection applies to a provider even if the provider's business is sold or transferred, or is no longer operating. If a provider ceases business, the provider shall notify the department how the department can access Medicaid recipient records in the future.

This regulation applies even if you move from Alaska or transfer your business to another certified and enrolled administrator. **Retained records must be kept per HIPAA standards, which is a business requirement of the certified and enrolled agency. They must also be kept accessible for review upon request.**

You may transfer records of living clients to another Care Coordinator, following the Care Coordination transfer policy and form. For clients who were served by you and then are deceased you still need to retain records according to the regulation.

Regulations for Documentation:

- 7AAC 105-7 AAC 160 Medicaid Coverage and Payment
- 7 AAC 105.400 Grounds for Provider Sanction
- 7 AAC 105.230 Requirements for Provider Records

Here is a table of attributes of a good case note, for Care Coordination notes, and for direct service notes.

Attribute	Care Coordination note	Other Service Provider note
The case note is based on facts not opinion	X	X
Includes the Care Coordinator/provider's signature and credentials	X	X
Includes the date and time of the note writing	X	X
Is written as soon as possible after the event/service occurs	X	X
If late entry, is noted as a late entry	X	X
Is typed/digital or if handwritten is blue or black pen	X	X
If handwritten errors are crossed out with one line and corrections written next to the error	X	X
Free of whiteout or blackout/coloring in to cover errors	X	X
The note addresses a personal and/or habilitative goal.	X	X
The Habilitative service has measurable goals and objectives.		X
The Habilitative service note references the goal, and the objectives applied during the service.		X
The Non Habilitative service note references the outcome.	X	X
Has the person's name on it.	X	X
An identifier such as Date of birth, CCAN, Medicaid Number	X	X
Documents one service at a time.		X
Each note occupies one individual page or digital document/section.	X	X
States type of service	X	X
Includes date of service	X	X
Service start and end times	X	X
How many hours if applicable	X	X
For a 15 minute unit of service: document each event or task		X
Provides a narrative at least once per event		X
For a Daily unit: documents each event/task		X
Narrative is provided at least once per provider shift (or CC visit)	X	
Justifies the duration of the service		X
States where the service(or CC visit) was done	X	X
Describes what the provider did to help the person reach the goal/outcome		X
Describes the person's response	X	X
Describes any progress made	X	X
Documents unusual occurrences	X	X
States if the person declines the service (including the CC contact)	X	X
Indicates any change in performance or needs for support	X	X
Does not include stand by time or other time that is not the approved service	X	X

UNIT 4

Medicaid Eligibility
TEFRA/ Katie Beckett Waiver
Cost of Care Co-Pay

People must have or in some cases be eligible for "regular" Medicaid in order to apply for the Waiver programs.

Look at the illustration above (umbrellas). You will see that regular Medicaid is the "big umbrella". Medicaid is an entitlement program created by the federal government. It is the primary public program for financing basic health and long-term care services for low-income Alaskans. This is medical coverage for Alaskan citizens who have financial limitations and/or medical conditions. The rules about who is eligible for Medicaid vary in states. In Alaska, people apply for Medicaid with the Division of Public Assistance (DPA). The applicant brings information about income and medical conditions to the local DPA office. In some cases DPA may do phone interviews if the applicant is ill and cannot leave home to come to the office. The applicant still needs to turn in financial/income information and medical documentation.

In some Alaskan communities there is no "DPA office". There is a "fee agent" which is simply an agency that DPA authorizes to accept Medicaid applications in that community. There is no "fee" to apply for Medicaid. The term "fee agent" in this case means that DPA pays that authorized agency a fee to take applications from people in that community.

After the person turns in their application, DPA assigns the person a functional team and then they do an interview. DPA determines the form of Medicaid the person will qualify for. The person then applies for Medicaid. If the person gets Medicaid, they will receive a letter and a Medicaid Denali Care card.

DPA still issues "screening coupons" for individuals who are initially applying for Medicaid and are likely to meet NFLOC for the ALI or APDD waiver. DPA knows this because the person has brought their medical information to DPA and has applied for long term care Medicaid. The "screening coupon" allows the CC to assist the person to make their first application for the ALI or APDD waiver (formerly known as a "screening". The CC can then be reimbursed for the initial application for the individual. If the person does not meet NFLOC they may reapply a year later, with supporting medical information that shows material change in condition. 7 AAC 130.211 Screening

How do care coordinators help with regular Medicaid?

A care coordinator can help the person know about the DPA office and help them fill out the application for Medicaid, if the person needs help. The person will need to fill out the "MED4" or ***Application for Adults and Children with Long Term Care Needs***. Applicants could meet eligibility criteria for a Regular Medicaid Category per DPA such as Adult Public Assistance, or Working Disabled, etc. OR, by the Special Income 300% category.
This means the person's total income could be 300 % higher than standard Medicaid eligibility criteria- if they meet Level of Care for the waiver.

DPAweb | DPA online resources
dpaweb.hss.state.ak.us

The DPA intake team will "do the math" about the person's finances. For this reason ***do not*** assume that someone will or will not qualify for Medicaid. If the adult or child has a disability which means they have long term care needs, or the person is a frail elder, he/she can apply for long term care Medicaid through DPA. If a parent has a child with a disability they can apply.

A person may already have Medicaid and ask you to be their care coordinator. You must verify current Medicaid. Having a card does not guarantee that Medicaid is active. Contact Provider Inquiry/Provider Services at X to confirm client eligibility/payment status: (907) 644-6800 (option 1) or toll free (800) 770-5650 (option 1, 1)

You can help the person reapply for Medicaid. Your client will get a Medicaid application each year. You will also get notice of Medicaid renewal for each person on your caseload. You can remind the person or their legal representative to reapply. It is important to know because if your client's Medicaid expires, their services will not be reimbursed.

A Note about Ethics

As a care coordinator, you may be working with elders who are facing long term care or families with disabled family members. People will see you as an authority on how to get basic things they need.
You may hear the following common questions and many others:
How do I get benefits? Should I give away all my money, property? When should I sell everything in order to qualify? How should I fill out the form? My family member needs a job, how do I get them paid to help me? Is it true I will lose my benefits if I have a job?

When it comes to decisions about one's assets, and health care choices- you need to give information so the person can make their own informed choice.

Did you know?
Every state makes a Plan for Medicaid. This is called the Medicaid State Plan. CMS approves the plan in each state and expects the state to follow it. All state offices that help people with Medicaid need to work together to follow the State plan. Click here to learn more about the Alaska Medicaid State Plan.

You will not have all the answers. You will learn how to refer people with these questions to places where they can get the answer. Agencies, authorities, and care coordinators facilitate or give benefits and/or services. They do not **advise** clients on what to do with their money, resources or health care decisions. They do not **tell** the client what services or programs the client needs. They do give resources so the client may make an informed choice. They do give information about eligibility and/or service choices after they person has applied or gotten an assessment.

You do not have to know every resource. You must be able to give basic information to find answers so people can choose. You should be able to connect with other care coordinators and reach out to agencies (including government agencies) that will be able to give the person more information.

TIP: You can always refer people with questions you cannot answer to the ADRC- Aging and Disability Resource Center.

At times this will be both a challenge and a joy to you. Remember you are working with people, and each person has his or her own understanding of the system and your role. You will be doing person centered plans and helping services be person centered too. A helpful strategy is to focus on the person. What does she want to have happen? What does he say he needs? Listen and give information where you can and referrals when you cannot.

In the illustration above (umbrellas), you will see that the Waiver programs are under a smaller umbrella. This means Waivers are part of Medicaid. To get under the smaller umbrella the person must have Medicaid and meet **level of care for the Waiver. Level of care is discussed later in this guide.**

Children who experience disability, and TEFRA/ Katie Beckett Waiver

Who was Katie Beckett?
Katie Beckett was an individual who experienced disabilities and was medically fragile. She lived in Iowa. She died in 2012 at the age of 34. She changed health care policy for children. In 1981, President Reagan heard about a little girl who spent most of her life in the hospital because she needed to breathe on a ventilator most of the day. At the time, Medicaid would only pay for the expensive treatments she needed if she stayed in the hospital. President Reagan signed the Katie Beckett waiver which allowed Medicaid to pay for medically complex care for children at home. It is now known as TEFRA.

Katie Beckett, 32, inserts a small suction device into her tracheotomy tube to help clear her lungs and throat.

If you work with the IDD or CCMC waivers you may have some clients who have TEFRA Medicaid. Some families with a disabled child may state they "do not qualify" for Medicaid because they make too much money. They can still apply for Medicaid for their child with disability regardless of family income because of TEFRA. Refer them to DPA.

Established in 1982 under the Tax Equity and Fiscal Responsibility Act (P.L. 97-248), the Katie Beckett Medicaid Program permits the state to "ignore" family income for certain disabled children. It provides Medicaid benefits to certain children 18 years of age or less who qualify as disabled individuals under §1614 of the Social Security Act and who live at home, rather than in an institution. These children must meet specific criteria to be covered. Qualification is not based on medical diagnosis; it is based on the institutional level of care the child requires. Title 42 Code of Federal Regulations outlines the criteria used to determine eligibility.

SDS does an assessment for these children- but this is not Waiver access. Rather TEFRA is a form of **Medicaid for children with long term care needs.**

Division of Public Assistance assists families who have children with disabilities to find out if they can access TEFRA.

Who Is Eligible?
For Medicaid eligibility to be established under the TEFRA/Katie Beckett Program, it must be determined the child:

- Is 18 years old or younger, AND
- Meets federal criteria for disability, AND
- Is financially ineligible for SSI benefits, AND
- Requires a level of care provided in a hospital, skilled-nursing facility or intermediate-care facility (including an intermediate-care facility for people with intellectual disabilities- ICF/IID); AND
- Can appropriately be cared for at home, AND
- Has an estimated cost of care outside of the institution that will not exceed the estimated cost of treating him/her within the institution

SDS determines Level of Care eligibility for TEFRA using the ICAP assessment or NFLOC (for children). (Please see ICAP (Inventory for Client and Agency Planning) section for more information about the ICAP assessment.
Children who have TEFRA can potentially access medically necessary services that are not covered by the parent's medical insurance, such as speech, physical and occupational therapy. **TEFRA does not cover services found in the Home and Community Based waiver.**

About Cost of Care Sharing (Cost of Care Co- Pay)

Division of Public Assistance (DPA) determines eligibility for Medicaid. DPA reviews each recipient's eligibility annually and anytime there are changes to income or benefits. Occasionally benefit income may change and he or she may be required to pay a cost of care co-pay.

What is Cost of Care?

- Certain Medicaid recipients who receive Long Term Care Medicaid Services (Waivers) are required to pay a portion of their income to their Cost of Care.
- Cost of Care is a **Medicaid Co-Pay to the Waiver provider**
- Medicaid providers must report cost of care payment they received on their Medicaid billing

Cost of Care Notices

DPA determines the Cost of Care co-pay and sends a letter to

- the recipient,
- his/her legal representative as applicable,
- the Care Coordinator
- the Assisted Living Home business office (if applicable).

This is why it is important to connect with DPA and make sure they have the correct names, addresses and releases of information (ROI) on file for each of these supports.

Care Coordinators can contact DPA or the individual's DPA team with specific questions about the Cost of Care Co-Pay.
*Must have the proper Release of Information document

Cost of care notification letters go out the month before the change is in effect (thirty days). ***Letters are not sent each month!*** Another letter will go out the month before the change is no longer in effect. Cost of Care must be assumed as due until another letter is received indicating it's ending.

Billing and Cost of Care Co-Pay

- The provider who receives Cost of Care co-payment can only apply the Cost of Care co-payment towards Long Term Care Medicaid Related Services
- For Assisted Living Homes and Waiver Providers (such as Care Coordinators) the Medicaid remittance must indicate they received a Cost of Care co-payment and the amount- they enter the Cost of Care amount received on Line 29 of their billing to Medicaid.
- If not using an Assisted Living Home, the individual can pay to the Waiver provider of his/her choice- the Care Coordinator can help the person decide.

Care Coordinators can help their client understand and report circumstances which may cause a reduction in the amount of the Cost of Care co-pay. DPA determines the reduction. A new notice is sent to the person whenever a change is made, or at the annual review. DPA determines the amount of Cost of Care co-pay after allowing all possible deductions.

Common reasons include:

- the personal needs allowance, (is recorded incorrectly)
- uncovered medical expenses (the person is paying for prescriptions or supplies out of pocket),
- insurance premiums that the person is paying,
- unanticipated or increase in income,
- spousal and dependent allowances (are miscalculated)
- change in benefit deductions,
- changes in income which are reported through the annual review.

The person's DPA functional team can help with individual-specific questions about Cost of Care Co-Pay

COASTAL - LTC, TEFRA, WAIVER
DIVISION OF PUBLIC ASST
P O BOX 240249
ANCHORAGE AK 99524
(907) 269-8950
(1-800) 478-4372
BENEFIT QUESTIONS:
(907) 269-5777 (ANCH ONLY)
(1-888) 804-6330
ORIGINAL SENT TO CLIENT

STATE OF ALASKA 604
DIVISION OF PUBLIC ASSISTANCE

CASE NUMBER: 05134128
CASELOAD ID: 262070

MAILING DATE: 12/09/11

A recipient who does not live in an Assisted Living Home may choose to pay Cost of Care to any waiver services provider. Generally the provider who delivers the most expensive services is a good choice. The provider must report cost of care payment received from the recipient on their Medicaid billing for the month in which it was received. It is considered fraudulent if not reported.

COST OF CARE CHANGE / ALH FACILITY

DEAR [redacted]
The amount you pay toward your monthly cost of care is changing. Your Medicaid ID number is [redacted] Your new monthly cost of care amount is $39.55. Please pay this to the assisted living facility for your waiver services.

How we figure the amount you must pay is shown below. If your cost of care is greater than the amount the facility bills you, you can pay the remainder to other providers. This change takes effect JANUARY 2012.

INCOME:	AMOUNT:	COMMENTS:
SSA	1019	
Veterans (VA)		
Pension		
Annuity		
Senior Benefits		
Earned Income	24.4	
Example Benefit	400	
Income Adjustment		
TOTAL INCOME	1443.40	

EXPENSES:	
Personal Needs	1396
Income Taxes	2.85
Spousal Maintenance	
Dependent Maintenance	
Insurance Premiums	
Uncovered Med Exp	5
Home Maint (6 mo limit)	
Expense Adjustment	
TOTAL EXPENSES	1403.85

This action is supported by Aged, Disabled and Long Term Care Manual section 570, and 7 AAC 100.550-100.579.
THIS AMOUNT SHOWN ABOVE SHOULD BE WRITTEN IN A CHECK SEPARATE FROM YOUR ROOM & BOARD CHARGES TO YOUR HOME, THE HOME IN TURN WILL LIST THE AMOUNT RECEIVED ON LINE 29 OF THEIR MONTHLY BILLING TO THE STATE, & ACS/DHCS WILL DO THE REST

Personal needs allowance here is NOT THE SAME as the amount of money the person allows their assisted living home to manage under ***7 AAC 75.310 Acceptance and Management of Residents' Money.*** *Personal needs allowance here is the maximum amount of money a person who has a Waiver can receive to use to pay for personal needs, if they live in an assisted living home. If a person lives in an assisted living home, they use their benefits income to pay for room and board, and these are considered personal needs. If a person lives in their own home they still need to pay for personal needs like food, rent, or other payments to live in the community. Some people will not have as much benefit income as 1396.00/1656.00. It depends on their benefit amounts. These max amounts (1396.00 and 1656.00) are set by legislature.*

Unit 5

- Eligibility for Developmental Disability Services
- DD Grant Funded Services
  - ICFIID: Intermediate Care Facility Level of Care
- Creating the Application for the IDD Waiver
  - ICAP Assessment
  - Interim Assessment

LEVEL OF CARE

ICF/IID Level of Care

Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID). This Level of Care is associated with the IDD Waiver and TEFRA children. The person needs a combination and sequence of special, interdisciplinary, or generic assistance, supports or other services that are of lifelong or extended duration and are individually planned and coordinated. These services are intended to help the person gain or maintain physical, sensory-motor, cognitive, affective, communicative and social skills. The person needs significant coordinated supports to help him or her with mobility/motor skills, self-care/personal living, communication, learning, self direction, social skills, life skills, community living and economic self-sufficiency and/or vocational skills. This level of care is the same which the person would need to meet to receive service in an institution.

ELIGIBILITY FOR DD SERVICES- DEFINITION OF ELIGIBLE DIAGNOSES

A diagnosis of Intellectual Developmental Disability for the purpose of applying for or receiving services through the Senior & Disabilities Services is very specific.

The person must have documentation of diagnosis of a severe chronic disability as defined by statute AS47.80.900(6).

(6) "person with a developmental disability" means a person who is experiencing a severe, chronic disability that

(A) is attributable to a mental or physical impairment or combination of mental and physical impairments;

(B) is manifested before the person attains age 22;

(C) is likely to continue indefinitely;

(D) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and

(E) reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated;

People of any age who experience Intellectual and/or Developmental Disability first need to apply for eligibility for services with SDS, by completing an *Eligibility Determination and Request for Services form*:
http://dhss.alaska.gov/dsds/Documents/SDSforms/IDD-01-eligibility-application.pdf

This form asks what kind of help the person needs now and in the future, and asks for information about the functional abilities of the applicant in the life skill areas listed above.

- SDS must know about the person and what substantial functional limitations the person experiences before services are accessed (including the waiver).

Completing this form is often done by a Short Term Assistance and Referral counselor. SDS does provide an instructional document for people who would like to know more about how to complete the *Eligibility Determination and Request for Services form.*
http://dhss.alaska.gov/dsds/Documents/dd/DD-eligibility-application-instructions.pdf

The Short Term Assistance and Referral (STAR) Grant

People and their families/supportive team can connect with a Short Term Assistance and Referral (STAR) Case Manager at a service agency for help in filling out the form. A Care Coordinator can help the individual, legal representative and/or supportive team by referring them to a STAR Case Manager at http://dhss.alaska.gov/dsds/Pages/grantservices/starmini.aspx . In some cases Care Coordinators help people apply for DD Eligibility using this form as part of an agency service to its community. ***This activity is not part of Waiver-reimbursed Care Coordinator activities.***

A STAR Case Manager can help the individual and family by giving authorized limited funding for immediate goods and services necessary for health and safety. The STAR Case Manager can request an expedited review (within 24 hours) of the *Eligibility Determination and Request for Services* form in cases of crisis involving health and safety.

Appropriate documentation of disability and/or diagnosis includes:

- ✓ Documentation from a physician,
- ✓ Speech/Language Therapist;
- ✓ Infant Learning Program (ILP) reports
  - o (such as those generated by PIC – Programs for Infants and Children),
- ✓ Individual Education Plan (IEP)
- ✓ Evaluation Summary and Eligibility Review (ESER) reports,
- ✓ medical evaluations (that pertain to developmental and/or functional skills),
- ✓ test results from Intelligence Quotient (IQ) tests,
- ✓ psychologist or other professional documentation must support each area of functional limitation addressed by the *Eligibility Determination Form*.

***Rural areas may provide documentation from a local physician or a medical professional from the village clinic but the documentation must address functional abilities and age of onset. (if no other information is available)

Children under the age of 16 must have at least three of the first five Functional Limitations (self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency) to be determined eligible for DD services.

After age 16, eligibility will take the capacity for independent living and economic self-sufficiency into consideration. People of any age must experience substantial limitations in at least 3 of these life areas in order to be determined eligible for DD services.

After submitting the completed form, and diagnostic materials, SDS evaluates the application for eligibility for DD services. If eligible, the person will then receive an approval letter of eligibility for IDD/DD services from SDS with instructions on how to apply to be on the Registry, and will then wait for selection to apply for the IDD waiver.

If eligible for DD services, the applicant or his/her representative, usually the STAR case manager, will update SDS about the person's needs using the *Developmental Disabilities Registration and Review form* *http://dhss.alaska.gov/dsds/Documents/docs/ddRegAndReview.pdf*. These updates should happen when there are changes in circumstances or level of need, or at least annually. You can view SDS policy on eligibility and the IDD waiver process here: http://dhss.alaska.gov/dsds/Documents/policies/IDDElig13111.pdf

Once the person receives eligibility for DD services, he or she could use services from grant funded agencies. (It is not necessary to have Medicaid to receive most grant funded services.)

Explore the Senior and Disabilities Services Grants website:
http://dhss.alaska.gov/dsds/Pages/grantservices/default.aspx

Grant funded services for people who experience intellectual/developmental disability

Community Developmental Disabilities Grant Program:
The Community DD Grant Program (CDDG) addresses the needs of individuals with developmental disabilities for Habilitation, which is the acquisition or maintenance of skills to live with independence and improved capacity, and reduces the need for long-term residential care. Services that a person with a developmental disability (DD) may receive from the Program vary depending upon the person's age and unique needs.

Services include supported employment, respite care, care coordination, day habilitation, case management, specialized equipment and Core Services. In some situations, the Program may provide residential care in a group living or independent living arrangement. For those who meet the diagnostic and income limits, the Home and Community Based Waiver Program may provide similar services. However, everyone having a developmental disability does not qualify for the Waiver Program. Additionally, everyone does not need the long-term residential care that the IDD Waiver is designed to provide. CDDGs allow cost effective service to be provided that is tailored to meet the needs of individuals, particularly for those whose families are their primary care givers.

This program also funds CORE Services. Core Services are limited to $3,000 per person and offered to individuals on the Waitlist who receive no other services from the Division. Early availability of Core Services may alleviate crisis until individuals are in need of long-term care and are selected off of the Waiting List.

Mini-Grants:
Mini-Grants are a one-time awards made to individuals not to exceed $2,500 per recipient for health and safety needs not covered by grants or other programs, to help beneficiaries attain and maintain healthy and productive lifestyles. The kinds of supplies or services the Mental Health Trust considers appropriate for Mini-Grants include, but are not limited to: therapeutic devices, access to medical, dental and vision care, or special health-care needs. Adult dental care is the most frequently requested service by those who receive Mini-grants.

DD Registry (formerly known as The Waitlist)

The DD Registry ranks applicants from the highest score (indicating greatest need for services) to lowest score (indicating lesser need) on the basis of the information provided on *the Developmental Disabilities Registration and Review form*.

Please note: Approximately 200 individuals are selected from the ID/DD Registry per year to receive notice of HCB Waiver selection so they may have the opportunity to choose the IDD Waiver and its services. Once an individual receives the letter of eligibility for DD services, he or she may access grant funded services from a community agency grantee.

A person may have a diagnosis of intellectual disability, and be eligible for DD services. For the HCB Waiver, he/she still needs to meet ICF/IID Level of Care:
He or she would need to be receiving care in an Intermediate Care Facility for Intellectual Disability (ICF/IID) right now, if no other care options were available to him/her. In other words, the diagnosis itself does not make the person eligible for the IDD Waiver. The person needs to have eligibility for DD services, then an assessment to determine level of care for the IDD waiver.

Advocacy has played a big role in the shape of the HBC Waiver and other state funded supports. Learn more about self advocacy by people who experience ID/DD at The Governor's Council on Disabilities and Special Education at http://www.hss.state.ak.us/gcdse/

ELIGIBILITY FOR THE IDD WAIVER: DIAGNOSIS

There are 5 IDD Diagnoses that could bring a person into the Waiver program. If the person does not have one of these 5, he or she may not be eligible for the Waiver program.

Cerebral Palsy: Diagnosis by a licensed physician as specified in 7 AAC 140.600 (c) (3)

Seizure Disorder: Diagnosis by a licensed physician as specified in 7 AAC 140.600 (c) (4)

Autism: Diagnosis by a licensed psychologist, child psychiatrist, or developmental pediatrician as specified in 7 AAC 140.600 (c) (5).

Intellectual Disability, Developmental Disability:
For an applicant/recipient three years of age and older: diagnosis by a licensed physician of a condition specified in 7 AAC 140.600 (c) (2), based on an evaluation demonstrating cognitive impairment indicated by a delay of at least 25%, or two standard deviations below the mean, in comparison to peer norms in at least three developmental areas or their equivalents (i.e., self-care, communication, learning, mobility, self-direction, and for those over age 16, independent living and economic self-sufficiency).

For an applicant/recipient younger than three years of age, and for an applicant/recipient over three years of age when an IQ has not be ascertained due to severity of the impairment or inability to test because of age:
Diagnosis by a licensed physician of a condition specified in 7 AAC 140.600 (c) (2), based on an evaluation demonstrating cognitive impairment indicated by delays in at least three developmental areas or their equivalents (i.e., self-care, communication, learning, mobility, and self-direction) as follows:
In at least two of the areas, a delay of 25%, or two standard deviations below the mean, in comparison to peer norms, and in at least one area, a delay of 50% in comparison to peer norms.

Other Related Conditions: diagnosis by a licensed physician of a condition specified in 7 AAC 140.600 (c) (2), based on an evaluation demonstrating cognitive impairment indicated by a delay of at least 25%, or two standard deviations below the mean, in comparison to peer norms in at least three developmental areas or their equivalents

7 AAC 140.600 (c) (2), a condition that is
(A) one other than mental illness, psychiatric impairment, or a serious emotional or behavioral disturbance; and
(B) found to be closely related to intellectual or developmental disability because that condition results in impairment of general intellectual functioning and adaptive behavior similar to that of individuals with intellectual or developmental disabilities; the condition must be diagnosed by a licensed physician and require treatment or services similar to those required for individuals with intellectual or developmental disabilities;

For a diagnosis of DSM-IV-TR Code 299.80, Pervasive Developmental Disorder Not Otherwise Specified (Including Atypical Autism), SDS requires two evaluations, with consistent diagnostic conclusions, that were completed on separate occasions by two individuals who are licensed psychologists, child psychiatrists, or developmental pediatricians.

To apply or reapply for the IDD Waiver, the individual must submit the following required diagnostic documentation with the HCB Waiver application:

An applicant/ recipient **younger** than three years of age must submit:

A diagnosis of a syndrome or chromosomal abnormality likely to result in intellectual/developmental disability; and an evaluation demonstrating cognitive impairment indicated by a delay of at least 25%, or two standard deviations below the mean, in comparison to peer norms, or a written statement of clinical judgment of significantly below average intellectual functioning by a licensed psychologist, psychological associate, or developmental pediatrician, completed within the previous 12 months.

An applicant/recipient **three years of age and older** must submit:

-A completed *Qualifying Diagnosis form* signed by a
licensed psychologist,
psychological associate,
developmental pediatrician
indicating a condition specified in 7 AAC 140.600 (c) (1),
Cerebral Palsy
Seizure Disorder
Autism
Intellectual Disability, Developmental Disability
Other Related Conditions: including the diagnosis

-A diagnostic report by a psychologist or school psychologist indicating eligibility for special education services, and specifying a category of Intellectual Disability, Cognitive Impairment, or Early Childhood Developmental Delay;

-An assessment with an individually-administered, standardized intelligence test of an IQ (intelligence quotient) of 70 or less (plus or minus 5 points allowed as a possible measurement error depending on the test used)

all evaluations should be completed with the last 36 months for initial applications

These documents can be repeated on reapplication

or the following alternatives:

When IQ is not ascertained due to severity of impairment, a statement from the evaluator indicating IQ could not be assessed because of the degree of impairment (refusal to participate or disruptive behaviors are not considered to be impairments for the purposes of this requirement).

When IQ is not ascertained due to inability to test because of age:

1) diagnosis of a syndrome or chromosomal abnormality likely to result in mental retardation and,
2) an evaluation demonstrating cognitive impairment indicated by
   a) a delay of at least 25%, or two standard deviations, below the mean in comparison to peer norms, or
   b) a statement of clinical judgment of significantly below average intellectual functioning, on provider letterhead and signed and dated by a licensed psychologist, psychological associate, or developmental pediatrician.

Applying for the IDD Waiver

In most cases when you are working with someone applying for an IDD waiver, the person has received a postcard from SDS indicating that he or she has been selected from the DD Registry and now is invited to apply for the IDD Waiver, starting with choosing a Care Coordinator. This person already has established eligibility for DD services in Alaska. He or she has received a letter of DD determination from SDS. This means that you will assemble an application packet for the person, and provide this to SDS to assist the person to apply for the IDD waiver.

The application packet contents will depend on the age of the applicant

Age of applicant	Up to 2yrs & 11months	3-7 years old	Age 8 and over	
Assessment method or document	IDD-10 Interim ICF /IDD Level of Care	IDD- 03 ICAP Assessment Info & Consent	IDD- 03 ICAP Assessment Info & Consent	IDD-10 Interim ICF/IDD Level of Care
Assessment Completed by:	Care Coordinator	SDS QIDP Assessor	SDS QIDP Assessor	Care Coordinator
How often?	Annually- until age 4	Annually- until age 8	**Every 3rd renewal year**	2 renewal years between ICAP
Evaluation Documents	A standardized age-appropriate norm-referenced diagnostic evaluation completed within the last 12 months	Diagnostic evaluation completed within the previous 36 months for initial determination. Then only when requested by SDS or doctors. Submit new documentation when its available.		

ICAP Assessment Information and Consent Form:

http://dhss.alaska.gov/dsds/Documents/SDSforms/IDD-03ICAP-Assessment%20Info-Consent.pdf

The ICAP is intended to provide an objective assessment of skills in the areas of development, learning, and self-sufficiency as compared to peers of the same age.

The ICAP involves an interview process, with three adult people (respondents) who know the applicant/recipient well. The Care Coordinator facilitates the ICAP Assessment by helping to identify the 3 respondents, and providing alternate respondents. One of the respondents can be a parent a or any adult living in the home, the others may be teachers, friends, staff, other family members, etc.

Refer to ***Guidelines for the ICAP Process*** on the approved forms page of the SDS website.

The Interim ICF IDD form for Level of Care: http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx

The purpose of the Interim form is to reconfirm diagnosis and level of need for support, either as a very young child, or in the years between the ICAP assessment. It is likely that people who have a diagnosis of developmental and intellectual disability will not experience sudden change in their condition which would greatly affect their needs for support throughout their lives. For this reason the Care Coordinator can collect information on the Interim Form.

For very young children under age 3, and those ages 8 and up, it serves as an informal assessment

document which is added to the document set that is reviewed by SDS to determine level of care for the IDD waiver. SDS reviews the document and other supporting documentation as part of a developmental review to determine Intermediate Care Facility level of care.

A Complete Initial IDD Waiver- Level of Care Determination Application Packet

Form #	Name
Uni - 05	Appointment for Care Coordination Services
Uni – 07	Recipient Rights and Responsibilities
HSS-06-5870	Release of Information- (CC to SDS)
IDD - 13	Qualifying Diagnosis Certification Form
IDD- 03	ICAP Assessment Information and Consent (age 3 and up)
OR	(Depending on age of person)
IDD- 10	Interim ICF/IID Level of Care Information (age birth to 3)
	Guardianship / POA's Documents
	Medical/Psychological Evals. w/ Cognitive & Adaptive testing (within the past 36months)

SDS staff will schedule an Assessment after receiving a **complete** Application (or renewal) packet.

The Qualifying Diagnosis Certification (QDC) form

http://dhss.alaska.gov/dsds/Documents/SDSforms/IDD-13QDCcertification.pdf

The person's diagnostic criteria are verified by their medical provider, and conveyed to SDS, using the QDC form. A current Qualifying Diagnosis Certification (QDC) form is required with the initial application packet for the IDD waiver, if the applicant/recipient is over 3 years of age. It is also required for renewal application packets. The individual's medical provider will fill out the form.

This form verifies diagnostic eligibility for the HCB Waiver, and supplies the Assurance that the person is provided a Level of Care evaluation on an annual basis (whether this comes from an ICAP assessment or a Demographic Form for Interim ICF/IID Level of Care). You will see that the form requires the medical provider to use an ICD-10 code to indicate diagnosis category (rather than just the diagnosis code itself). This is a requirement of CMS (Centers for Medicare and Medicaid Services) national Medical Coding Requirement. The Care Coordinator should review the codes entered here by the medical provider to ensure that they are ICD-10 codes and not mistakenly written procedure codes. You can learn about how to match an ICD-10 code to its diagnosis here:

http://patients.about.com/od/medicalcodes/a/findicdcode.htm

Care Coordinators do not fill out the Qualifying Diagnosis Certification (QDC) form- the medical provider does this.

ICD-10 codes- "ICD" stands for International Classification of Diseases. ICD 10 codes are the 10th generation of a worldwide coding system that was invented in the 1800's to help track diseases and causes of death worldwide. New sets of codes are made as medical research advances. Centers for Medicare and Medicaid Services (CMS) requires that states use ICD-10 codes as of October 1,2015 in Medicaid Waiver program documents due to the use of electronic health claims processing (billing) and electronic health records.

Send completed applications for annual IDD LOC determinations, including all supporting documents to: DSM address IDD Anchorage

The IDD Annual Assessment

The ICAP Assessment and ICF/IID Level of Care

After SDS receives a complete Level of Care Application, we schedule an ICAP interview with each of the identified respondents. Some children may have a current ICAP assessment on file, because they were receiving TEFRA Medicaid.

The SDS Assessment tool for ICF/IID Level of Care is the ICAP- Inventory for Client and Agency Planning

- The purpose is to identify adaptive and maladaptive behaviors, developmental strengths, the level of need for services, and other physical, health related or social concerns.
- An ICAP assessment is done once a year for children age 2 yrs 11 months to their 7th birthday.
- An ICAP is done every 3rd year for applicants over 7
- Completed by a SDS QIDP (Qualified Intellectual Disability Professional)
- The actual assessment is an interview process with 3 respondents who know the applicant well
- The Care Coordinator helps by identifying respondents to SDS using the form ***IDD-03 ICAP Assessment information and Consent***
    - Who is a good ICAP respondent?
        - An adult who knows the person well. One of the respondents can be a parent or any adult living in the home, the others may be teachers, friends, staff, other family members, etc
- The SDS ICAP Assessor will use the information on the form to travel to the respondents, make appointments with them, and interview them.
- The Care Coordinator should be ready to do more to help then just turn in the form-
    - You can help the family and individual know what to expect
    - You can help the family and individual identify alternate respondents for the ICAP if the first choice people are not able to do it.
    - You can help the person identify good ICAP respondents. The SDS Assessor will visit each person and ask him or her a series of questions. This is the ICAP interview. The questions are about how the individual functions in daily life, in different domains, such as physical abilities, social skills, and executive functioning.

Did you know?

You can visit http://icaptool.com to learn more about the ICAP. The Inventory for Client and Agency Planning (ICAP) is one of the most widely used adaptive behavior assessments in the United States.

After the interview is completed with all three respondents, SDS sends a letter of eligibility (or ineligibility) for the DD Waiver services.

If the person was found eligible for Waiver Services, the CC should create the POC and submit it to SDS within 60 days. (Initials ONLY)

Interim year Assessment

For applicants younger than 3 years of age, or on an interim year, the QIDP will conduct a developmental review and determine Level of Care from the documents provided.

Once Level of Care has been re-determined SDS will send a notice by DSM to the CC and by mail to the recipient. Make sure you keep this notice for a complete record set.

Remember whether it's an ICAP or Interim year, the person must need the same care that is provided to people who live in an intermediate care facility for individuals with intellectual/developmental disability (ICF/IID). By applying for the Waiver the person is requesting this care in their home/community.

> ICF/IID facilities provide coordinated specialized habilitative services. The person needs specific supports to be able to learn about and gain more independence in daily life. Habilitative services assist the recipient to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to live and socialize in the most integrated setting appropriate to the recipient's needs.

IDD LOC Reapplication

Renewal LOC Applications for ICF/ IID LOC are not necessarily on the same schedule as the Plan of Care start & end dates.

Refer to your CC monthly status report to calculate the reapplication date 90 days prior to the level of care expiration date.

7 AAC 130.213. Assessment and reassessment

(c) To request a reassessment of a recipient's continuing need for home and community-based waiver services, the recipient must submit a new application with current information in accordance with 7 AAC 130.207 not later than 90 days before the expiration of the period covered by the preceding level-of-care approval. A new application is required in order to continue to receive home and community-based services after the expiration of the previous period.

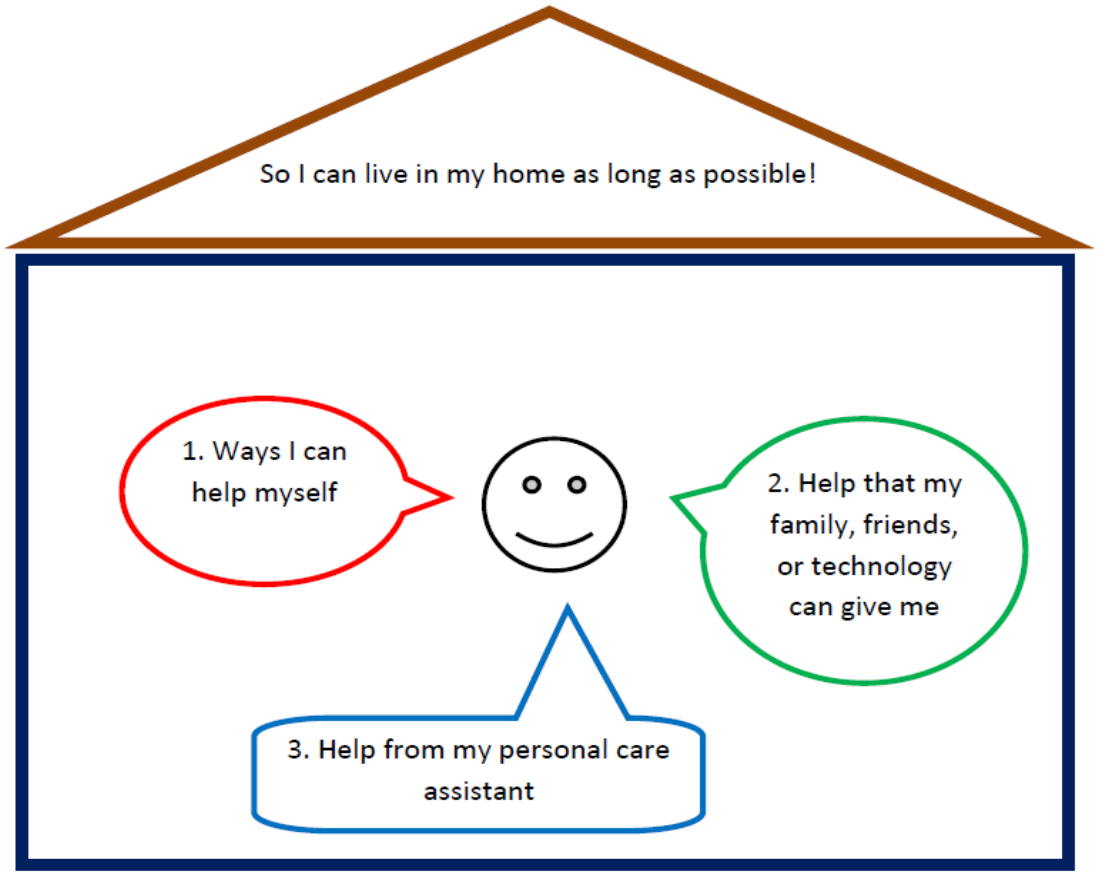
The LOC Reapplication will include:

- ☐ IDD-03 ICAP Assessment Information and Consent or IDD-10 Interim ICF IDD Level of Care
- ☐ IDD-13 Qualifying Diagnosis Certification Form
- ☐ HSS-06-5870 Release of Information
- ☐ Updated Legal, Medical and Diagnostic Information if available

Submit the Application (in one message) by DSM to: **IDD Anchorage**
or FAX to: 907-269-3639

Unit 6

Medicaid Personal Care Services
Eligibility for ALI, APDD & CCMC
    NFLOC: Nursing Facility Level of Care
Grant Funded Services
Creating an Application for ALI/ APDD Waiver
Creating an Application for the CCMC Waiver



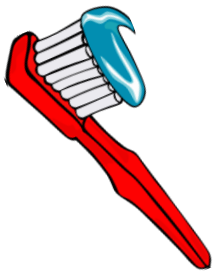
Personal Care Services (PCS) is a Medicaid service **but it is not a HCB Waiver service.**

In addition to receiving Medicaid, the person must need assistance (hands-on help) with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs), to remain at home. A person who needs hands on help at home must select a certified PCA agency to inquire about PCS.

PCS are available to people who have regular Medicaid, and who have medically necessary needs for hands-on help at home with activities of daily living and/or instrumental activities of daily living. People access PCS through a PCS agency, who requests an assessment for PCS. Senior and Disabilities Services Assessors visit people in their own homes to determine PCS needs, and create the individual service plan for PCS agency to implement.

Personal Care Services can include:

Activities of Daily Living such as:



- Body Mobility
- Assistance with Transferring
- Assistance with Locomotion
- Dressing
- Eating
- Toilet Use
- Personal Hygiene
- Hair
- Bathing

Instrumental Activities of Daily Living:

- Light Meal preparation or Main Meal Preparation
- Shopping
- Light Housework
- Laundry In-home
- Laundry-Out of home/Incontinence

People may choose to direct their own Personal Care Assistant (PCA) through Consumer Directed PCS or they may choose to have the PCA Agency direct/oversee the PCA about the how the services are rendered.

Prior to offering the Screening (for the HCB Waiver application) to the person, if it is clear that Personal Care Services are all that is needed, the CC may assist the person to choose a Personal Care Services agency. The CC may not choose to pursue waiver services after explaining all options to the applicant. According to SDS Service Principles, people should be independent in their own care as much and as long as possible.

The CC is under no obligation to act as Care Coordinator for an individual until signed documents obligate this.

Your client may have both the Waiver and PCS
Sometimes recipients receive services from both the Waiver and the PCS programs. In this case, the Care Coordinator needs to make sure that the services the person is applying for under each program do not duplicate each other. The PCS will also be listed in the Plan of Care, because the Plan of Care is an accurate picture of ALL supports the person accesses- not just Waiver supports.

Nursing Facility Level of Care

Nursing Facility Level of Care (NFLOC), is associated with the **ALI Waiver, the APDD waiver, and the CCMC waiver.**

Care is characterized by the person's need for skilled nursing or structured rehabilitation ordered by and under the direction of a physician.

The person will experience SIGNIFICANT LIMITATIONS in the following areas:
BED MOBILITY (turning and repositioning while in bed)
EATING (how the person eats or otherwise takes in nutrition)
LOCOMOTION (getting around within the home- room to room)
TRANSFER (getting from one surface to another- for example- bed to chair)
TOILETING (including how the person accomplishes personal hygiene)

There may also be significant limitations in the area of dressing- putting on clothing for the day or activity; cognition- how they understand the need to do something; behavioral health- if there are or are not behaviors that put the person or others at risk; however, these alone will not qualify for the waiver.

People will not qualify for waiver if they only need cueing, reminders, direction to do the tasks, or companionship/protective custody.

Measuring Self Performance:

- Independent - No help or oversight - or - Help/oversight provided occasionally.
- Supervision - Oversight, encouragement or cueing provided
- Supervision plus non-weight-bearing physical assistance provided occasionally
- Limited Assistance - Person highly involved in activity; received physical help in guided maneuvering of limbs, or other non-weight-bearing assistance
- Extensive Assistance - While person performed part of activity, Weight-bearing support is provided often
- Total Dependence - Full caregiver performance of activity
- Cueing - Spoken instruction or physical guidance which serves as a signal to do an activity

Nursing Facility Level of Care means that the individual would need to reside in a Nursing Facility, if there were no other services or people helping them. A person who chooses the Home and Community Based Waiver will not receive "all their care" from Waiver services. They will also get healthcare related services from their medical provider, many other community supports, and they will do some things for themselves.

It's important to understand that NFLOC consists of ***skilled nursing care and intermediate care.***
Skilled care means care that requires special training to do. The person doing the care has received licensed medical training and they are a nurse, doctor, or other licensed specialist. Intermediate care means some tasks that require professional licensed training and some that do not.

The HCBW offers services mostly done by UNSKILLED (not nurses) staff. Although there are some professional medical services offered in the Waiver, they are mostly considered the INTERMEDIATE level of NFLOC.

Admission to a Skilled Nursing Facility

A client may choose to enter a nursing facility instead of using the HCBW. Review the Long Term Care Nursing Facility Authorization form. The admitting facility usually completes this when someone would like to enter their facility. Use this link: http://dhss.alaska.gov/dsds/Documents/SDSforms/LTC-01%20LTC_FacilityAuthorization.pdf

A HCBW Care Coordinator does **NOT** fill out this form. The facility does this, regardless of the funding source the person is using to pay for the nursing facility care. It is a Federal requirement that ALL people in a nursing facility be given a choice of cares to remain in their home or community if it is safe to do so.

The HCB Waiver assumes and expects that clients will receive supports for their health, safety, welfare and wellbeing from a collection of resources, not just one way. (The client in the nursing home receives all medically necessary services from the nursing home). This is why the Plan of Care that you write will include all supports- medical, social, informal, and self-provided.

All authorized services in Medicaid are "medically necessary"- which is defined as "health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine." This is why all waivers require an assessment to determine the level of care. The assessment determines how the person functions within their disability, and what kind of help they could choose to remain in the home and community. "Functions" means how the person takes care of themselves doing regular things people do every day, and how they engage with the community and those around them.

The HCBW offers supports to help people live safely in their home and community. The client receives other services and supports from their medical provider, family, friends and other organizations. This creates the total spectrum of care.

A person directs his or her own plan and process. Home and Community Services must be person centered. This means that the person has chosen the service and how it will be meaningful for and benefit him.

I can get help from- home, family, friends, what I do to help myself, medical provider, nurse, case manager, care coordinator, supervisor, colleague, waiver staff, PCA worker, day care worker, volunteer, faith community, special interest group, clubs, associations, etc

Here is a table of Nursing Facility Level of Care, skilled services and intermediate services. We've added what Waiver service or PCA could provide, if any. This is for training- it is not an assessment tool.

IF THE PERSON NEEDS:	Is it ALWAYS DEFINED AS NFLOC?	Can a person get this service from a licensed MD, Nurse, ANP?	Can a nurse delegate to waiver staff or others?	Is this defined as ***Intermediate*** NFLOC?	Do HCBS Waiver (unskilled staff) provide this service?	What Waiver service(s) could do this if it is approved in their plan?	Could a PCA do this?
SKILLED CARE							
Patient assessment	Y	Y	N	-	N	SPDN, NOCM	N
Make nursing plan	Y	Y	N	-	N	SPDN, NOCM	N
Delegation of allowable tasks	Y	Y	Y	-	N	NOCM	N
Make treatment plan	Y	Y	N	-	N	SPDN, NOCM	N
Health education	Y	Y	N	-	N	SPDN, NOCM	N
Receive/Transmit Dr orders	Y	Y	N	-	N	SPDN, NOCM	N
IV therapy	Y	Y	N	-	N	SPDN	N
Sterile wound/decubitus care	Y	Y	N	-	N	SPDN	N
Home dialysis	Y	Y	N	-	N	SPDN	N
Oral tracheal suctioning	Y	Y	N	-	N	SPDN	N
Med mgmnt of unstable condition- need monitoring	Y	Y	N	-	N	SPDN	N
Place and administer nasogastric tubes	Y	Y	N	-	N	SPDN	N
Assess and manage new G tube placement/nutrition	Y	Y	N	-	N	SPDN/NOCM	N
Injectable meds	Y	Y	N	-	N	SPDN	N
Administer non-herbal nutritional supplement	Y	Y	N	-	N	SPDN	N
Any task that requires medical license to do	Y	Y	N	-	N	SPDN could do nursing	N
Medication administration- routine scheduled meds with predictable results and training for waiver staff. NOT INCLUDING INJECTIONS	Y	Y	Y	Y with delegation by Nurse	Y with delegation by Nurse	SPDN	Y with delegation by Nurse or CDPCA At home
24 hr observation and assessment	Y	Y	N	-	N	SPDN	N
Intensive rehab svcs ordered by physician (5 x/wk)	Y	Y	N	-	N	SPDN	N
24 hr direct svcs that a nurse is licensed to do, or direct supervision of a nurse	Y	Y	N	-	N	SPDN	N

	BEGINNING CARE COORDINATION						
IF THE PERSON NEEDS:	Is it ALWAYS DEFINED AS NFLOC?	Can a person get this service from a licensed MD, Nurse, ANP?	Can a nurse delegate to waiver staff or others?	Is this defined as ***Intermediate*** NFLOC?	Do HCBS Waiver (unskilled staff) provide this service?	What Waiver service(s) could do this if it is approved in their plan?	Could a PCA do this?
New colostomy/ileostomy care	Y	Y	N	-	N	SPDN	N
O2 Therapy when careful regulation or monitoring needed	Y	Y	N	-	N	SPDN	N
Gastrostomy care and feeding such as new G tube care/assess nutrition	Y	Y	N	-	N	SPDN	N
Tracheostomy- when 24 hr care needed	Y	Y	N	-	N	SPDN	N
Radiation/Chemo- when close observation for side effect needed	Y	Y	N	-	N	SPDN	N
Sterile dressing requiring prescription med	Y	Y	N	-	N	SPDN	N: ABPCA Y: CDPCA At home
Infected or complex decubitus care	Y	Y	N	-	N	SPDN	N
Uncontrolled diabetes care	Y	Y	N	-	N	SPDN	N
New CVA care until stable	Y	Y	N	-	N	SPDN	N
New hip fracture care	Y	Y	N	-	N	SPDN	Y, allowed tasks, daily care at home
New amputation care	Y	Y	N	-	N	SPDN	Y, allowed tasks, daily care at home
Comatose care	Y	Y	Y delegate-able tasks	-	N	SPDN	Y, Allowed tasks, daily care in home
Terminal cancer care	Y	Y	Y delegate-able tasks	-	N	SPDN	Y, Allowed tasks, daily care at home
New heart attack care	Y	Y	N	-	N	SPDN	N, generally not done at home
Uncompensated congestive heart failure care	Y	Y	N	-	N	SPDN	N, generally not done at home
New paraplegic care	Y	Y	N	-	N	SPDN	Y, allowed tasks, daily care at home
New quadriplegic care	Y	Y	N	-	N	SPDN	Y, allowed tasks, daily care at home

	BEGINNING CARE COORDINATION						
IF THE PERSON NEEDS:	Is it ALWAYS DEFINED AS NFLOC?	Can a person get this service from a licensed MD, Nurse, ANP?	Can a nurse delegate to waiver staff or others?	Is this defined as ***Intermediate*** NFLOC?	Do HCBS Waiver (unskilled staff) provide this service?	What Waiver service(s) could do this if it is approved in their plan?	Could a PCA do this?
Frequent lab diagnostics per med administration- anti-coagulants, arterial blood gas, blood sugar when unstable diabetic care	**Maybe (not for this only)**	Y	N	N	N	N, not for home/community setting- these are done in healthcare facilities	N- not done at home
Treatments- observation, eval and assistance for correct use/safety – oxygen hot packs, whirlpool, diathermy, etc) care	**Maybe (not for this only)**	Y	N	N	N	N, not for home/community setting- these are done in healthcare facilities	N
Behavioral problems Needing tx or observation by skilled professional- to the level of nursing home care	**Maybe (not for this only)**	Y	Y	N	N	N, not for home/community setting- these are done in healthcare facilities	N
INTERMEDIATE CARE: observation, assessment, and Tx for long term illness or disability when condition is relatively stable- maintain health rather than rehab. Can be for longer recovery period post surgery.	Definition. More tasks in this category can be done by waiver settings and staff.	Y	Y Treatment needed daily at home only, delegate-able tasks	Y	N	SPDN/NOCM	N
Observation and assess needed 24 hr by nurse	Y	Y	N	N	N	SPDN	N
Nurse needed for restorative care: re-teach ADLs	Y if Nurse needed	Y	N	N	N	SPDN	N
Prevent/slow contractures with positioning, devices, pillows, handrails, ROM exercises	Y if Nurse needed	Y	Y	Treatment needed daily at home only, delegate-able tasks	Treatment needed daily at home only, delegate-able tasks	Treatment needed daily at home only, RSL, Res Hab, with delegation	N: ABPCA Y: CDPCA with prescription
Ambulation/Gait training w/wo assistive device	Y if Nurse needed	Y	Y, Treatment needed daily at home only, delegate-able tasks	N	Treatment needed daily at home only, delegate-able tasks	Treatment needed daily at home only, RSL, Res Hab, with delegation	N: ABPCA Y: CDPCA with prescription

IF THE PERSON NEEDS:	Is it ALWAYS DEFINED AS NFLOC?	Can a person get this service from a licensed MD, Nurse, ANP?	Can a nurse delegate to waiver staff or others?	Is this defined as ***Intermediate*** NFLOC?	Do HCBS Waiver (unskilled staff) provide this service?	What Waiver service(s) could do this if it is approved in their plan?	Could a PCA do this?
Services required to be done by nurse	Y	Y	N	N	N	SPDN/NOCM	N
Medication that needs daily observation for effect or side effect	Y if Nurse needed	Y	Y, Treatment needed daily at home only, delegate-able tasks	N	Y, Treatment needed daily at home only, delegate-able tasks	SPDN/NOCM Needed daily only, with delegation all waiver svcs except CC, chore, transportation, meals, EMOD, usually not IAT	N
Assist with ADLs- bathe, eat, toilet, dressing, transfer/ambulation-maintenance of catheter, ostomy, special diets, skin care of those incontinent	Y if Nurse needed	Y	Y, some pieces of these tasks may require delegation but usually not	Y	Y	SPDN/NOCM Needed daily only, with delegation all waiver svcs except CC, chore, Transportation (except transfers) meals, EMOD, usually not IAT	Yes
Colostomy/Ileostomy maintenance, daily monitoring, intervention for elimination and skin health re elimination	Y if Nurse needed	Y	Y, some pieces of these tasks may require delegation but usually not	Y	Y	SPDN/NOCM Needed daily only, with delegation all waiver svcs except CC, chore, transportation, meals, EMOD. Usually not IAT	Y
Oxygen therapy for temp or intermittent	Y if Nurse needed	Y	Y	Y with delegation	Y, Treatment needed daily delegate-able tasks	SPDN/NOCM Needed daily only, with delegation all waiver svcs except CC, chore, transportation, meals, EMOD. Usually not IAT	Y, prescribed only

	BEGINNING CARE COORDINATION						
IF THE PERSON NEEDS:	Is it ALWAYS DEFINED AS NFLOC?	Can a person get this service from a licensed MD, Nurse, ANP?	Can a nurse delegate to waiver staff or others?	Is this defined as ***Intermediate*** NFLOC?	Do HCBS Waiver (unskilled staff) provide this service?	What Waiver service(s) could do this if it is approved in their plan?	Could a PCA do this?
Diabetes care- when nurse needed for daily observation of dietary intake and/or med administration to control diabetes	Y if Nurse needed	Y	Y, some pieces of these tasks may require delegation but usually not	N	Y with delegation	SPDN/NOCM Needed daily only, with delegation all waiver svcs except CC, chore, transportation, meals, EMOD. Usually not IAT	N, but can record i/o Can do med admin with CDPCA. NOT INJECTIONS
Behavioral such as wandering, verbal disrupt, combative, inappropriate- when it can be managed safely in a nursing facility	Y if Nurse needed	Y	Y	Y	Y	Y IAT, and all waiver svcs (to degree person is safe) except CC, chore, transportation, meals, EMOD.	N
TRANSPORTATION for MEDICAL PROCEDURES or APPOINTMENTS	NO	Y- Healthcare provider can schedule MEDICAID RIDE	Y, they could if nurse is healthcare provider	N	N	N	N
MEDICAL AIDE for Approved MEDICAL TRAVEL	NO	Y- Healthcare provider can arrange for MEDICAL AIDE	Y, they could if nurse is healthcare provider	N	Maybe but not Waiver reimbursed	None	Y but not PCA reimbursed reg Medicaid
Supervision	N	N		N	Y, approved hab svcs, and respite	Y, approved hab svcs and respite	N
Protective Custody	N	N		N	N	N	N
Routine med management	N	N		N	Y	Y	Y
Personal care services NOT A WAIVER SERVICE	N	N		N	Y- as approved in POC	RSL, Res Hab, Adult Day, Day Hab, In Home hab supports, Supp Emp Services provides this	Y

Conclusions-

- **The HCBW offers a choice to receive services that are NFLOC in home/community. Waiver is for ongoing predictable medically necessary home/community care.**
- **Waiver is not for crisis/emergency/healthcare requiring clinical judgement, medical license to perform, or not approved in regulation/individual plan of care.**
- **NFLOC consists of SKILLED CARE and INTERMEDIATE CARE.**
- **Not ALL NFLOC care tasks can be done by unlicensed personnel providing waiver services.**
- **The individual choosing the Waiver receives TOTAL CARE in his/her community by accessing a combination of resources: Waiver supports, community and family supports, their medical (healthcare) provider, and hands on nursing care either as SPDN, NOCM in some cases, or Regular Medicaid (health care provider).**
- **The individual choosing Nursing Home receives TOTAL CARE in the Nursing Home and from medical (healthcare provider).**
- **PCS does not require Nursing Facility Level of Care. The person needs hands on help at home with ADLs and IADLs.**

RESOURCES used:
http://commerce.state.ak.us/dnn/Portals/5/pub/NursingStatutes.pdf (Alaska nursing regulation and statute)
http://www.cdc.gov/nchs/data/nsltcp/long_term_care_services_2013.pdf (definition of long term care in the home and community)
http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol2/pdf/CFR-2010-title42-vol2-sec409-33.pdf (CFR, nursing facility level of care)
7 AAC 130 Home and Community Based Waiver Services, NFLCO and ICF/IID Level of Care (Waiver regulations)
7 AAC 125.010-199 Personal Care Services (PCS Regulations)

Once the complete application is received an SDS Assessor is scheduled to visit the person in his or her residence, to determine needs for support. The Assessor wants to know what the person can do to help him or herself with activities of daily living, within the last 7 days, and, what kinds of help the person needs for these activities.

The CAT (Consumer Assessment Tool) is the NFLOC assessment tool
The CAT involves a detailed functional assessment and observation of the person, an interview with the person, and consideration of supporting documentation. The Nurse Assessor enters information on each section of the CAT which creates a numerical score for the different areas of functional skills and observations.
There is a separate CAT for children, which is used for the CCMC waiver.

SERVICES THROUGH GRANT FUNDED AGENCIES

The Division of Senior and Disabilities Services provides grants to nonprofit, municipality or tribal organizational partners across Alaska. These partners use the funds to provide vital community based supportive services to families and individuals experiencing Developmental Disabilities (DD), Alzheimer's Disease and related Disorders (ADRD), family caregivers of seniors aged 60 and over, grandparents raising grandchildren aged 55 or over, seniors aged 60 and over, and/or frail or disable seniors who need assistance in the home. These grants are awarded to agencies every three or four years through a competitive process. Funding for these programs comes from the U.S. Administration on Aging, the Alaska Mental Health Trust Authority, and state general funds.

These services are also available to individuals who are waiting or do not qualify for Home and Community Based services under the Medicaid Waiver program, or who only require minimal supports that can be provided by the grant services.

Elder grant funded services

Home and Community Based Senior Grants assist agencies to provide services to physically frail individuals 60 years of age and over, individuals of any age with Alzheimer's Disease or Related Disorders (ADRD) and caregivers to assist these Alaskans to maintain as much independence as possible and improve their quality at home or in a community-based setting. HCB Senior Grants include the following programs:

Adult Day Services:
Day care services at a center for adults with impairments, primarily, Alzheimer's Disease or Related Disorders, provided in a protective group setting that is facility-based. Therapeutic and social activities are designed to meet and promote the client's level of functioning through individual plans of care. Adult Day services provide support, respite and education for families and other caregivers, provide opportunities for social interaction and serve as an integral part of the aging network.

Senior In-Home Services:
Services that provide a flexible menu of in-home services designed to meet the individual's and family's needs. Services include care coordination, chore, respite, extended respite and supplemental services.

National Family Caregiver Support Program Services:
Services provided to the caregiver of anyone 60 and over or grandparents who are 55 and over raising grandchildren. Services include information and assistance accessing services, respite, caregiver support groups, caregiver training and supplemental services.

ADRD Education and Support:
A statewide grant program providing outreach, information and referral, education, consultation and support provided to individuals with ADRD (Alzheimer's disease and related disorders), their family caregivers, professionals in the field and the general public about ADRD. A goal of the program is to raise awareness of ADRD and the issues faced by families and communities.

ADRD Mini-Grants:
Grants available on a statewide basis to Alaskans diagnosed with ADRD [Alzheimer's disease and related disorders: including Parkinson's Dementia, Multi-infarct Dementia (stroke related), Pick's Disease, Lewy Body Dementia, Huntington's Disease or Creutzfeldt-Jakob Disease.] The maximum benefit per individual per year is $2,500 and pays for supplies or services that are not covered by other sources.

Nutrition, Transportation, and Support Services Grants:
Nutrition, Transportation, and Support Services Grants fund non-profit agencies to provide meals (in groups and in private homes) and nutrition and health education information to seniors. Grantees provide transportation services that enable seniors to maintain mobility and independence. Supports programs that promote active and involved lifestyles as we age.

Senior Residential Services:
Senior and Disabilities Services receive funds from the Alaska State Legislature to support Senior Residential Services (SRS). The SRS grant provides essential funds to rural-remote providers to operate and sustain supported residential living services to frail Elders. The intent of the SRS program is to provide support in a residential setting so Elders can remain in their communities of choice as they age; recognizing the importance of community, family and culture for one's well-being while avoiding the need to leave their families, culture and familiar surroundings for institutionalization in larger urban settings. Residents receive individual support in a residential setting which includes assistance with Activities of Daily Living, Instrumental Activities of Daily Living, in addition to social and cultural activities.

Nursing Home and Nursing Home transitional services

For people experiencing intellectual/developmental disability who are living in a Nursing Home: OBRA Services are Individual Assistance Plans specifically for the specialized services provided to individuals who live in nursing facilities and who experience a developmental disability. The Omnibus Reconciliation Act of 1987 required states to eliminate inappropriate nursing home placement for persons with Developmental Disabilities. For those recipients who choose to remain in Nursing Homes, the specific services requested are the development and implementation of habilitation plans, case management and individualized services.

For people who wish to transition from living in a Nursing Home to living in the community:
The funds from the Nursing Facility Transition Program can be used to help an elderly person or individual with a disability transition from a nursing facility back into the community. We can provide one-time funds for:

- Home or environmental modifications;
- Travel/room/board to bring caregivers in from a rural community to receive training;
- Trial trips to home or an assisted living home;
- Payment for an appropriate worker for skill level needed;
- Security deposits;
- One-time initial cleaning of home;
- Basic furnishings necessary to set up a livable home;
- Transportation to the new home.
- Other needed items or services may be approved by Program Coordinators.

An eligible person is one who qualifies both medically and financially for the Medicaid Home and Community Based Services Waiver (HCBS) program. The grant is used *only* for one-time costs associated with the transition; thereafter, the Medicaid program will pay for all services when the HCBS waiver is approved.

Who Qualifies?

- Age 65 or older
- Age 21-65 with physical disability
- Wants to be transitioned to community care
- Services/supports available and in place for client to live in community
- Have, or anticipated to have, Medicaid Waiver eligibility within 6 months.

Applying for the ALI Waiver

The ALI Waiver is available to persons age 22 and over. Once an individual asks for a consultation regarding possible waiver needs and eligibility, the Care Coordinator makes an appointment to meet with them in their usual place of residence as soon as possible.

Care Coordinators (CCs) do not do the formal level of care assessment; however it is important that in the pre-assessment visit (screening) the CC determines that real needs exist. (CCs are required to have educational and experiential background to support the ability to informally assess treatment and care needs, as found in the Care Coordinator certification process.)

Screening

Per 7 AAC 130.211 Screening for the ALI or APDD waiver can occur once every 365 days. If an applicant meets Nursing Facility Level of Care, they will not be screened again. If the applicant does not meet Nursing Facility Level of Care, he or she will not be screened again for 365 days, unless a documented material change in condition occurs sooner.

Care Coordinators are reimbursed for the screening of the initial ALI or APDD recipient only.

When to complete a Screening (initial application)

- What are the initial issues and background of the individual?
- What's the current situation?
- What strengths would be useful in resolving the issue or need?
- What does the person state they need to make their life more stable?
- Who helps them now?
- Your observations about their cognitive functions
- Would they need to live in a Nursing Facility if they had no other supports?

A request for an additional screening prior to 365 days MUST be accompanied by medical and functional documentation clearly showing a material change in condition. This documentation must show that SDS would likely make a different decision about Level of Care.

Requesting an expedited assessment

The Care Coordinator completes Uni-12 Request for Expedited Consideration and submits with the application. Here is a list of qualifying circumstances which are evaluated for an expedited assessment. An expedited assessment means completing an assessment and NFLOC determination within 10 days.

- diagnosis of a terminal illness, with a life expectancy less than 6 months
- imminent or recent discharge from an acute care facility within 7 days
- unplanned absence of a primary unpaid caregiver due to an emergency
- declining health of a primary unpaid caregiver making them unable to provide the care
- death of the primary caregiver within the previous 30 or fewer days prior to the date of application
- referral from Adult Protective Service or the Office of Children's Services

ALI/APDD Application packet

Complete and assemble the application packet. Prior to submitting this packet all documents should be complete including signatures of the individual and/or legal representative.

Uni - 05	Appointment For Care Coordination Services
Uni - 04	Waiver Application for ALI/APDD/CCMC
Uni - 07	Recipient Rights and Responsibilities
HSS-06-5870	Release of Information forms
ALI/APDD - 04	Verification of Diagnosis
	Guardianship / POA's Documents
	Medical and Functional Documentation

The application packet will be processed by SDS staff. It's important to have accurate and COMPLETE information such as correct address and contact information, if an Assessment visit is to be scheduled.

7 AAC 130.207 (b)

> No later than 14 business days after the date the application is received, SDS will send the Care Coordinator and the applicant notice of any missing information or documentation to make the application complete. Unless the missing information is received no later than 15 days after notice of the incomplete application, SDS will deny the application.

The Verification of Diagnosis form

The Verification of Diagnosis form is intended to convey information from the medical provider to SDS about the person's medical conditions that form the need for long term care. The person's medical conditions are verified by their medical provider, and conveyed to SDS, using the VOD form. This form is required at both initial application and renewal. This is because medical conditions can change- they may improve or decline. You can obtain a copy of the Verification of Diagnosis form on the SDS website: http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx Please use the most updated form.

***Please note- Care Coordinators do not fill out the Verification of Diagnosis form- the medical provider does this.

Applying for the APDD Waiver
(Adults with Physical and Developmental Disabilities)

If a person is age 21 or over, and experiences a physical disability and an intellectual/developmental disability, he or she **will need to follow the process in the previous section to apply for eligibility for DD services**. The person must be listed on Alaska's DD registry. This individual may apply for the Adults with Physical and Developmental Disabilities waiver (APDD), and upon determination of Nursing Facility Level of Care, access both the habilitative and non-habilitative services offered through the Home and Community Based Waiver. The person will receive an initial and annual assessment to reconfirm NFLOC, with an SDS Assessor.

If you are working with a young person on the CCMC waiver (age 18-22) and he or she intends to apply for the APDD waiver (age 21 and over), you will need to make sure that the young person applies or has applied for DD eligibility through the DD registry. The CC can refer the person to the STAR coordinator. (See DD eligibility section). If the person does not experience an intellectual or developmental disability, he or she may apply for the ALI Waiver. Start the application process at least 6 months before the last day of the recipient's 22nd year.

Send completed applications for annual NFLOC determinations, including all supporting documents to DSM address: NFLOC-initial-application or NFLOC-Reapplication

SDS NFLOC Assessment

When the complete LOC Application is received by SDS we will schedule an Assessment within 30 days (within 10 days for a valid expedited assessment) A scheduler from SDS will contact the person and/or legal representative and arrange for the assessment appointment. This should be at the person's home or Assisted Living Home. An SDS Assessor will visit the person to determine if he/she meets Nursing Facility Level of Care (NFLOC); *meaning the person would need to be in a nursing facility right now if there were no other community care options available to him/her.*

The Assessment consists of an interview with the person, a review of health care needs, and a functional assessment of his/her ability to physically perform specific tasks requested by the assessor. The Assessor wants to know what the person can do for him/herself and what kinds of hands on help have been needed within the last 7 days.

Prepare for the Assessment

- Tell your recipient what to expect
- Encourage the family to limit attendance
- Have copies of documentation available for the assessor
- Let the assessor know that you will have comments after the interview is concluded
- Makes notes during the assessment to discuss with the assessor after they are done
- Hold your comments during the assessment, unless a question is directed to you

The Assessor uses the Consumer Assessment Tool (CAT) to determine LOC. A Care Coordinator can help the person with the Assessment appointment and can attend the Assessment at the request of the applicant and/or legal representative.

Reminders:

- Assessments are scheduled within 30 business days once a **complete** application has been received
  - With all additional forms attached
- Assessments generally take anywhere from 45 minutes to 2 hours
- Attendance by providers is not mandatory, but is helpful
- SDS is charged a cancellation fee ($160) if an interpreter is cancelled with less than 48 hours' notice
- Assessors have a 3 day submission timeline unless on travel status, computer failure or some other unplanned event

TIP: When a Care Coordinator receives notice of an assessment being scheduled, CHECK THE ADDRESS on the notice! If the address is not where the recipient is currently residing, immediately notify the Scheduler at SDS.

If the person is found to meet Nursing Facility Level of Care (NFLOC), the applicant and the Care Coordinator will receive a notice (letter) of Level of Care Determination and a copy of the CAT from SDS. If SDS finds that the applicant does not meet Nursing Facility Level of Care at initial assessment, SDS will send the person a letter indicating the denial.

Applying for the CCMC Waiver
(Children with Complex Medical Conditions)

The application for CCMC does not start with the Care Coordinator

The CCMC Waiver serves children and young adults under the age of 22 years, who require a level of care ordinarily provided in a nursing facility. Recipients need to have Medicaid as determined through DPA, and meet Nursing Facility Level of Care as determined through the Assessment with SDS.

Young people who receive the CCMC waiver experience medical fragility and are often dependent on frequent lifesaving treatments or interventions, or are dependent on medical technology for everyday living.

Initial screening is done only by a Nursing Oversight & Care Management (NOCM) nurse, who fills out the screening form and gathers supporting documentation for complete application packet. The NOCM Nurse has been specially trained by SDS to complete this process.

Contact the NFLOC Unit Supervisor at 907-269-3666 to arrange this training if you are an RN.

Care Coordinators should refer CCMC applicants to a NOCM Nurse if they have not already connected with one: http://dhss.alaska.gov/dsds/Documents/docs/dd_nursing_oversight_agencies.pdf

Initial CCMC Application

1. The NOCM agency Nurse completes CCMC Screening packet
2. SDS Nurse Assessor then makes the NFLOC determination.
3. The individual/guardian will receive a notice of LOC determination and a postcard with resources to formally choose ongoing nursing oversight and/ or separate Care Coordination. The post card must be returned to SDS.

The Care Coordinator develops and submits an initial Plan of Care within 60 days of the date that the person was determined to meet Nursing Facility Level of Care, per regulation **7 AAC 130.217 Plan of Care Development and Amendment**

UNIT 7

- Table of HCBW Services
- Special Service Considerations
  - Residential Services
  - Transportation
  - When the Plan of Care includes PCA
  - Environmental Modifications
  - Specialized Medical Equipment
  - Nursing Oversight & Care Management
  - Supported Employment
  - Acuity Rates

Service Definitions, Regulations, and Basic Exclusions

These definitions are offered for training purposes, to help increase understanding of the service, the use and intent of the service, best practices and basic exclusions. **Always consult regulation for the regulatory definition of each service.** All services requested in a Plan of Care are subject to approval of Senior and Disabilities Services.

Habilitative and Non Habilitative- Definitions

Non Habilitative Services: Outcomes based service. Service plans states personal goal. Not accompanied by measurable goals and objectives.

Habilitative Services: For the purpose of acquiring, building, maintaining or developing a skill of self-help, socialization, or adaptation. Accompanied by measurable goals and objectives.

Service Non- Habilitative Habilitative	Definition	Regulation	Service-related Exclusion(s)	Unit size Max. Allowed
Care Coordination	Care Coordinators assist individuals who are eligible to receive waiver services or who already do, in gaining access to needed waiver and other state plan services, as well as needed medical, social, and other services, regardless of the funding source for the services to which access is gained. Care Coordinators may also assist people to access grant funded services.	**7 AAC 130.240 Care coordination services**	CC cannot provide other reimbursed Medicaid services to individuals on their caseload.	12-Monthly 1-Annual POC
Adult Day Services	Meaningful daily activities provided in a protective setting outside the home.	**7 AAC 130.250 Adult day services**	PCA during Adult Day Service time	1st unit is 1-4 hours After 4 hours, 15 min unit up to 6 hrs. total 10 hours per day max reimbursed.
Residential Supported Living (Licensed ALH)	24 hour support in a licensed assisted living home (residential setting).	**7 AAC 130.255 Residential supported-living services**	PCA, Chore, Respite, and home delivered meals. Waiver does not pay room and board.	Daily unit
Transportation	A ride to community services and resources by a transportation provider. Vehicle owned/leased by transportation provider or employee/volunteer if approved due to no other resources in that community	**7 AAC 130.290. Transportation services**	Not medical transportation. Do NOT request transportation for access to doctors appts., therapies or regular medical procedures Not allowed for errands when participant is not in vehicle.	One way trip segments. Intermittent stops are not additional trips. Make a separate request for longer distance >20 miles.

Escort	An individual who accompanies and assists the recipient during transportation.	**7 AAC 130.290. Transportation services**	The escort person rides along with recipient to ensure his/her health and safety. The Escort is not an employee of the transportation company.	During trip segments if necessary to help with mobility needs. *Reimbursement is paid to the Transport provider for the 2nd person
Home Delivered Meal	Meal delivered to a Recipient at home. Written directions must be given if no one there to receive the meal.	**7 AAC 130.295. Meals services**	Not available during 24 hour out of home residential services: residential supported living, group home, family habilitation.	One meal Not to exceed 2 meals per day.
Congregate Meal	Meal provided in an approved setting with a gathering of people such as an adult day center which is also a meals provider.	**7 AAC 130.295. Meals services**	Not to duplicate or replace what other services must provide. May conflict with PCA meal prep or chore food prep	One meal Not to exceed 2 meals per day
Chore	Regular cleaning of the residence in areas used by the person. Shopping and light meal prep. Heavy household chores. Snow removal for safe access and egress to residence. Chopping wood and hauling water, disposing of human waste. Must describe exactly what chores are to be done for the person when requesting.	**7 AAC 130.245. Chore services**	Not available with 24 hour out of home residential service. 10 hr week max. 5 hr for APDD, CCMC or IDD unless documented respiratory issues, then 10 hr/wk available. If more than one person with Chore in same residence, requests are reviewed for duplication of Chore. May limit Chore hrs authorized. Not available with PCA IADLs. Can't replace what unpaid person can do to assist, or what is done by landlord/property management. Paid provider of chore cannot live in the same residence as the recipient.	15 minutes

Respite **Out of home daily respite** **In-Home daily respite** **Hourly respite**	Caregiver to give the primary unpaid caregiver a break. 24 hour respite in a licensed assisted living home. 24 hour respite in the person's own home. Respite hours, generally less than 12 hours in one day. Hourly respite can be in the community or in the respite provider's home, or the client's home.	**7 AAC 130.280. Respite care services**	Not available when person is using 24 hour out of home residential care. Not available with Residential supported living or group home. Available for family habilitation. Family habilitation may not provide paid care for another individual at the same time as respite. Not to allow an unpaid provider to work. **MUST identify the primary caregiver and tasks in the POC!**	Hourly: 15 minutes Daily: 1 day 14 full days per year (12+ hours) 520 hours per POC year
Family Directed Respite	Caregiver to give the primary unpaid caregiver a break. Family refers staff to enrolled agency who is employer of record. Family directs staff through employer agency. **MUST identify the primary caregiver and tasks in the service request!**	**7 AAC 130.280. Respite care services**	Not available for family habilitation. Unpaid caregivers may not provide family directed respite to other recipients of family directed respite. Not out-of-home respite.	Hourly: 15 minutes Daily: 1 day
Specialized Private Duty Nursing	Nursing service provided by a licensed nurse. Can be time limited or ongoing to meet a specific medical need (postsurgical dressing changes, IV medication administration, etc.) Must be specific care for an individual, included in the Plan of Care. Requires direct hands-on skilled nursing needs and prescribed by attending physician.	**7 AAC 130.285. Specialized private-duty nursing services**	If IDD, must be 21 yrs +. Cannot replace home health or other regular Medicaid health services. Must provide the Doctors directions for SPDN as supportive documentation	15 minute
Environmental Modifications	Physical adaptations to a person's home. Done by an enrolled builder/contractor.	**7 AAC 130.300. Environmental modification services**	Not available in licensed assisted living homes. Cost limits and procedure apply. Available for family habilitation homes.	As approved

Specialized Medical Equipment and supplies	"SME": Medically necessary equipment to help a person control, interact with or perceive their daily environment, and/or provide assistance with activities of daily living. Limited repairs to pre-existing items. Allowable Items are found on the SME list.	**7 AAC 130.305. Specialized medical equipment and supplies**	From SME equipment list. Cannot duplicate durable medical equipment or other items available through regular Medicaid. Need must be documented in writing by professional per regulation. See section on SME.	As approved, from SME schedule Can include repairs. Can include shipping costs.
Nursing Oversight and Care Management	Evaluation of a person's care needs and training needs by a registered nurse. Creating and implementing the required nursing oversight plan.	**7 AAC 130.235. Nursing oversight**	Required for CCMC. See CCMC section. Available to IDD- must meet health requirements of CCMC. Local and Non-local categories.	15 minutes

Day Habilitation	Meaningful activities for community skill exploration, skill building or maintenance. Commonly associated but not limited to social skill building. Provided in a non-residential community setting.*** Includes transportation time to and from activity. Accompanied with goals and objectives for day habilitation service. ***May be provided in a residential setting upon approval of SDS- for areas without other types of community gathering spaces	**7 AAC 130.260. Day habilitation services**	Age 3 and up only. Limitations depending on combinations of service, for example hours of supported employment, day hab, and group home on the same day. The services the person receives must not duplicate or replace each other on a daily schedule of services. Includes transportation to and from the day hab activity/site but is not considered solely "transportation". **Transportation not billed separately.** Family or other caregiver may opt to provide transportation as a choice documented in the POC. More than 15 hrs/week not available with group home unless approved by SDS	15 minutes Available in 2 forms: GROUP day hab- 2 or more served as a group. INDIVIDUAL: 1:1 support. Use separate service blocks to request group vs. individual explain how goals & objectives will be worked on in each environment

Supported Living	Supporting a person who lives in his/her own home- not assisted living- not family habilitation- not a licensed setting- with implementing goals and objectives related to activities of daily living.	**7 AAC 130.265. Residential habilitation services**	18 yrs and older. Requested Chore, home delivered meals, PCA and transportation must not duplicate.	15 minutes 1:1 service Limited to 18 hrs per day, from all providers combined, subject to approval of SDS.
In Home Supports	Supporting a person under the age of 18 who lives in his/her own home with an unpaid caregiver; implementing goals and objectives related to activities of daily living. Must be provided 1:1	**7 AAC 130.265. Residential habilitation services**	Individuals under 18 yrs PCA, Chore, Transportation, Meals or services provided by another resident of the home are not allowed.	15 minutes 1:1 service Limited to 18 hrs per day, from all providers combined, subject to approval of SDS.
Group Home (licensed ALH)	24 hour year round residential service in a licensed assisted living home. Accompanied with goals and objectives for residential service.	**7 AAC 130.265. Residential habilitation services**	PCA not allowed. PERS not allowed. Other SME may be allowed. Transportation, chore, respite, home delivered meals, and services provided by another group home resident not reimbursed.	1 day
Family Habilitation (licensed ALH that has oversight from an SDS Certified Agency)	24 hour residential care in a licensed home with a paid primary caregiver not a member of person's immediate family. Family setting has been determined to be most therapeutic for the person. Available to children and adults. Accompanied with goals and objectives for *Regarding numbers of individuals served in family habilitation homes, the home must be appropriately licensed and able to provide high quality care and ensure health and safety of all who need care in the home regardless of being a waiver recipient or not.*	**7 AAC 130.265. Residential habilitation services**	Chore, PCA, home delivered Meals, transportation not allowed on family hab. home days. Services done by another resident of the family hab home are not reimbursable. EMODS are allowed in a family habilitation home. PCA upon approval allowed for child with OCS placement. Home must be licensed. Family habilitation home must work through an enrolled certified family habilitation provider. The CC must report to SDS when the recipient moves or primary provider changes.	1 day unit. Possible to request family hab days needed- does not have to be requested as a full year of care. Family hab. home is limited to serving: **3 children with CCMC, adults with physical & developmental disabilities, or individuals with ID/DD** (unless there are additional siblings and residential placement together is determined to be the best option.) To serve more than three, provider must receive SDS Director approval.

Acuity Rate Request (separate service request)	For group home or residential supported living home only	**7 AAC 130.267**	Please see regulation for requirements	1 day
Intensive Active Treatment	Professional provision or supervision of a time-limited intervention or service that addresses a personal, social, behavioral, mental or substance abuse disorder. Professional develops and implements intervention plan.	**7 AAC 130.275. Intensive active treatment services**	Treatment or therapy and plan created by a licensed professional: AS 08. Not for routine or ongoing behavioral challenges or solely for training staff. Local and non-local categories.	15 minutes
Supported Employment	Long term support to help a person at a worksite. Support is: adaptation, supervision, and training that the person requires due to disability- intensive ongoing support to perform in a work setting. Accompanied with goals and objectives for supported employment service. Must be provided by enrolled certified Supported Employment provider, in a setting that also employs people who do not experience disability. Can support a person to be self-employed.	**7 AAC 130.270. Supported-employment services**	Not to supplant or replace service available through Division of Vocational Rehabilitation. Evaluated for age appropriateness. Cannot replace services done by educational service (school). If used by someone age 18 - 22 accompany request with reasons why education is not providing this service. Is not workplace accommodation routinely provided to employees by the employer, or routine supervision of an employee. SUPPORTED EMPLOYMENT is available ongoing to provide assistance on the job in order to maintain employment. PRE-EMPLOYMENT or JOB PREPARATION is available for building skills toward employment, for ONE 3 month time period total during the whole time the individual has the waiver.	15 minutes These services may be provided as a group: 2 recipients or more are served as a group. Or as 1:1 Supported Employment.

Requesting Services during temporary absence

Per 7 AAC 130.231 it may be necessary to request Waiver services for a recipient who is temporarily absent from their home community but are within Alaska or the United States.

Waiver services during temporary absences are limited to the following: **day habilitation, hourly respite, supported living, and in-home supports,** as approved in the Plan of Care or Amendment.

Adult Day is available in all certified locations in Alaska. There are no certified locations out of the state.

An absence is defined as at least 24 hours but not longer than 30 days. All services during temporary absences need to be requested and approved Follow the process found in the policy:
http://dhss.alaska.gov/dsds/Documents/policies/HCCBwaiver-services-temp-absences.pdf

Please note there are no 24 hour services reimbursed while the client is absent from their community. For example, it is not possible to bill 24 hr (daily) respite, group home, family habilitation, or residential supported living while the client is on vacation or camping.

Medicaid funding does not pay for services outside the United States

Special service considerations

Residential Services

Transportation

When the Plan of Care includes PCA

Environmental Modifications

Specialized Medical Equipment

Nursing Oversight and Care Management

Supported Employment

Acuity Rates

Residential Services

When working to assist people who are looking for residential services (meaning outside their own home) there can be many challenges. You may be working in a community that does not have many resources for licensed and certified assisted living homes. It may be difficult to quickly find a good fit for your client. You may find a home that is a good match but there may be other unanticipated barriers to the home being able to serve your client. You can find out more about these potential situations by visiting, asking questions and following up with the home and your client.

Here are some tips from experienced Care Coordinators:

1) Call homes and agencies to inquire about openings and what may be a good match.

2) Ask your client what he or she envisions for a home. Visit a few homes if possible. If the person has a guardian- the guardian is responsible for "placing" the person in the home assist the guardian to know what choices are available. Work with the guardian and waiver recipient together- if possible arrange for the guardian to see the home.

3) When you find a possible home, ensure that the home is licensed to serve your client. For example, for an adult with physical disability, or an elder, the home would need to have a current valid license to serve people from these populations.

4) Meet with the administrator and his or her designee, and talk about the home and what it offers.
    a. Ask about the charges for room and board.
    b. Ask to see the resident's rights document, ask about staffing patterns and how individual goals are addressed in the home.
    c. Are there training plans for staff in the home?
    d. Is there a nurse who interacts with the residents?
    e. Ask to see a sample residential agreement.
    f. What is the emergency evacuation procedure for the home?
    g. How does the home implement any necessary safety plans for people?
    h. Think about the needs of your client and what you learn about the home's capacity to serve.

5) Visit the home with your client and see if you can meet some of the staff and perhaps others who live in the home. Always respect confidentiality and get a release of information form. Talk with your client again about his or her choice for homes after doing your research.

Make sure you know about residential exclusions for example the number of people (adults or children) who can be served in a family habilitation home.

- Become familiar with Assisted Living Regulations

- Become familiar with Nursing regulations as they pertain to care tasks that can and cannot be delegated to staff in the Assisted Living Home. http://commerce.alaska.gov/occ/pub/NursingStatutes.pdf

Delegation by a nurse means that the medically necessary task (remember that the people we serve through Waivers have been determined to meet nursing facility or intermediate care facility level of care) is done by an unlicensed staff who has been trained by a nurse in care methods specific to that person. Some tasks are considered delegate- able and do not require specialized training, such as assistance with activities of daily living (ADLs).
ADLs are things that the person does, or needs help with most days, carry minimal risk to the person and can be done by a person who does not have nursing skills training.

Delegation training does not refer to generic caregiver training

Responsibilities of the nurse who is delegating:

- Assessing the person and the staff to determine if delegation is appropriate.
- Provides and documents all necessary person-specific training.
- Finding the staff to be trained is competent to do the care.

Here is a summary table of care tasks in the Assisted Living Home that may be delegated, may be delegated with person-specific training by a nurse, and cannot be delegated.

Also see Nursing Regulations 12 AAC 44.950.

Allowed to delegate, may include person-specific training	Delegate with person-specific training only, done by the Nurse	Not delegate-able
All tasks below- Not requiring complex nursing skills Standard procedures with predictable results Minimal risk to the person	Nurse makes a delegation plan Duties require more training but not professional nursing education	Injections
Bathing, Oral hygiene, toileting	Placing leads and electrodes for electrocardiogram, monitoring	Clipping fingernails and toenails when people have diabetes or circulatory issues
Assistance with eating, hydration	Adding fluid to established G tube or changing feeding bags	Administration of a non-herbal nutritional supplement
Skin care	Removing internal or external catheters	Assessment and management of nasogastric tubes
Personal Care tasks	Caring for an established Tracheostomy	Medication management for unstable conditions
Measuring and recording fluid/food intake and output	Changing simple nonsterile dressing- NO wound packing or debridement	Oral tracheal suction
Non invasive collection of physical specimens	Assisting people with self medication	Assessment of the person, making a health plan
Transporting people	Obtaining blood glucose levels	Evaluating responses to treatment
Taking and recording vital signs	Suctioning of oral pharynx	Health education and counseling
Monitoring bodily functions	Administration of medication MAY be delegated:	Receiving or transmitting orders from a health care provider
	Only to the HCBW provider or residential supported living provider	Intravenous therapy of any kind
	Staff must accomplish training course in med administration- training by a nurse. See Board of Nursing website.	Sterile wound care, decubitus (bedsore) ulcer care
	Non-controlled PRNs MAY be delegated.	Home dialysis
	Routine medication (NOT INJECTIONS) when written instructions are given for the specific medication	
	Staff is taught the brand name, generic name, directions for storage and administration	
	Staff is trained dosage amount, correct measurement, timing of administration, recording, expected outcome and any contraindications	
	Staff is trained how to observe and report side effects, complications, errors, missed dosages, or unexpected outcomes and how to respond. A procedure is in place to report to delegating nurse if medications are changed	

Guidance for Use of Waiver Transportation Services

The following guidance is offered to assist care coordinators include and support these trip units in a recipient plan of care. Transportation consists of one way trips into the community. Trip segments may be requested, which means travel to a location where the recipient disembarks for an approved purpose. Incidental stops are intervals of 15 min or less during which the recipient may or may not leave the vehicle and the vehicle operator waits for the recipient or runs an errand for the recipient while the recipient waits in the vehicle. Transportation is not any ride in which the recipient is not present in the vehicle (for example running errands without the client present).

1) List the service within the plan of care under Section *IV-A "Summary of Non Habilitative Services"* as a separate service block, separating the service request and justification from other transportation services.
2) Include a written justification that includes the purpose for the trips requested including the reason the recipient's needs cannot be met in the recipient's local community area.
3) Note that this service cannot be used to supplant services available through alternate resources and cannot be billed separately as part of Day Habilitation.
4) This service category is based on a flat rate reimbursement for a single one-way trip greater than 20 miles and therefore cannot be multiplied as an ongoing factor of distance, *(example: Cannot bill 2 trip-units if the distance traveled is 40 miles.)*
5) *Add the number of requested one way trip segments to create a total of trips requested for the plan year or amendment.*

7 AAC 130.290. Transportation services

Transportation services may be provided to recipients when natural supports are not available to provide transportation, and the services are necessary to enable recipients to travel to locations where waiver or grant services are provided, or to other community services and resources. These services are to be used for community integration purposes rather than for medical services transportation available under 7 AAC 120.405 – 120.490.

The provider who chooses to offer transportation services must be certified as a provider of transportation services under 7 AAC 130.220 (b)(1)(I), meet with the requirements of 7 AAC 130.290, and operate in compliance with the Transportation Conditions of Participation standards. In addition, agency-based transportation services providers must operate in compliance with the Provider Conditions of Participation.

Additionally transportation escorts are not paid employees of the transportation company but rather someone chosen by the recipient and familiar with their needs. Your client may not need escort. If they do, you will need to justify the request in the plan of care. Escort helps the client by meeting the client's mobility needs.

The transportation provider may use vehicles they own to provide transportation. SDS will approve a transportation provider to use employee or volunteer vehicles only in situations where there are no other options to provide the waiver transportation service.

Waiver transportation is not requested for rides to/from medical appointments or procedures

It is for accessing the community.

Please contact our SDS Transportation Coordinator for Medicaid rides to and from medical appointments. Only Care Coordinators can call (not recipients or family members/friends).

Sarah Bumpus

907-745-3500

When the Plan of Care includes PCA

In addition to receiving Medicaid, the person must need assistance (hands-on help) with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs), to remain at home or to prevent job loss.

This person must receive an Assessment from a PCA Assessor with Senior and Disabilities Services. Also, the person must provide a Verification of Diagnosis, by having his/her medical provider fill out the Verification of Diagnosis form.

Usually a person who needs hands on help at home will contact a PCA agency to inquire about PCA services. Sometimes the person has a Care Coordinator (if he/she has a HCB Waiver) and the Care Coordinator may inquire to the PCA agency about services. The person needs to choose who will deliver the PCA service (which company), if found eligible for PCA.

When the Plan of Care includes PCA- the Care Coordinator must be aware of regulatory limits under non-duplication of services.

- The waiver service: Chore Services, 7 AAC 130.245. Chore services includes the possible tasks of cleaning in the home, shopping and food preparations.
- Personal care Assistance IADLs- Instrumental Activities of Daily Living- also include possible tasks of cleaning in the home, shopping and food preparations. 7 AAC 125.030. Personal care covered services
- **The individual or his/her legal representative needs to choose which option to receive these services- the tasks that need to be done which best serve the person's needs.**

About Chore and a Spouse:

Chore is generally not available if the person has a spouse. A spouse is expected to provide this service. If the spouse is away from the home for work, submit a care calendar to indicate the times when the spouse is not in the home, during which Chore may be requested.

If more than one person living in a household has Chore:

The number of waiver Chore hours allowed will be based on the recipient category, how much Chore is necessary for each recipient or for all recipients in the household, and whether there is any duplication of Chore tasks in each person's plan or request.

About requesting PCA for children:

When PCA is requested for a child who also receives waiver services, the care supports performed by a PCA worker, or a waiver service provider, cannot replace those ordinarily provided by the child's primary caregiver. The plan must be carefully written to portray what supports will be given, by whom and when. It is helpful to use the 24 hour care calendar to map out an actual day of care when supports are complex. The Care Coordinator will request services that clearly do not duplicate each other and will meet needs as seen in the assessment, with reliance on other supports the individual has as resources. Neither PCA nor the Waiver can replace unpaid supports or supports through other sources. Likewise these services cannot duplicate existing supports the person utilizes or relies on.

HCBW Chore Services vs. PCA IADL

- 7 AAC 130.245. Chore services
- 5-10 hours per week
- regular cleaning within the residence used by the recipient;
- performing heavy household chores, including
  - (A) washing floors, windows, and walls;
  - (B) tacking down loose rugs and tiles;
  - (C) moving heavy items of furniture;
  - (D) snow shoveling in order to provide safe access and egress;
- food preparation and shopping for recipients in the following recipient categories:
  - adults with physical disabilities;
  - older adults;
- other services that the department determines necessary to maintain a clean, sanitary, and safe environment with respect to the residence used by the recipient.

- 7 AAC 125.030. Personal care covered services –IALD's
- **Hours determined by SDS Assessor**
- meal preparation, the preparation, serving, and cleanup in the recipient's home
- light housekeeping:
  - (A) picking up, dusting, vacuuming, and floor-cleaning of the living spaces used by the recipient;
  - (B) cleaning of the kitchen and dishes used for preparation of the recipient's meals;
  - (C) cleaning of any bathroom used by recipient;
  - (D) making the recipient's bed;
  - (E) trash removal;
  - (F) service animal care;
- Laundering
  - (A) changing a recipient's bed linens;
  - (B) in-home or out-of-home laundering of a recipient's bed linens and clothing;
- shopping in the vicinity of a recipient's residence
- Assisting with meds administration, wound care or therapies
- Traveling with recipient for routine medical appointments

Environmental Modifications (E-Mods)

7 AAC 130.300 Environmental Modifications

Environmental modification services result in physical adaptations to a recipient's living space that meet the recipient's needs for accessibility, protect health safety and welfare, and further the individual's independence in community living.

Like all HCB Waiver services, E-Mods are done by certified and enrolled providers- building contractors who are certified and enrolled to provide this Medicaid service.

Starting July 1, 2013, recipients may request E-Mods reimbursed up to $18,500 in a continuous 36 month period.

An E-Mod does not:

- ✓ include new construction or renovation,
- ✓ increase the square footage of the residence,
- ✓ include general utility adaptations,
- ✓ modifications, or improvements to the existing residence,
- ✓ cover work or improvement to outbuildings, yards, driveways, or fences,
- ✓ improve the exterior of the residence not directly related to the need for access,
- ✓ or additional work that is not part of the requested SDS sponsored project scope regardless of how funded

An E-Mod does not include feature or material upgrades that exceed what would be considered routine construction grade materials, or the installation of privately purchased equipment or materials.

An E-mod cannot duplicate existing modifications regardless of funding. An E-mod does not include installation or repair of prohibited items such as elevators, hot tubs, saunas, or hydrotherapy devices.

E-Mod is not available to licensed assisted living homes under AS 47.33 or AS 47.35.

Request an E-Mod only for a home that is considered the primary residence of the recipient. This service is available when the recipient is living in a joint custody situation and spends time at 2 homes. E-Mods are available with family habilitation.

In the Plan of Care, or Amendment, list all Environmental Modifications already completed for the person's use regardless of funding source. Identify future E-Mod needs based on the current accessibility needs of the recipient: more info then just "TBA". Attach E-Mod request documents if an E-Mod is requested. You can find E-Mod request documents at http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx

How to begin an E-Mod Request:

You can request an E-mod in a plan of care. You may find using an amendment more helpful due to the research needed.

The SDS Medicaid waiver regulation changes effective on July 1st include changes to the process for requesting environmental modification (EMOD) project estimates. First, you should note that EMOD process policies are shared among three regulatory
components:

1. **New EMOD COP:** http://dhss.alaska.gov/dsds/Documents/docs/EMOD_COPs.pdf
2. **Care Coordination COP (section-V):** http://dhss.alaska.gov/dsds/Documents/docs/CareCoordinatorCOPs.pdf
3. **7AAC 130.300:** http://dhss.alaska.gov/dsds/Documents/docs/7AAC-130FinalAmendmentsEFF7-1-15.pdf

Research ways a person may receive the E-Mod that are not waiver services. For example, a volunteer group may build or repair a ramp, or a building company may provide the modification as part of a community service. Document attempts to provide the E-Mod through sources that are not part of the waiver. If needs are not met by this inquiry, request an E-Mod through the waiver. Include documentation of the previous inquiry with the Plan of Care or Amendment.

The proposed project should meet a recipient's current and chronic needs opposed to only temporary needs or a disability not yet realized.

Make a calculation to ensure the person is eligible for the proposed E-Mod project that does not exceed $18,500 in a continuous 36-month period. Begin with July 1, 2013. The total cost of the E-Mod (s) available to the person may not exceed a total of $18,500 in each subsequent continuous 36-month period that the person remains on the waiver.

The total for an E-Mod may exceed 18,500.00 within 36 months if the request is for a repair or replacement of a pre-existing environmental modification, and the excess does not exceed 500.00 per year of the remaining 36 month period. Also, if the additional cost is due solely to shipping/freight to a rural community as defined in **7 AAC 130.300. Environmental modification services:**

The provider will give the care coordinator a project estimate using the required form. The EMOD provider needs to use SDS only sponsored estimate documents, available at http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx. The provider will complete all forms fully, including a full list of proposed materials, labor, permits, and special fees where applicable filling in N/A where appropriate.

All E-Mod project estimates need to be the same scope of work to be accomplished, estimated independently per the specific SDS project form.

The Property Owners Consent form needs to be complete without any missing or required information. The completed form should be signed with the contractor's name or business included that represents the lowest submitted estimate.

All project estimates must be collected and held private (do not communicate project estimates among multiple E-mod providers).

Start by emailing ALL EMOD providers to request cost estimates for the EMOD. Please note that excluding any currently enrolled EM provider for any reason will result in a denial of service.

You can use this list to obtain all the email addresses for current EMOD providers.
http://dhss.alaska.gov/dsds/Documents/SDSforms/EMOD-ProviderList.pdf

In your email, include the following:

1. Your (care coordinator's) name and contact information;
2. The location of the proposed project, and a statement indicating providers may arrange with the care coordinator for on-site viewing of the area to be modified;
3. Attach the *Request for Cost Estimate* form or forms from http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx appropriate to the type of physical adaptation included in the environmental modification project;
4. Photographs of the area to be modified with sufficient detail for provider review; and
5. Written notice of a time limit of at least 14 days for submission of estimates, unless a different timeframe was already approved by Senior and Disabilities Services.

The EMOD provider needs to use SDS only sponsored estimate documents, available at http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx. The provider will complete all forms fully, including a full list of proposed materials, labor, permits, and special fees where applicable filling in N/A where appropriate. They will return the forms to you.

Collect all responses and documents you receive by the end of the 14 day period. Attach them to the Plan of Care or Amendment. SDS will review them. If the service is approved the project will generally be awarded to the provider with the lowest estimate.

Use this checklist to see if you have evaluated and submitted correctly.

SDS EMOD Review Checklist

This Checklist is provided as a Guide to Assist Recipients/Guardians, Care Coordinators, & Contractors with E-Mod Planning **(Revision 07.01.15)**

1. ☐Yes ☐No **Were all EMOD providers emailed to request cost estimates?**

2. ☐Yes ☐No **Was a digital photograph provided as part of the E-Mod project request?**

3. ☐Yes ☐No **Does the proposed E-Mod meet a recipient's current and chronic needs opposed to only temporary needs or a disability not yet realized?** *(Example #1: Recipient's mobility is reduced only short term as part of normal recovery time for knee surgery. Example #2: Recipient uses a cane for assistance but is expected to "someday" be completely wheelchair bound)*

4. ☐Yes ☐No **Is the E-Mod requested for a home that is considered the primary residence of the recipient?** *(Example: Requesting a ramp or bathroom modification for a vacation home or friend's home based on the recipient visiting there occasionally would not be authorized.)*

5. ☐Yes ☐No **Is the proposed E-Mod project included as part of new construction to the recipient's residence or any other renovation planned or in progress?**

6. ☐Yes ☐No **Does the proposed E-Mod project increase the square footage of the residence**? *(Example: A bathroom is made larger to facilitate access by extension into a garage, carport, or outside space not considered current living area.)*

7. ☐Yes ☐No **Does the proposed E-Mod project contain what could be considered** general utility adaptations, modifications, or improvements to the existing residence? *(Example: general utility adaptations include routine maintenance or improvements, including flooring and floor coverings; bathroom furnishings, carpeting, roof repair, central air conditioning, heating system or sewer system replacement, appliances, cabinets, and shelves.)*

8. ☐Yes ☐No **Does the proposed E-Mod project include any work or improvement to outbuildings, yards, driveways, or fences?**

9. ☐Yes ☐No **Does the proposed E-Mod project include any improvements to the exterior of the residence not directly related to the need for access?**

10. ☐Yes ☐No **Does the proposed E-Mod project include any additional work that is not part of the SDS sponsored project scope regardless of how funded?** *(Example: A recipient wants the contractor to tile his/her bathroom walls and floor as part of a roll-in shower installation. The tile work would be considered private work requested/contracted by the recipient and therefore cannot be combined with the SDS E-Mod project.)*

11. ☐Yes ☐No **Does the proposed E-Mod project include any feature or material upgrades that exceed what would be considered routine construction grade materials?** *(Example: The entrance door to a residence is widened to permit wheelchair access and thereby must be replaced. A standard exterior grade door would be appropriate whereas a custom ordered cherry wood door with a decorative stained glass window would not.)*

12. ☐Yes ☐No **Does the proposed E-Mod project include installation of privately purchased equipment or materials?**

13. ☐Yes ☐No **Could the proposed E-Mod project be considered a duplication regardless of funding?** *(Example #1: A bathroom was modified in the recipient's residence to meet all mobility needs by a grant and a second bathroom is now being requested for modification under the waiver E-Mod program. Example #2: The recipient has a ramp to their front door and wants another ramp to extend from the back or side door.)*

14. ☐Yes ☐No **Does the proposed E-Mod project include installation or repair of prohibited items such as elevators, hot tubs, saunas, or hydrotherapy devices?**

15. ☐Yes ☐No **Is the proposed E-Mod project intended for a waiver recipient whose residence is licensed as an assisted living home?**

16. ☐Yes ☐No **Does the proposed E-Mod project contain only estimate documents that are SDS sponsored?** *(private contractor bid or estimate forms in addition to, or used instead of the appropriate SDS sponsored project estimate forms are not authorized. (Only SDS approved project forms are accepted for waiver funded E-mod projects.) All SDS project estimate forms can be found online: http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx*

17. ☐Yes ☐No **Are all submitted E-Mod project estimates similar in the scope of work to be accomplished?** *(All E-Mod projects should be estimated independently wherever the specific SDS project form exists. Example: Do not combine a ramp installation project on the same estimate form for a stair-lift).*

18. ☐Yes ☐No **Was a calculation made to ensure recipient is eligible for the proposed E-Mod project that does not exceed $18,500 in any 3-year period starting July 1, 2013?** *(Keep in mind that the rolling 3-year period is the same for all waiver recipients regardless of waiver start date).*

19. ☐Yes ☐No **Is the Property Owners Consent complete without any missing or required information?** *(Note: This form cannot be signed by anyone other than the registered property owner. Exception: a valid Power of Attorney or other court document that establishes another individual to make decisions for the property owner can be acceptable but may need legal review for that determination. The completed form should be signed with the contractor's name or business included that represents the lowest submitted estimate.)*

Checklist Key: If any items on this checklist are answered with a red highlighted response for **Yes** or **No**, the proposed E-Mod project will not likely meet regulatory/policy guidelines

Specialized Medical Equipment

Specialized Medical Equipment is a specific list of equipment, vehicle modifications, and repairs to certain Environmental Modifications. These are medically necessary items and equipment to help the person control, interact with, or perceive their daily environment, and/or provide assistance with activities of daily living.

Submit a request in a Plan of Care (or an Amendment). Include written supportive contemporaneous documentation from the following medical providers licensed to practice in the State of Alaska: physician, including an osteopath, a physician assistant, an advanced nurse practitioner, an occupational therapist, or a physical therapist- stating that the specific item requested is appropriate for the recipient, consistent with the plan of care, and necessary to avoid placing the recipient at risk of institutionalization.
Specialized Medical Equipment is subject to approval and listed on the SME Fee Schedule

http://dhss.alaska.gov/dsds/Documents/pca/PCA-service%20-waiver-rates201407.pdf

The current list of possible Specialized Medical Equipment requests includes but is not limited to:

- Vehicle Modifications and Repairs, such as hand controls, a van lift, and/or wheelchair tie downs for a person's own vehicle. (Check to see that the vehicle is owned by the recipient or guardian. Also it is recommended to have the vehicle modification added to the vehicle's insurance rider so it may be replaced in the event of an accident.)
- Repairs to a stair lift for the staircase in a person's home, repairs to a platform lift, repairs to a ceiling mounted lift system
- A reclining lift chair, or repairs to one
- A sit-to-stand system
- A standing frame system
- Reachers and grabbers to pick up objects
- A personal Emergency Response System
- Hand held Low Vision aids (non-spectacle type)
- Handheld shower
- Items that assist with everyday self care such as sock donners, big handle utensils, alarmed medication dispensers
- Switches to activate devices
- Humidifier, air purifier
- Portable wheelchair ramps

Include item warranty if applicable

Nursing Oversight and Care Management

This section describes the basic activities of the nurse who provides Nursing Oversight and Care Management (NOCM). It does not constitute formal training for a nurse who will provide this service. Such training is available to Developmental Disability Nurses who are certified and enrolled to provide NOCM, usually working in an agency.

Please contact the training staff if you are a nurse who needs to complete formal NOCM training.

Who may provide NOCM?

The nurse who provides NOCM is licensed in the State of Alaska under AS.08, and has certified with SDS to provide NOCM, and enrolled with Alaska Medicaid (Xerox) as a provider. This nurse may also be a certified and enrolled Care Coordinator for the AK Home and Community Based (HCB) Waiver. The nurse who provides NOCM is also a Developmental Disabilities (DD) nurse, who has experience in serving special populations who experience developmental disabilities. You may learn more about the field of DD nursing here: https://www.ddna.org/

What is NOCM?

Nursing oversight and care management is required for the CCMC waiver. It is also available to individuals who have needs for nursing care to the level of CCMC, and who have the IDD waiver. A nurse oversees the implementation of the services in the plan of care. The nurse provides a plan for nursing services which includes visiting the individual, making recommendations, providing nursing services, and training for agency staff and family members who will care for the child. Some techniques of care the child needs may be delegated- under nursing regulations AS.08.

The nurse is a mandatory reporter and will also fill out Critical Incident reports as necessary. The nurse works as a team member with the Care Coordinator to communicate on behalf of the observed needs and situation surrounding the individual.

Why are NOCM services necessary?

The waiver is a choice to receive services in one's home and community rather than a nursing facility. The CCMC waiver serves children who are medically fragile. It helps children stay as healthy as possible while living at home. Historically there was little awareness that long term nursing services would be required in a home setting. Nursing services in a home setting were usually short term and intermittent. Long term nursing services usually happened in a nursing home. Long term nursing formerly (prior to the HCB Waiver) has required admission to a nursing facility. However the individuals who are served by the CCMC waiver and in some cases the IDD waiver may experience medically complex conditions which require long term nursing services.

How are NOCM services funded?

NOCM services do not supplant those provided through private insurance, regular Medicaid, or other sources. NOCM is funded through the HCB Waiver. It is a separate service requested in the plan of care and has its' own regulation: **7 AAC 130.235. Nursing oversight and care management services**

What are NOCM Roles and Responsibilities?

DD Nursing is a relatively new field. The DDNA has established standards and ethics to guide professionals working in this field. Nurses who provide NOCM must:

- Comply with Nursing statues and regulations
- Comply with all regulations related to Medicaid and the Home and Community Based Waiver
- Be an employee of a HCBW enrolled agency
- Complete annual reviews of cases and provide these to SDS
- Follow guidelines for providing services and follow reimbursement requirements
- Visit the individual they are serving at least once every 90 days or more often depending on the health needs of the individual and/or training needs of those who support the individual.

NOCM referrals, intakes and screenings:

- Screen individuals who are likely to need NOCM as referred, and submit screenings to SDS.
- Submit required verification of diagnosis document to the individual's physician.
- Track, follow up and submit screenings/re-screenings (to SDS) for new and current applicants.
- Prepare the NOCM plan for the plan of care- the Care Coordinator convenes the planning team and the nurse is a required team member
- Provide documentation if a referred individual is not screened for the CCMC waiver
- Refer applicants who do not meet the requirements for CCMC to the STAR Program or other sources (applicants may re-apply at any time)
- The SDS program will send the written notification (and a postcard) to approved CCMC applicants, which indicates SDS approval to proceed with CCMC waiver planning.
- Applicants or their parents/guardian must send the postcard back to SDS indicating their choice of Care Coordinator, agency and NOCM Nurse.
- SDS will then contact the applicant or parent/guardian, Care Coordinator and the DD Nurse to schedule the SDS Nurse Assessment.

Assessment- NFLOC

The Care Coordinator convenes a comprehensive planning team.

The nurse providing NOCM will complete and assessment of the individual's nursing needs and develop a nursing plan, identify training needs for those caring for the individual, provide the necessary training, and create a training checklist.

Additional information may be requested from the nurse- such as:

- a 24 hour care log to be completed by the primary caregiver;
- physician's records from the past year;
- records for ER visits or overnight hospitalizations;
- records from a physical therapist, speech therapist, or occupational therapist as applicable;
- a nutritional assessment;
- current education plans from school;
- any other documents that help establish nursing facility level of care.

The nurse providing NOCM will provide the nursing plan to the Care Coordinator for inclusion in the Plan of Care.

Planning and Training

All training and delegation by the nurse is expected to fall within the scope of practice as outlined by the Board of Nursing http://www.dced.state.ak.us/occ/pnur.htm .

Nurses providing NOCM and parents/guardians are responsible for training of care providers in the home setting. Specific training needs are based on the nursing needs identified in the nursing facility level of care, documents in the training checklist, and described in the NOCM nursing plan. The nurse providing NOCM signs the training checklist to verify that the individual caregiver has learned the correct technique and can provide this care to the individual.

Training checklists and manuals created by the nurse are specific to the individual and are meant as working documents which are readily available to caregivers and anyone else who may train those caring for the individual (for example those who may provide CPR/1st aid training to the caregiving staff, but who are not the NOCM nurse). Training and checklists are updated when there are new techniques or medications, etc needed.

Nurses providing NOCM give the recipient, and/or parent/guardian a Home Safety Screening Tool. The Nurse facilitates any needed assessments for equipment and follows up with the family and vendor. When making evaluations of or recommendations for equipment to be used in the home, the nurse ensures that these are completed by a vendor which is a provider for Medicaid.

Transition of NOCM services to another nurse

Planned rather than crisis driven, transitions are situations that involve moving from one home to another, moving from one part of the state to another, changing schools or changing provider agencies and similar situations. Transitions can affect the health and safety of the individual. It's a good idea to minimize multiple transitions happening at once. The nurse will help with planning how health and safety will be protected before during and after the transition, and continue to provide the oversight and training which will be necessary to accomplish this. Individuals and families may choose different providers, including the NOCM nurse.

If a transition involves the NOCM nurse, the originating nurse will obtain a release of information from the individual or parent/guardian. The original and new NOCM nurse will meet to exchange all NOCM information related to the individual's case. All parties need to agree to an official date of the transfer of NOCM services. The date of the transition and activities accomplished before, during and after the transition must be documented by the original NOCM nurse. The Care Coordinator submits transfer of NOCM information to SDS.

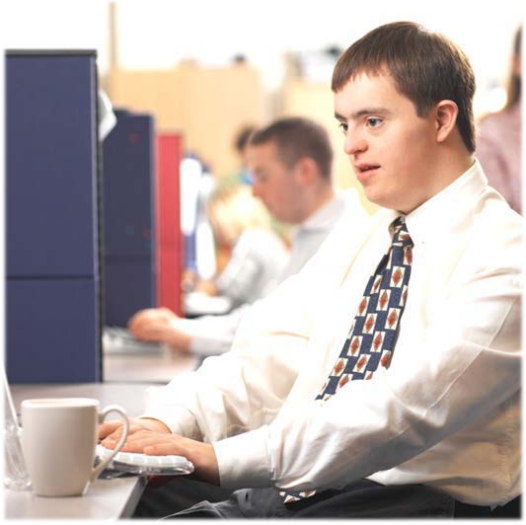
Supported Employment:

Supported Employment has a long and interesting history. It is still one of the most important services which is still changing today. Arranging for and participating in Supported Employment is challenging, across the nation.

Alaska is now an Employment First State! Read more about this here:
http://dhss.alaska.gov/gcdse/Documents/committees/legislative/2014_priorities/HB211-FullPacket.pdf

Here are some questions to consider when helping a person who desires supported employment:
What are the individual's?

- Long-range employment and life goals?
- Interests and talents?
- Learning styles?
- Positive personality traits?
- Achievements?
- Social skills?
- Work experiences (paid, volunteer, at home, at school, in the community) and where might he/she like to work?
- Specific challenges and strategies for dealing with them?
- Needs for accommodations and support?
- Options of interest (college, trade school, military, employment, living arrangements, healthcare, recreation, etc.)?



These questions need to be explored when planning so the person may avoid the following:

- sit at home with nothing to do
- be stuck in a "dead end" job
- wait...and wait...and wait for services from adult community service agencies
- spend his or her days at a job training workshop earning far less than minimum wage and have little assistance in finding a "real" job

(resource: parent brochure, Transition to Adult Life)

Also, the Care Coordinator should refer the person to Division of Vocational Rehabilitation. There are many useful resources through DVR, such as a case manager, job coach, situational assessment for a job, and benefits analysis.

http://labor.alaska.gov/dvr/

Job coaches through DVR are not long term care. It is possible to start with DVR services and move to SE through the HCB Waiver. SE exists for the eligible person who needs long term job coaching and skill building in order to maintain employment, above and beyond what employers do to accommodate employees on the job.

Even though people with disabilities can and do work in real jobs, the unemployment rate remains about 70%. The Alaska Works Initiative has worked to help increase employment rates for people with disabilities.

www.alaskaworksinitiative.org

Some of the barriers to employment faced by people with disabilities, as determined by an Alaska Works Initiative survey are;
Fear of loss of health benefits
-Disability itself
-Limited work opportunities
-Fear of loss of benefits and the ability to supplant loss of benefits with income
-Negative attitudes of employers and co-workers
-On a policy level, lack of work-first option or requirement

Reality: The less amount of time people are on benefits, the more likely they are to not see these issues as barriers to work.
Solution: help people work as soon as possible!

Become more familiar with issues and resources surrounding Supported Employment. Remember, this service is to help the person get a job or create a career/business for him or herself in the community. Supported Employment requires much teamwork with the direct support staff. People can undergo job development, and skill exploration through job development but this should not become an end unto itself. The goal of supported employment as a service is to get a job!

Requesting Services while traveling

Per 7 AAC 130.231 it may be necessary to request Waiver services for a recipient who is traveling outside of Alaska, or their home community in Alaska but within the United States.

Waiver services during temporary absences are limited to the following: **day habilitation, hourly respite, supported living, and in-home supports,** as approved in the Plan of Care or Amendment.

The temporary absence can be understood as an absence that has medical necessity as documented by a licensed physician, is an educational opportunity not available in Alaska, a vacation, or an absence necessary to prevent institutionalization. As in all waiver services, services while traveling need to be necessary to maintain the recipient's current level of functioning and prevent placing the person at risk of institutionalization.

SDS may approve up to 30 days of service, after receiving a prepared request which follows the policy. The Care Coordinator convenes a team including the individual and providers, to create a written plan for how the individuals' needs will be met during the temporary absence. Any extension of 30 days must be specifically approved by SDS. All requests must state the reason for the request with supporting justification.
The provider must continue to oversee the provision of the service while the person is temporarily absent from the state of Alaska.

You can read the policy and required procedure to request services during a temporary absence here:
http://dhss.alaska.gov/dsds/Documents/policies/HCCBwaiver-services-temp-absences.pdf

Medicaid funding does not provide for travel expenses, food, lodging etc. Medicaid funding does not pay for services outside the United States.

Requesting Acuity Rate of Reimbursement for out of home residential services:

Acuity rate refers to needs for care that rise to the level of 24 hour hands on care across environments. Meaning that there is staff provided to the person by the assisted living home to directly assist **only this person**, and not to work with others in the home or other environments. An Acuity Rate is a higher rate of reimbursement for the provider. Acuity Rate is subject to review and approval of SDS

For example:

the person needs hands on care to keep him or her safe at home, at any day program that he or she attends, during meals, overnight awake staff doing hands on care, and while in the restroom either at home or in the community.

The Acuity plan is intended to be a limited duration- so there will be a plan for longer term appropriate supports.

The current regulation for developing Acuity Rate Requests is:
7 AAC 130.267Acuity payments for qualified recipients.

If requesting an Acuity Rate the Care Coordinator can expect to provide significant documentation of what has been done to date to keep the person safe. This documentation must include what kind of physical needs or behavioral needs are thought to indicate the person needs 24 hour hands on care. The CC must describe the interventions or supports applied and indicate which was successful or not successful. Also include how the acuity rate reimbursement will be used to meet the person's needs. The CC needs to demonstrate how the additional service is consistent with services the person is already receiving.

If the rate is requested due to medical needs, there must be a description of how medication is currently administered or managed. Include the most recent medical or psychological evaluations, and any other health and safety related records that impact the request.

All requests for the acuity rate will be reviewed using the following statutes and regulations:

- 7 AAC 145.520(m) - requirement for dedicated staff one-to-one on a 24 hour basis
- 7 AAC 130.230(c) which requires contemporaneous documentation of a recipient's needs
- 7 AAC 130.230(f) and 7 AAC 130.230(g) which require the requested services prevent institutionalization and are not otherwise provided under 7 AAC 105 - 7 AAC 160
- 7 AAC 130.255 related to residential supported living services
- 7 AAC 130.265 related to residential habilitative services
- Licensing statutes in AS 47.32 and any regulations implementing them
- Assisted Living Home statutes in AS 47.33 and any regulations implementing them

UNIT 8

Person Centered Planning

- Writing in Plain Language

Writing Narrative in the Plan of Care

Including Personal Goals
Addressing functional abilities, strengths, and limitations
Developing Goals for Habilitative Services

Person Centered Approach
What kinds of help do people access?

A person accesses various forms of support, including but not limited to family, friends, community supports, and other forms of health insurance before Medicaid. Medicaid and the HCB Waiver are generally the "payers of last resort" for services.

Additionally, services funded by the Medicaid Waiver **cannot be duplicated** by any other source including similar Waiver or other services, family, community supports or unpaid supports.

Care Coordinators take a person centered approach.

- What supports are already in place for the person?
- Who helps with care now?
- What goal(s) does the person have for their life?
- Their services?

The Plan of Care that the Care Coordinator eventually writes needs to give an accurate picture of all supports the person is using or wants to use, starting with supports that are not within the Waiver system.

The referral process, and Home and Community Based services are part of a Person Centered framework. This framework assumes that people are in charge of defining the direction for their lives, and what happens in their daily life. It requires a conscious commitment to listening to what is important to the person, rather than focusing solely on service systems.

Person Centered planning can be part of a formal service process, but it does not exist only within it. We can be "person centered" without a formal process. Person centeredness is an approach in which the person defines what is important to him or her. A person who is accessing services is a whole person with resources and experiences that influence who he/she is today. People have unlimited choices for daily life and life direction throughout the planning process, rather than just from "the menu" of waiver services.

Because of this, supports and formal plans are customized, and paid supports will "fill in the gaps".

Self Determination is the basic human right to define yourself and what is important to you. Services should support the opportunity to make choices, to share ordinary places, to go places, to have relationships and grow them, to know people, to experience respect and have a valued social role, to have the opportunity to share one's gifts, or a legacy.

Community Membership means having real connections to a community, belonging. Being part of a community is one way that people define themselves. A person centered approach uses partnerships and collaborative relationships with the community as a source of enduring supports.

A Person Centered Approach is not always "easy". It can shatter myths and assumptions about disability and aging. It can foster inclusive communities, and uncover what is already there: the extraordinary gifts and capacities of a person. A person centered approach assumes that the person and those who are close to him/her are the primary authorities in the planning process.

What makes a good person centered plan? Individuals and families have access to information and assistance in managing/directing supports. Individual providers have basic competencies and specific skills to support the person. The plan has individualized strategies for support. There's an effective process for monitoring the delivery of service in a person centered way. Providers know the person, the plan, the preferences, goals, needs and support strategies. There is a means of identifying quality trends. People have an effective way to resolve problems or concerns about their plan. The person gives feedback about the plan.

Person centeredness: Each plan is individualized

Individualized planning for each person has now become the standard for all sorts of care plans, including the Alaska Home and Community Based Waiver Plan of Care. No two plans should be the same. When we customize plans to the person we are helping to increase the chances that the person will be able to take full advantage of the services in the plan. We should avoid making assumptions about what people need without consulting them first. It is possible to assemble a "menu" of services that we think would be of interest to the person. However until we truly listen to what our client is telling us about his or her life, history, strengths, beliefs, and needs for support, we are unable to make a person centered plan. Make time for listening and observing, then you may be better able to convey how formal supports can come into play. Your inquiry should go beyond "quantity" of supports. Quality, in terms of how the supports interact with the person and how your client has participated in their design, will make services relevant and allow the person to receive the full benefit of person centered service. To do this you will need to portray the details of your client's preferences, strengths, abilities and concerns.

Centers for Medicaid and Medicare Services now requires plans of care to be person-centered. You can read more about the requirements here. SDS is working with stakeholder groups to find out more about how to make person centered plans and services in Alaska.

CMS Final rule includes changes to the requirements regarding person-centered service plans for HCBS waivers under 1915(c)
The person-centered service plan must be developed through a person-centered planning process

- The person-centered planning process is driven by the individual
- Includes people chosen by the individual
- Provides necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible
- Is timely and occurs at times/locations of convenience to the individual
- Reflects cultural considerations/uses plain language
- Includes strategies for solving disagreement
- Offers choices to the individual regarding services and supports the individual receives and from whom
- Provides method to request updates
- Conducted to reflect what is important to the individual to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare
- Identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the individual
- May include whether and what services are self-directed
- Includes individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education and others
- Includes risk factors and plans to minimize them
- Is signed by all individuals and providers responsible for its implementation and a copy of the plan must be provided to the individual and his/her representative

The Written Plan Reflects-

- Setting is chosen by the individual and is integrated in, and supports full access to the greater community
- Opportunities to seek employment and work in competitive integrated settings
- Opportunity to engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS
- Reflects individual's strengths and preferences
- Reflects clinical and support needs
- Includes goals and desired outcomes
- Providers of services/supports, including unpaid supports provided voluntarily in lieu of waiver or state plan HCBS

- Risk factors and measures in place to minimize risk
- Individualized backup plans and strategies when needed
- Individuals important in supporting individual
- Individuals responsible for monitoring plan
- Plain language and understandable to the individual
- Who is responsible for monitoring the plan
- Informed consent of the individual in writing
- Signatures of all individuals and providers responsible
- Distributed to the individual and others involved in plan
- Includes purchase/control of self-directed services
- Exclude unnecessary or inappropriate services and supports
- Must be reviewed, and revised upon reassessment of functional need as required every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

Personal Goals in the Plan of Care

All Plans of Care need to include the recipient's personal goal. This is one of the Assurances found in Unit 2. Plans which include the Habilitative services must have measurable goals and objectives (see next section). How does the Care Coordinator include personal goals in Plans of Care for the ALI waiver?

A personal goal is just that- something that is meaningful and relevant to the person. A Care Coordinator may discover what to include simply by listening to the person. Here are some helpful insights about taking a person centered approach when working with any Waiver.

With person centered planning you simply meet the person where they are.

When working with elders, and adults who experience physical disability, many times you are serving people who have accomplished a lot in their lives and achieved a lot of goals. They may express that they aren't looking for more things to do so, when you ask them if they have goals they may say "I don't have goals" – however, sometimes if you listen like a detective you can find their goals. When you are developing or updating plans of care listen for goals -- direct quotes from the person are encouraged. Then expand their wishes and wants into clearly developed goals

Some examples of common goal ideas expressed to Care Coordinators are listed below, then one possible example of an expanded statement goal statement.

1. Goal - "I want to have my privacy respected" Respite services are used so that Sarah's primary unpaid provider, her daughter Brittany, will have some time away from her care giving duties to relax with her husband. Respite service caregivers will ask questions as needed to provide safe and appropriate care for Sarah and not ask personal questions unrelated to her care. Sarah will volunteer personal information if she is comfortable doing so.
2. Goal: "I want to die at home where I live with my family and friends" Respite services are requested so that her primary unpaid caregiver has relief from the time demands of care. She has comfort one and hospice services in place to support her decision, to help with pain management, and to assure that her wishes not to be moved to an institution are respected.

3. Goal: "I just want to stay out of a nursing home and maintain my independence" John wishes to receive services in his home and live independently. He will receive meals on wheels, chore and transportation services as well as PCA services to help him remain in his home with reliable safe transportation to his medical appointments and support services.
4. Goal: "I just want to have time to enjoy the life that I have made with dignity" Patty wants to live at Happy Hearts ALH which is in the neighborhood she has lived in for 20 years. The ALH location will help her maintain contact with lifelong friends and her church family. The ALH staff will provide assistance with IADLS and ADLS particularly with self administration of medication, and other tasks listed on page 13 of the POC under residential services.
5. Goal: "I want to live in my the home that I built with my hands" While Tom continues to live in his home; Meals on Wheels will be provided to meet his need for a healthy diabetic meal each day, Chore services will be provided to help with tasks such as laundry, vacuuming, to maintain the his home.
6. Goal: "I don't want a bunch of strangers in my home; I want my family to take care of me." Helen's granddaughter Beth will be her respite provider so that her primary caregiver, daughter Sophie will have time off from providing care.
7. Goal: "I wish that my kids would quit worrying about me "Nana will have lifeline installed to allow communication with emergency services when needed. Transportation services will provide safe and reliable travel to medical and support services. Chore services will be requested to help her with household chores such as vacuuming, snow shoveling, laundry, grocery shopping.
8. Goal: "I'm afraid of falling" Sadie will be safe as she moves about, assistance and equipment will be provided to her to reduce the risk of falling. A walker has been received through Medicaid Durable Medical Equipment funding. The ALH staff will offer assistance with moving about the home and prompt or offer the walker if she forgets to bring it when leaving the home.
9. Original wish statement from legal decision maker or concerned family member and planning team member: I want my mother to have help with taking her medicine. Goal: Nan will regularly take her medicine as prescribed, the ALH staff will provide prompting and assistance with self-administering her medications.

Dream and give yourself
permission to envision a
You that you choose to be.
~Joy Page

Some Resources for Person Centered Planning

This training has utilized the following resources for educational purposes. You are encouraged to research Person Centered Planning using these and many others available on the Internet.

Cornell University ILR School Employment and Disability Institute. (2008) http://www.ilr.cornell.edu/edi/pcp/index.html

Capacity Works, (2008). http://www.capacityworks2.com/

Human Services Research Institute, The MEDSTAT Group. (2006). *Individual providers, a guide to employing individual providers under recipient direction.* National Quality Contractor, for Centers for Medicare and Medicaid Services. www.hcbs.org

National Resource Center for Recipient-Directed Services http://www.nrcpds.org

What is plain language?

Communication that your audience or readers can understand the **first time** they hear or read it.

Muddy language is not confined to policies alone. Each of you has seen replies to simple questions in which the meaning was lost through hopelessly obscure wording. When a person writes to the Veterans Administration, he is entitled to an easily understood, frank, and courteous reply. If our replies cannot be understood, they are not only, *not worth writing*, but they simply create additional work.
General Omar Bradley, the second administrator of VA, 1947

What are the main elements of plain language?

- Logical organization
- The active voice
- Common, everyday words
- Short sentences
- "You" and other pronouns
- Lists and tables
- Easy-to-read design features

Plain Language Myths

Plain Language is NOT:

1. Baby talk or an attempt to be folksy, playful, or politically correct
2. Stripping out necessary technical and legal information
3. Just editorial "polishing" after you finish writing
4. Imprecise
5. Just using pronouns in a Q and A format
6. Something the lawyers will never go for
7. Something the Federal Government will never go for
8. Easy

Why use Plain Language?

We're all busy people.
We don't want to waste a lot of time trying to translate difficult, wordy documents.
And we want to scan, not read.

Additionally Plain Language:

- Shows customer focus
- Communicates effectively
- Eliminates barriers
- Reduces time spent explaining
- Improves compliance

What Happens When Readers Don't Understand?

You may have to:

- Answer phone calls
- Write interpretative letters
- Write explanatory documents
- Re-do your work
- Litigate

Additional work!

_____

_____

_____

The information we at the Department of Health and Human Services provides can literally make the difference between life and death for our fellow Americans.
~HHS Secretary Tommy Thompson, endorsing plain language, 2002

Goals of Plain Language

Help the reader **find** the information

Help the reader understand the information

Remember: If your document doesn't do both, it's not plain language.

Identify your audience,

☹ **NOT…**

What do **I** want to say?

How can **I** protect **my** interests?

What can I do to **impress** you?

Focus on the reader

☺ **BUT…**

What does **the audience** need to know?

How can **I** serve **the audience's** interests?

What can I **clearly express** to the **audience**?

"Clear writing from your government is a civil right."
~Former Vice President Al Gore, 1998

Great! So how do you apply plain language to your writing?

Short paragraphs with short sentences

The Coast Guard has conducted an investigation to determine what carbon monoxide (CO) detection devices are available to recreational boaters, such that, when installed and activated could reduce the risk of being exposed to high levels of CO -THAT SILENT KILLER. A variety of technologies is available for detecting the presence of CO on boats and should be considered by recreational boaters to reduce their risk of injury or death while boating. (72 words)

-OR-

Carbon monoxide is a silent killer. The Coast Guard recommends that you use a carbon monoxide detection device on your boat to reduce the risk of being exposed to high levels of CO. You may choose from a variety of devices. (39 words)

Eliminate

-Excess Words

-Excess content

-Repetitiveness

-Give small bites of information

Don't sound so clinical-The POC is about the person not their diagnosis. Talk about the person as a person

_____

_____

_____

Write in the 'Active Voice' vs. a 'Passive Voice'

- Active voice is more clear, concise and direct

_____

_____

_____

_____

_____

_____

'Passive Voice'

- Can disguise who does what:
- Is wordy:
- Is awkward:
- Passive is a characteristic of bureaucratese
- "Mistakes were made." Instead of "the company made a mistake" or even more descriptive- specifics?

_____

_____

_____

USE THE CORRECT PRONOUN IN THE CORRECT PLACES

HE'S ARE MALE

SHE'S ARE FEMALE

Avoid hidden verbs ***-verbs disguised as nouns***

Conduct an analysis _____

Present a report _____

Do an assessment _____

Provide assistance _____

Came to the conclusion of _____

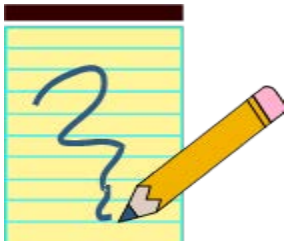
RE-write this, use the active voice; be concise….

Once the client's goals are established, one or more potential objectives are identified. A preliminary implementation plan is developed with the provider. The plan is presented to a provider who agrees to implement an individualized plan that meets the health and safety needs of the client, the client's objectives and the provider's capacity to serve the client.

EXTRA CREDIT: PERSON CENTERED?

Use lists

(But not too long)



Use Consistent terms = Common language in all you do

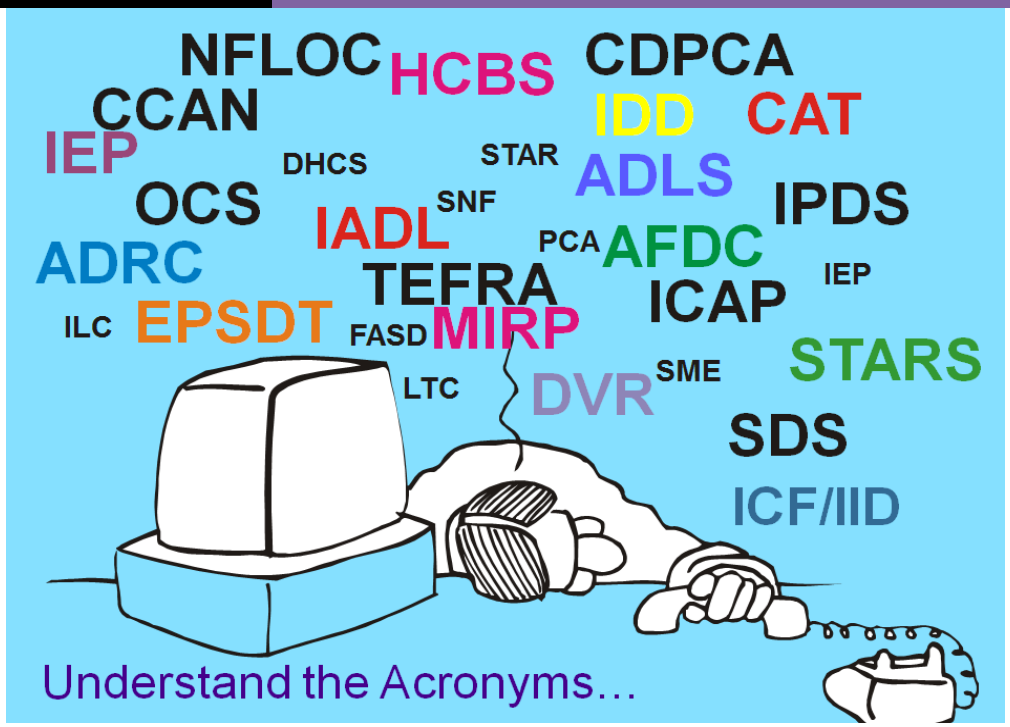
...be consistent in your documentation, throughout your Plan of Care and in Applications

–avoid "shall"

In just about every jurisdiction, courts have held that "shall" can mean not just "must" and "may," but also "will" and "is."

~Bryan Garner
The world's highest-paid writing instructor

- Avoid "***Shall.***" It is ambiguous and is not used in everyday speech
- Use "***must***" for an obligation
- Use "***must not***" for a prohibition
- Use "***may***" for a discretionary action
- Use "***should***" for a recommendation



Limit acronyms and abbreviations

- **Use "we" for the agency and "you" for the client**
- **Make them pronounceable (STARS, TEFRA, NOCM)**

Use Everyday Words:

- **Anticipate** _____
- **Attempt** _____
- **Commence** _____
- **Demonstrate** _____
- **Implement** _____

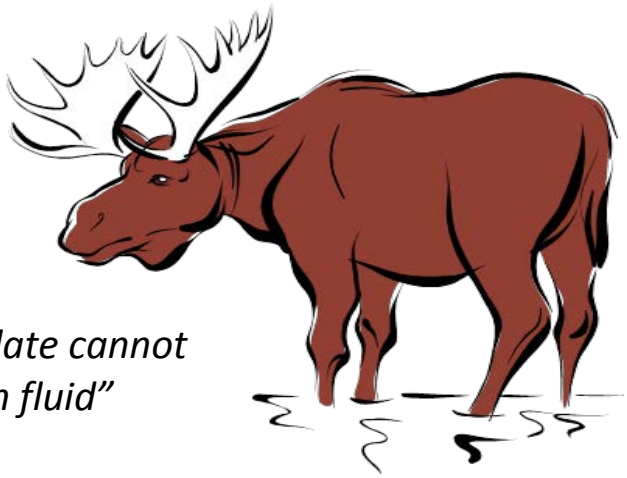
in the event that_____

submit _____

terminate _____

What is this?

Use every day common words



Simpler is Better

"An Alces Alces ungulate may be propelled toward a body of aqueous fluid, but such ungulate cannot be compelled or forcibly induced to imbibe such fluid"

Place Words Carefully

Keep subjects & objects close to their verbs.
Put conditionals such as "only" or "always" next to words they modify.

"Yesterday a mad dog bit five men and women in the south end."

Who will sign in agreement to this plan?

Who is being discussed?

What are all the purposes of this plan?

Gobbledygook may indicate a failure to think clearly, a contempt for one's clients, or more probably a mixture of both.
A system that can't or won't communicate is not a safe basis for a democracy.

~Michael Shanks, former chairman of the National Consumer Council (Great Britain)

Out of intense complexities intense simplicities emerge. Broadly speaking, the short words are the best, and the old words when short are best of all.
~Winston Churchill

Resources for writing

- NIH plain language training
- Plainlanguage.gov
- Federal plain language guidelines
- Center for Plain Language

Writing Narrative in the Plan of Care

A Plan of Care is not written based solely on a diagnosis. A Plan of Care is written to describe a person's functionality within the diagnosis. This will bring strengths, functional abilities and needs for support into play.

Use person first language to accurately describe disability

Everyone wants to convey disability in modern terms. You will be able to clearly and respectfully convey the concept of disability and needs for support if you follow person first concepts.

- *Person first*: Identify the person first, rather than the disability. "Jan experiences developmental disability". Or, "Jorge is a 50 year old man who experiences partial paralysis."
- Avoid using terms such as *"afflicted with", "suffering from", "cripple", "victim", "handicapped", "wheelchair bound", "confined to a wheelchair"*, etc. You can write that someone "uses a wheelchair"- which is actually a mobility device- by putting the person first.
- *Mental retardation*- now referred to as "intellectual disability" or "developmental disability" See Rosa's Law.
- *Blind*- be specific about blindness. The person may have partial sight, partial vision, low vision, or a visual impairment.
- *Deaf*: Be specific. Deaf refers to total loss of hearing, or even deaf culture or lifestyle. Partial hearing, hard of hearing and hearing impairment can help you be specific.
- *"Mute" and related terms:* This is an outmoded way to describe how someone may communicate without words. We can all agree that inability to speak does not convey lack of intelligence. The modern choice is "nonverbal" and then be specific about how the person communicates- sign language? Gesture/ eye gaze? Using adaptive equipment such as a switch or a speech generation device?
- *"Mental illness", "psychotic", "neurotic", "schizophrenic"*: These are now seen as pejorative labels. Avoid using them to describe behaviors or instances when a mental disorder is not diagnosed by a professional. Mental Disorder can be used, and if necessary the specific diagnosis can be written.
- Use caution about phrases such as "overcoming disability", or "in spite of her handicap". These phrases inaccurately describe the barriers that people with disability sometimes face. Barriers faced by people with disability can be seen as located in one's environment. For example, a person can succeed in spite of an inaccessible environment or overcome society's preconceptions about his or her disability.

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Be clear and precise

Avoid being general and vague. Be specific about what you are conveying in your narrative. Think about what it "looks like" – your observation- when you are addressing potentially vague or nonspecific topics. Professional narrative should avoid making assumptions about another person. Document emotional states and other potentially subjective information by writing "as evidenced by". For example, rather than stating "Alice is angry", the narrative could say "Alice becomes angry as evidenced by her frowning facial expression" or "Alice states when she is angry".

Be specific and objective about what may be generating the person's responses. For example, instead of writing "Fred gets angry often" it could be written that "Fred expresses his frustration when he must wait, for example, when he is waiting in line for longer than 5 minutes."

You may add your observation by leading the statement with "Care Coordinator observation". Avoid speaking for the person in the plan. Indicate the person's own concerns or viewpoint in the narrative by using quotes and stating, for example: "Janice's concern about this is…….".

Identify strengths

If a plan will address functionality within the diagnosis, and it is to portray an accurate picture of supports, you will need to identify your client's strengths. These are attributes that may be useful when the person is working towards his or her goals, and in creating a person centered plan. Here are some factors to look for:

- Supports in the community or within the person's group. Is there a church or spiritual group? A cultural group, or recreation program? Are there any other services the person accesses? Does this person have a circle of friends, ties to family and/or community?
- Are there values, practices, beliefs or religious/cultural preferences that your client prefers? How does your client use these for support and comfort?
- What interpersonal skills does your client have when interacting with family, friends, pets, community members, staff?
- What special abilities or skills does the person have?
- If the person had his or her choice as to what they would prefer to do, what would he or she most likely choose?
- If you client has contact with family, what do they do when they are together? (go to events, go out to eat, watch TV, other activities?)
- Is your client interested in any hobbies, recreation, or developing talents?
- What people, activities, pets, or community groups give comfort to your client?
- With whom does your client spend most of his or her time?
- Is there anyone outside of the family or their immediate circle who has shown interest or provides support to this person?

When you identify strengths you can create an individualized plan. You will be better able to portray specific supports that will focus on your client, and services will be carried out in more relevant ways. Your resulting plan of care can become a reference document for direct service staff so they may participate with the person, and deliver person centered services.

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Identify Barriers

There are many reasons to identify barriers in your plan of care narrative. Barriers can prevent direct service staff and others who are working to support your client from fully understanding and helping this person. Even if you feel as though you have identified all barriers, it is possible that additional barriers will arise as services play out for your client. If you are aware that barriers diminish effectiveness of the plan and services, you can address the issues accordingly. You can create a plan or process that will help reduce problems later. Taking time to address barriers is the most effective way to help your client take advantage of services.

Here are some common barriers:

Language/communication: The person may not be able to communicate adequately with others because of a difference in primary language. Direct service or other staff may not be able to communicate because of a difference in language. Also, supports may not understand exactly how the person communicates. Accurately describe how the person communicates in your plan.

Culture: The person may be challenged to negotiate an unfamiliar culture. Direct service or other staff may not understand your client's culture. People tend to understand each other in light of our own personal cultural standards. If culture may be a barrier you can address this in the plan of care. Please note that culture can also be a strength!

Disability: Your plan should be written so that your client can participate with all the details of the plan. To stay person-centered, keep objectives and outcomes in alignment with what the person will be doing for the plan duration. Additionally direct service or other staff may over or underestimate the person's abilities. It may be difficult for others to understand how the disability affects the person's capabilities. Accurately describe the person's strengths and abilities. You may provide examples that show a piece of the person's average day, what he does for himself, and what supports do to assist the person, or accomplish for the person on their behalf.

Lack of resources: The person may not have the resources needed to fully participate in the plan. An example would be- lack of reliable transportation. Direct service staff may observe the person not arriving for work or to appointments and perceive it as a failure on the person's part.

(Summers, N. *Fundamentals of Care Management Practice,* 4E. 2012. Wadsworth, a part of Cengage Learning, Inc. by permission. www.cengage.com/permissions)

Refer to the assessment and other documents

A Plan of Care includes narrative information which describes the person's strengths, needs, and current situation. This information is based on the interview with the person, medical documentation, the assessment, and any other documentation that relates to levels of support. Examples include but are not limited to Critical Incident Reports, records of medical procedures, behavioral health treatment plans, supported employment case documents, or assisted living plans. Avoid cutting and pasting from assessment documents. Remember, you are working to show functionality within diagnosis, what supports are needed, and what supports will do to help.
You can do this by:

- Stating your observation of the person's functionality in daily life- you may provide an example of how a person completes a task or accomplishes part of their day.
- Stating how the supports assist the person to accomplish this
- Providing supporting evidence from the assessment

Here are 2 examples from Section III in the Plan of Care, for an ALI Waiver Plan of Care:

- Summary of life situation, home environment & relationships

Mr. Jones lives with Kindest Care ALH in Anchorage, Alaska. Occasionally his family visits him there for social interaction. He visits his adult son once a week on the weekend and stays for about 5 hours. He states that he has a positive relationship with his son and emotional support from his son's wife, her family and their friends. He likes to watch television and keep up with current local events. On an average day he watches TV, has the newspaper read to him and speaks with friends and family members, in person when they visit and on the phone. He likes social interaction.

- Situational limitations, and/or obstacles

Mr. Jones experiences functional limitations and mobility issues related to Stroke, Arthritis and HTN, per his diagnosis by Dr. Smith. His muscles and bones are in constant pain. They swell regularly, which causes difficulty in mobility as well. His CAT indicates that he uses a four footed walker for mobility within the home, and about 3 days per week he must rest in a seated position for approx 20 minutes after moving from one room to another. He makes every effort to move physically, but is limited by his medical conditions. Mr. Jones' cognition appears to be declining as he sometimes will choose to wear just a light shirt when intending to go outside in the winter, and need reminders that a warm coat is required. He also has been observed shaking salt on his pancakes instead of pouring syrup, as he is accustomed to do. Mr. Jones' CAT indicates cognition and memory changes in the time since the last assessment.

Here is an example of narrative for Section III in the Plan of Care, for an IDD Waiver Plan of Care:

- Summary of life situation, home environment & relationships

Jamie continues to live at the group home, with the same housemates and primary staff as last year. This living situation is positive, Jamie states she is happy. The housemates have a routine and know each other well. The families of the individuals work well with the primary house staff, and together have created a caring home where the residents feel safe and are healthy.

Jamie's ability to communicate her wants and needs is still an area she needs to work on. Her ICAP assessment score indicates that communication is a major life skill area in which Jamie should be supported to keep and gain skills. Jamie likes her housemates, one with whom she shares a hobby, and the other is one she tries to communicate with, as this housemate communicates nonverbally. This housemate provides her with a chance to learn about understanding communication in a different way. She can practice her communication skills at home in a natural way.

The group home is in a safe and quiet neighborhood. The housemates are able to walk in the neighborhood, and the neighbors on the block know them. The housemates had a garage sale last year that helped them establish connections with immediate neighbors. Going for walks after dinner on nice days (weather-wise) has been beneficial to Jamie's weight/health this past year. She also participates in dance class and yoga.

Jamie's mother stays in contact with her and household staff, and continues to take her to appointments. Jamie's sister and her family also are an important part of her life. She spends time with them on occasional weekends and for holidays.

Especially for Renewals and Amendments, collect ongoing supporting information when you visit

In the case of a renewal, avoid cutting and pasting from the last plan. Also, avoid cutting and pasting narrative from other individuals' plans. This will ensure that there are proper pronouns (example: he vs she) and that each Plan of Care is created for the individual.

In the case of a renewal, consider the events of life in the last year. Although there may not be significant changes in daily life, we must describe how the supports for the person have created a change for him or her. In the case of maintaining skills, or finding new skills, indicate how this was supported by services and what kind of incremental change the person experienced

.Best Practices when designing Plans of Care

To create a good Plan of Care, start with the person.

- ✓ What does the person want to see happen in his/her life?
- ✓ What is the person's goal? What can others do to support this?
- ✓ How can supports be involved?
- ✓ How are formal and informal supports helping or will help meet needs that were found in the assessment?

The Plan of Care conveys the services that are in place to support the person. It incorporates all services and supports, starting with what the person can do to help him or herself. The Plan of Care conveys Waiver services that are requested to support the person. A best practices approach is to consider:

1. What the person can do to help him/herself
2. What the family, friends, the community or technology can do
3. What support the waiver can provide

The Care Coordinator portrays a social history of the person in the Plan of Care, to include an informal assessment of health and safety risk factors as identified by the Care Coordinator.
Since the Plan of Care contains all supports available and utilized by the person, it is based on all resources, including formal and informal assessments, and the background information which brought the person to engage with the Home and Community Based Waiver.

When including waiver supports in the Plan, the Care Coordinator must consider combinations of services requested. Consider the schedule of the person's day. Are services duplicative of each other? Are services replacing what is done or could be done by other sources outside the waiver? If services are requested in combinations that happen on the same day, the Plan of Care or Amendment must indicate how services are not duplicative.

> Change occurs when one becomes what he is, not when he tries to become what he is not.
> ~Beisser (1970)

Developing Goals and Objectives for the Habilitative Services

Care Coordinators are required to portray measurable goals and objectives for all Habilitative services in the Plan of Care. Here are some basic guidelines to creating measurable goals and objectives. The examples given are for educational purposes. Each goal and objective developed will come from the person and his or her supportive team. Goals should be person centered.

What is a goal?
Consult the person and his or her supportive team to find out what the goal is. A goal is the end result that the person wants to achieve with the supports of the habilitative service. Because of this the goal needs to be meaningful to the person, and relevant to the service. The goal may be dependent upon supports in many areas of the person's life, not just waiver services. Plans of Care may include more than one goal. A suggestion is to consider choosing 1-3 goals for each habilitative service, with the thought that the person should be able to achieve them within 3-5 years. In this way goals and objectives can stay meaningful and relevant to the person's life and progress or maintenance of the goal. It is possible to change goals and objectives during a Plan of Care duration based on the person's direction. A goal contains a result that is a gain (rather than decreasing or stopping something such as a behavior). A goal is portrayed in a statement.

This example goal would be relevant to skill-building through the residential habilitative services:

"John would like to live in his own house someday."

It is acceptable to design a goal around a person's need or want to keep skills they already have (rather than skill-building). An example would be:

"John would like to continue choosing activities of interest to him."

(This example would be relevant to either the residential habilitative services or day habilitation.)

What is an objective?
An objective is one step that needs to be taken to move towards the goal. A person, the CC and supportive team can break down steps into pieces that are as small or large as needed. Each objective should contribute to the overall goal. Direct support staff will be helping the person achieve the goal through each objective. There may be more than one objective under each goal. Objectives are tailored to the specific learning needs of each person. The individual and the team will need to decide what objectives are best for working towards the goal.
Objectives use a sentence format that conveys the measurability of the progress towards the goal. They contain a **subject** and **verb**. They may describe an **action** and an **object** that receives the action. They also convey **frequency** and **duration** of the objective.

This example would be related to the example goal described above:

"John would like to live in his own house someday."

In this example we would meet with John and his supportive team to figure out what kinds of activities John would be working on in order to move towards his goal- to live independently. Part of this would be learning how to shop for one's own groceries.

> When it is obvious that the goals cannot be reached, don't adjust the goals, adjust the action steps.
> ~Confucius

Relevant objectives, portraying measurability:

John will review food in the pantry twice a week.
John will prepare a grocery list once a week.
John will shop for necessary groceries once a week.

What does "measurable" mean?
Measurable means that the person and his/her supportive team will be able to see progress or maintenance of the skills that are described in the objectives, through the documentation done by the direct support staff. Likewise, the Care Coordinator will be able to see progress, or maintenance, including relevance of the objectives to the person, in the documentation. This information will help with planning for habilitative services in the renewal Plan of Care.

What is "methodology and intervention"?
Methodology and intervention describes the support the person will need when working on these objectives. What will staff be doing? How is it best to help the person with skill building or maintenance? What methods will be used? What interventions (supports)? This section describes the action of helping direct support professionals. Methodology and intervention statements also use actions and objects that receive the action.

Here is an example that relates to the above objectives:

"Using a picture schedule, staff will remind John to check the refrigerator. Staff will review John's shopping list and discuss items. Staff will take John to the grocery store and remind him to buy items on the list. Staff will say "great choice John" when he selects items on the list."

How the objective will be measured/recorded:
Indicate what documentation will be kept to indicate the result of working on objectives with the person. Examples include, case notes, daily service notes, etc.

Frequency, duration and method of evaluation:
How often and how long will the supportive team and/or the person take a look at his or her progress and staff supports to see how the supports are working? Example: Once a week, John and his team will review progress in the case notes at a meeting of ½ hour.

Who is "Person responsible for implementation"?
This portrays the person who will be providing the supports. Staff, job coach, and case manager are all possible examples.

What is done for goals and objectives in a Renewal?
Review documentation of habilitative services during the previous Plan of Care. This is a great source for including service requests in a renewal. It is possible to use observation of progress to determine if services need to change or stay the same. Also, the Care Coordinator will need to address progress and/or maintenance in the narrative regarding habilitative services.

What if goals change during the current Plan of Care?
If a person wishes to change his/her goals or objectives during the current Plan of Care, work with the person and the supportive team to develop new goals and objectives. Document these (have the person and his/her legal representative as applicable sign the document to acknowledge changes) and keep the documentation on file to include in the renewal plan of care, or an amendment as applicable.

What is SDS looking for? Goals and the accompanying objectives must be:

- Person centered
- Measurable
- Based on information provided in Section III
- Adequate for the amount of services requested
- Relevant to the service being requested. For example, a goal of better oral hygiene with assistance in tooth brushing as an objective would not apply to a service that is intended to teach community inclusion. It would apply to a service that helps teach self-care skills at home.
- Relevant to the time of day or place in the person's daily routine. For example, goals and objectives are provided only for a morning routine but the service is requested to occur in the morning and again in the evening.
- For habilitative services that are 15 minute units, each 15 minutes needs to contain goal-related activity.
- The purpose of day habilitation is to provide community inclusion. Portray the specific skills the recipient will be practicing while participating in community activities.

Be Cautious of these types of goals:

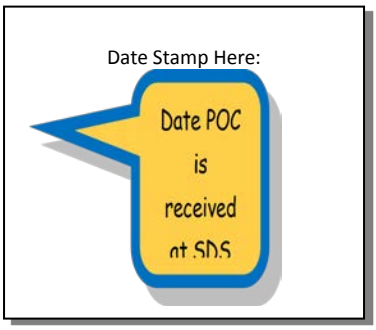
1) "NOT" or "Stopping" goals
2) Absolute goals
3) Subjective goals
4) The same goal for everyone in the program- is it truly something the person/guardian would like to work on?
5) Is the goal statement actually a goal or is it an objective?

UNIT 9

Visual Guide to the Plan of Care
Overview Sheets
Complete POC for IDD
Complete POC for ALI/APDD
Complete POC for CCMC

DOWNLOAD a PLAN OF CARE FORM AT
http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx

Always use the most current documents, found at http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx
The basic Plan of Care document itself should not be altered, with the exceptions of adding additional service blocks using cut and paste, and formatting to allow filling in forms (such as Xs in blocks). Also, you may insert relevant electronic documents, for example, a comprehensive service plan that supports a habilitative service.
If a service section does not apply, use N/A to indicate not applicable. Do not delete sections that don't apply. Make sure nothing other than "N/A" is written in the sections that don't apply. This is how reviewers will know that sections were not inadvertently left out.



SDS WAIVER PLAN OF CARE COVER SHEET

Complete the cover sheet, filling in all information blocks.
Check POC New, or Renewal.
Check Waiver type. Include Care Coordinator name and agency name.
Fill in LOC and POC start and end dates. POC dates are the same.
Indicate if new or renewal and if renewal, does this plan of care include only provider changes or no changes in services.

To be completed by Care Coordinator:

Recipient Name: _____

CC Name: _____

CC Agency Name: _____

POC Type: _____ **ALI - Alaskans Living Independently**

_____ **APDD - Adults with Physical and Developmental Disabilities**

_____ **CCMC - Children with Complex Medical Conditions**

_____ **IDD - Individuals with Intellectual and Developmental Disabilities**

_____ **Grant**

New_____ **Renewal**_____

If Renewal: **No Service Change** _____ **Provider Change Only** _____

LOC Start Date _____ **LOC End Date** _____

POC Start Date _____ **POC End Date** _____

Use the most recent SDS LOC to base this POC upon.

State of Alaska • Department of Health and Social Service • Division of Senior and Disabilities Services
Plan of Care (POC)

Legal Name (Last, First):

CCAN#: **POC Start Date:** **POC End Date:**

Fill in the header completely. It will automatically fill in on subsequent pages of the document.

Fill in the header section.
The CCAN (Care Coordination Assignment Number) is a unique identifier for all waivers. This identifier matches the recipient's demographic data in SDS' tracking system (DS3).
Ensure the CCAN is correct throughout the entire document.

Use recipient's full legal name, including middle name and/or initial, as indicated by the birth certificate or court acknowledged change due to marriage, adoption, etc.
If a nickname is used, include in parentheses. A nickname does not substitute for a legal name.
Note changes of the recipient's name from previous waivers or related documents. Provide a copy of related supporting court/legal documents, signed by the judge. If the name change is new, ensure DPA is notified.

All Plans of Care are based on information about the person provided in the Level of Care Assessment, as well as additional supporting documentation such as but not limited to IEP plans (for those in school), psychological evaluations, and Critical Incident Reports, and the interview with the person and/or their interdisciplinary team.

Complete all fields with correct current information.
Do not include Social Security number.
Provide current Height/Weight data.
Ensure correct date of birth.

Section I ~ Information

POC Type (Check one): **ALI** ☐ **APDD** ☐ **IDD** ☐ **CCMC** ☐ **Grant** ☐

Medicaid#: **DOB:**

Male ☐ **Female** ☐ **Married** ☐ **Single** ☐ **Height:** **Weight:**

Ethnicity: **Primary Language:** **Primary Means of Communication:**

Work-Phone: **Home-Phone:** **Cell-Phone:** **Email:**

Substitute landmarks or geographic location, i.e., *the blue house next to the village church* for village addresses where house numbers and streets are not named.
Indicate mailing address if different than physical address.
Do not use PO Boxes or alternate (neighbor/friend) mailing addresses. SDS mails copies of approved Plans of Care and other documents containing protected health information. These will go only to the recipient and his/her legal representative if applicable.
Assessment visits require accurate information about the person's physical location so the Assessor may visit.
Ensure that the recipient contact phone number (if applicable) connects to the physical location provided. Include email if recipient has an email address.

Recipient's Physical Address or directions to home in rural areas (No P.O. Boxes)

Address: **City:** **State:** **Zip:**

Mailing address if different than physical)

Mailing Address: **City:**

Correct address is needed because SDS mails out information to the recipient and legal representative. Define the legal representative's role and relationship.

Recipient's Legal Representative

Does the applicant want SDS documents mailed to the Power of Attorney (POA)? **yes** ☐ **no** ☐

Name: **Role/Relationship:**

Mailing Address: **City:** **State:** **Zip:**

Work-Phone: **Home-Phone:** **Cell-Phone:** **Email:**

Ensure the Emergency Contact provides at least one contact phone number.
A state (Office of Public Advocacy) guardian (if in place) is assumed to be the emergency contact.
If no emergency contact is selected, N/A is acceptable: Explain recipient's

Recipient's Emergency Contact

Name: **Relationship:**

Address: **City:** **State:** **Zip:**

Work-Phone: **Home-Phone:** **Cell-Phone:** **Email:**

School ***(If Applicable)***

School Name: **Contact Name:** **Phone:**

Address: **City:** **State:** **Zip:**

Identify only current school enrollment.

Employment ***(If Applicable)***

Place of Employment: **Contact Name:** **Phone:**

Address: **City:** **State:** **Zip:**

Identify only current active employment.
Do not include volunteering.

Care Coordinator

Name: **Agency:** **Work-Phone:** **Cell-Phone:**

Address: **City:** **State:** **Zip:**

Email: **Fax#:**

CM#: **CMG#:**

This is now the Provider ID # assigned by XEROX

This is now the Provider Group ID #

Ensure the identified Care Coordinator name matches all documents in the signature process unless otherwise specified/justified *(i.e. change in Care Coordinator during waiver application process).* Include a new completed Appointment of Care Coordinator form if the certified Care Coordinator has changed from the last Appointment of Care Coordinator Form on file.

Section II ~ Diagnosis & Medical

Primary Diagnosis including ICD code from the VOD or QDC:

Secondary Diagnosis including ICD code from the VOD or QDC:

Source(s) for diagnostic information (the medical professional** from the VOD or QDC**):

This should be the doctors who completed VOD's

Ensure Primary & Secondary diagnosis information is accurate, current, and supported by medical or psychological documentation. Ensure primary diagnosis matches the Level of Care (LOC).

Health Synopsis

Within a summary of health history over the past 12 months:

Ensure the health synopsis contains current information/narrative related to the person's health condition and needs.

Current information examples:

- ✓ Doctor's appointments,
- ✓ expected or unexpected health events,
- ✓ critical incidents,
- ✓ and/or improvements in health from the past year,
- ✓ emergency room visits,
- ✓ hospitalizations,
- ✓ surgeries or treatments (If applicable include description of scheduled or anticipated surgeries and/or treatments)

Provide scheduled health appointments and procedures from last year.
Provide information about health even if there was no significant change in health.
Quote the recipient's own concerns and viewpoints on his/her health if applicable.

Emergency Response and Back Up System

It is the recipient's responsibility to have a contingency plan.

I reside in a licensed residential living facility which has an emergency plan ☐ **Yes** ☐ **No**

I have discussed my personal emergency plan with my care coordinator. ☐ **Yes** ☐ **No**

Provide emergency response and backup system information. For example if using an Assisted Living home, refer to the emergency and evacuation plan in place through this service. If agency emergency plan is provided, explain how this plan will ensure the recipient's health and safety.

Examples: Indicate safety resources closest to the recipient, how the recipient will access these resources, and how these resources will know how best to assist the recipient.
If there are no services that provide an emergency plan, for example: people who live alone or with family/friends:

- Share resources with the person about emergency response in the person's community, such as Red Cross and local emergency shelters and evacuation procedures.
- Document how the recipient was assisted to understand and establish their own emergency response in the event of a natural disaster or other emergency.
- Indicate how this plan will adequately meet the needs of the recipient with specific regard to their living environment and physical ability to self-assist.
- Include the person's concerns for his/her own safety and level of risk.

EXAMPLE for an ALI waiver:
Mr. Green has expressed that he prefers to live alone in his own home. He has expressed concerns about how he can communicate his needs to emergency personnel if he were to need help. Regarding an emergency response and backup system, Mr. Green needs to have a reliable way to connect with supports in the event of a natural disaster such as an earthquake or other emergency that would mean he would need to evacuate his home, and to ensure that emergency personnel are aware of his needs should they be helping him
at his home in the event of an emergency. The following supports have been put into place:
Mr. Green has a list of emergency contacts to notify in case of need for evacuation. There is an emergency backup plan set up with his brother and sister, who live within 3 miles of his home. They are available to directly assist in case of emergency or natural disaster. Mr. Green will use his cell phone or home phone to call for help. There are sufficient exits in the home and emergency assistance numbers are posted. In his community, The Fire Department, and State Troopers have collaborated to provide an emergency protocol for persons with disabilities at home. The Care Coordinator has reviewed the Community plan of emergency protocols and evacuation with Mr. Green. Mr. Green has an "Emergency Info" kit- vital information in an "Emergency Info baggie" attached to the refrigerator door. An "Emergency Info" sticker is on the front door so that EMS services are aware of the info baggie on the refrigerator. The Care Coordinator will assist the Mr. Green in keeping updated info in the baggie. The Care Coordinator is also going to refer Mr. Green for personal emergency response system services.

Provide current information: first and last name of medical professional(s), address, and phone and fax numbers. (There are many "Dr. Smiths"!) Provide expected frequency of visits. Cut and paste to add blocks as necessary.

***Medical and/or Psychiatric Contacts* (Copy & paste additional table rows as needed)**

Include a fax number for a primary physician as well as a contact phone number for all providers listed.

Full Name	Address	Phone/Fax	Reason for Visits and frequency

Provide current medications. Provide dosage, reason prescribed, and level of assistance when recipient takes medication. Cut and paste to add blocks as necessary. Medications will likely change after the POC is written. This block is meant to provide a current list as of the time the POC was written.

Current Medications ***(Copy & paste additional table rows as needed)***

Current Medications	Dosage	Reason prescribed and prescriber	Means of administering & Level of assistance

7 AAC 130.305
Identify unfulfilled equipment needs and plans for acquisition. Include borrowed equipment. All requested SME is required to have written supportive contemporaneous documentation from a licensed physician, occupational therapist, physical therapist, a physician assistant, or an advanced nurse practitioner, that the specific item requested is appropriate for the recipient, consistent with the plan of care, and necessary to avoid placing the recipient at risk of institutionalization.
SME cannot be authorized if provided by regular Medicaid under DME provisions.
SME request must include specific model numbers, specifications, and/or manufacturer descriptions/ photos. Refer to current list of SME (fee schedule).

Adaptive Medical Equipment (DME/SME)

List all adaptive medical equipment currently in use/available to the recipient regardless of funding source:

List adaptive medical equipment needed, pending future request:

Environmental Modifications (EMOD's)

List all environmental modifications completed for this recipient regardless of funding source:

List environmental modifications needed, pending future request:

7 AAC 130.300
List all E-Mods completed for the recipient's use regardless of funding source.
Identify future E-Mod needs based on the current accessibility needs of the recipient.
Attach E-Mod request document if an E-Mod is requested. Refer to E-Mod section for additional information. Hint- E-Mods are usually requested on an amendment rather than the Plan of Care due to the extensive documentation required.

Provide current information about recipient resources and needs within all subject areas listed. Focus on the individual, keeping a person centered approach. The Care Coordinator is writing to address all areas as the voice of the person (and their interdisciplinary team). If the individual would like to include his or her own quotes in the plan of care, indicate that these are quotes, such as "(Person's name) reflections on this plan are quoted as follows". If quotes are included the individual must attend the planning meeting. Reference the assessment(s) you have reviewed to justify the need for services in each area.

Include information about incremental changes in the last plan, even if it is observed that there are no changes to the services requested. Include information about the impact that services had on the outcomes experienced through each topic area. For habilitative goals in new plans- use planning from previous sources such as grants, school plans, and informal sources. For non-habilitative services, indicate how the services have or will help the person achieve stated outcomes. For example if the goal is to be able to stay in one's own home as long as possible, state how this has been accomplished, or is expected to be (in the case of a new plan) achieved through the supports given in the plan.

Include other planning sources from the past year, and the present to include the impact or expected impact services will have in supporting the person. Writing should be original and not cut and paste from previous plans or sources. If using historical information, justify its impact with current facts.

SECTION III ~ Personal Profile

Recipient's Personal Goal:

The individualized service-planning process offers the recipient the opportunity to identify personal goal(s). Recipients request services to meet their identified needs, and achieve expected outcomes. Explain how the recipient prefers those services to be delivered. Include specific reference to functional abilities and needs for support as found in the assessments you identify below.

Include in the summary the recipient's:

- **Overall life situation, home environment & relationships**
- **Progress toward previous goals**
- **Desirable future outcomes**
- **Social environment: friends, hobbies, favorite activities, places, spiritual/cultural preferences, etc**
- **Functional abilities and strengths**
- **Situational limitations, and/or obstacles**
- **What works and does not work when providing direct support**
- **Critical behaviors if applicable. If so, what are their interventions?**
- **Any additional information that could impact the level, or type, of requested service(s)**

Write a summary of the client that addresses the specified areas.
Include in your summary a discussion of functional abilities and/or medical needs identified in the assessments you list on the POC. Be sure that you validate any needs for waiver support you will be requesting in this section. If this plan will have habilitative goals and objectives, be sure to relate them to something you write here.

Section III is where the Care Coordinator portrays the social history of the person.

Some of the areas in which you can draw information may include:

- ✓ Background information about the person's life- as it impacts this plan of care- such as:
- ✓ Family of Origin
- ✓ Birth and Childhood
- ✓ Marriages and Significant Relationships
- ✓ Current Living Arrangements
- ✓ Education
- ✓ Military Service
- ✓ Employment history
- ✓ Medical history
- ✓ Current health and Safety Risk Factors
- ✓ Legal History
- ✓ Social and Recreational Interests
- ✓ Religious Activities
- ✓ Personal Strengths, successes, and resources

Here are examples for 2 of the areas in the personal profile. The Care Coordinator will fill out ALL of the areas, with a paragraph or more describing life in that area for the person.

Overall life situation, home environment & relationships

Example: *Mr. Jones lives with Kindest Care ALH in Anchorage, Alaska. Occasionally his family visits him there for social interaction. He visits his adult son once a week on the weekend and stays for about 5 hours. He states that he has a positive relationship with his son and emotional support from his son's wife, her family and their friends. He likes to watch television and keep up with current local events. On an average day he watches TV, has the newspaper read to him and speaks with friends and family members, in person when they visit and on the phone. He likes social interaction.*

Situational limitations, and/or obstacles

Example: *Mr. Jones experiences functional limitations and mobility issues related to Stroke, Arthritis and HTN, per his diagnosis by Dr. Smith. His muscles and bones are in constant pain. They swell regularly, which causes difficulty in mobility as well. His CAT indicates that he uses a four footed walker for mobility within the home, and about 3 days per week he must rest in a seated position for approx 20 minutes after moving from one room to another. He makes every effort to move physically, but is limited by his medical conditions. Mr. Jones' cognition appears to be declining as he sometimes will choose to wear just a light shirt when intending to go outside in the winter, and need reminders that a warm coat is required. He also has been observed shaking salt on his pancakes instead of pouring syrup, as he is accustomed to do. Mr. Jones' CAT indicates cognition and memory changes in the time since the last assessment.*

Assessments Reviewed

List all assessments completed and reviewed in this planning process including source:

Example: *Consumer Assessment Tool, (also for example- ICAP Assessment, psychological evaluation, IEP, etc)*

The person centered approach considers community and natural supports to be primary. Document all non-waiver services provided or available to the recipient here. List community and natural supports.

Section IV ~ Summary of Non-Waiver Supports and Services

List all other services currently utilized by the recipient; regardless of funding source. Examples include but are not limited to: PCA, other regular Medicaid services, community/social programs, and family supports. The Plan of Care is an all-inclusive description of the recipient's life.

Does this recipient receive General Relief (GR) funds? ☐ **Yes** ☐ **No**

Natural/Family Supports ***(Copy & paste additional table rows as needed)***

Service	Provider of Service	Specific Service Frequency (Minimum of weekly avg.)	Total Service Duration (State exact # of weeks)
Transportation to all speech therapy appointments	***Guardian (mother)***	***3 hours per week (need to see weekly average rather than daily expected use)***	***52 weeks/year***

Description of service that will meet recipient needs identified in Section III:

Provide a description of service that will meet recipient needs identified in Section III.

- *What is it about the supports that will be given through this service that relates to the person's desired outcome or goal?*

This example shows how a natural support is depicted as providing a service.

Community Supports ***(Copy & paste additional table rows as needed)***

Service	Provider of Service	Specific Service Frequency (Minimum of weekly avg.)	Total Service Duration (State exact # of weeks)

Description of service that will meet recipient needs identified in Section III:

Personal Care Assistance (PCA)

PCA Type (Agency/Consumer Direct)	PCA Agency	Specific Service Frequency (Minimum of weekly avg.)	Date of last Assessment
Personal Care Assistance	*Vendor Agency 907-111-1234*	*10 hours per week (need to see weekly average rather than daily expected use)*	*July 1, 2013*

Description of service that will meet recipient needs identified in Section III:

Provide a description/justification of service that will meet recipient needs identified in Section III:
This must relate to factual information in Section III and to assessment findings.

- *Why does this person need this particular service?*
- *What is it about this service that is necessary for health and safety?*
- *What is it about the supports that will be given through this service that relates to the person's desired outcome or goal?*

Does the PCA plan contain instrumental activities of daily living (IADLS)? ☐ **Yes** ☐ **No**

Do any PCA providers reside with the recipient? ☐ **Yes** ☐ **No**

Are any of the PCA providers related to the recipient? ☐ **Yes** ☐ **No**
If yes, identify by name & describe relationship:

The name of the live-in PCA needs to be listed to avoid any conflicts with other services

Regular Medicaid (Copy & paste additional table rows as needed)

Service	Provider Agency	Specific Service Frequency (Minimum of weekly hourly avg.)	Total Service Duration (State exact # of weeks)

Description of service that will meet recipient needs identified in Section III:

Provide a description/justification of service that will meet recipient needs identified in Section III:
This must relate to factual information in Section III and to assessment findings.

- *What is it about the supports that will be given through this service that relates to the person's desired outcome or goal?*

Durable Medical Equipment and Medical Supplies; Related Services

Durable Medical Equipment (DME) is not a waiver service but can be included in the Plan as a support under Medicaid. DME is equipment that can withstand repeated use, and is primarily and customarily used to serve a medical purpose. It is generally not useful to the individual in the absence of an illness or injury, and is appropriate for use in the home, school or community. Examples are wheelchairs, hospital beds, and orthotics.

Medical supplies are supplies that are not designed or meant for repeated us, and are primarily to serve a medical purpose. Medical supplies are generally not useful to an individual in the absence of an illness or injury, and they are appropriate for use in the home, school or community. Examples are adult diapers, wipes and bedpans.
The individual's physician will prescribe the durable equipment and supplies. The Care Coordinator can gather information about the items and list this in the Plan of Care.

Other Supports (Copy & paste additional table rows as needed)

Service	Provider of Service	Specific Service Frequency (Minimum of weekly hourly avg.)	Total Service Duration (State exact # of weeks)

Description of service that will meet recipient needs identified in Section III:

Provide a description/justification of service that will meet recipient needs identified in Section III:
This must relate to factual information in Section III and to assessment findings.

- *What is it about the supports that will be given through this service that relates to the person's desired outcome or goal?*

Section IV-A ~ Summary of Non-Habilitative Waiver Services

List and fully describe all non-habilitation services. NOTE: These services should clearly and concisely communicate the strengths, needs, desires and plans for the recipient in such a manner that a provider could pick up the document and use it as a working tool to provide uninterrupted services.

Non-Habilitative Services (Copy & paste additional table rows as needed for each service requested)

Service	Provider Agency & Contact Phone#	Specific Service Frequency (Minimum of weekly unit average)	Total Service Duration (Exact # of weeks or date range)
Care Coordination	*Example Care Coordination Inc. 907-123-4567*	*2x/month visit POC development at LOC renewal*	*52 weeks*

Description/justification of service that will meet recipient needs identified in Section III:

Care Coordination is required to participate in the HCBW. Care Coordinator will assist the recipient in identifying choices for service providers and outcomes for service provision.

Expected outcome(s):

Mr. Jones experiences a person centered plan that is relevant to his needs as based on the assessments reviewed and interviews with the recipient.

Do any providers for this service reside with the recipient? ☐ **Yes** ☐ **No**
Are any of the providers for this service related to the recipient? ☐ **Yes** ☐ **No**
If yes to either question, identify by name & describe relationship:

This is the entire service block

"COPY AND PASTE ADDITIONAL SERVICE BLOCKS TO INDICATE ALL NON-HABILITATIVE SERVICES REQUESTED"

Service	Provider Agency & Contact Phone#	Specific Service Frequency (Minimum of weekly average)	Total Service Duration (Exact # of weeks or date range)
Residential Supported Living	*Kindest Care Assisted Living Home, 907-222-1234*	*Daily, 24 hours, 7 days a week*	*07.10.2013 – 07.09.2014*

Description/justification of service that will meet recipient needs identified in Section III:

Provide a description/justification of service that will meet recipient needs identified in Section III. This must relate to factual information in Section III and to assessment findings.

When composing your narrative under each service block, consider the following questions:

- *Why does this person need this particular service?*
- *What is it about this service that is necessary for health and safety?*
- *How will the supports given through this service relate to the person's desired outcome or goal?*

Take a person centered approach. Providers will refer to their service section for information about how to provide service and how to document what was provided. Recipients rely on the writing here to communicate what the service will do to assist them. Providers receive a copy of the POC or their section from the CC, per Distribution of Documents policy.

For example:

Mr. Jones needs the service of Residential Supported Living for this plan duration. He has lived with Kindest Care for the last year. He is comfortable with the staff at Kindest Care and states he is satisfied with their services. Mr. Jones states that his family is welcome to visit him at Kindest Care. He has a favorite staff person at the home. Due to his decline in cognition, Mr. Jones and his family feel that he should stay in the same living setting where his needs are known and he has familiar surroundings. Kindest Care ALH staff are experienced in supporting Mr. Jones regarding his changes in memory and cognition. Kindest Care also engages the service of Ms Marie, RN, who accomplishes training and medication delegation for staff serving Mr. Jones.

Expected outcome(s*):* *Mr. Jones will experience the best possible health and safety within a supportive Home living setting in his community, rather than living in a nursing home.*

Do any providers for this service reside with the recipient? ☐ **Yes** X **No**

Are any of the providers for this service related to the recipient? ☐ **Yes** X **No**

If yes to either question, describe: N/A

Please note: the Care Coordinator will list all non-habilitative services requested, by cutting and pasting service blocks, after listing Care Coordination. Plans of Care will not request every service available. The Plan of Care will request services based on information in the assessment, consultation with the person, availability of services in the home community, and regulations. This example Plan of Care does not list all possible services.

Section IV-B ~ Summary of Habilitative Waiver Services *(with Goals & Objectives)*

List and fully describe the services that will be provided to meet the needs of the individual as identified in Section III. The habilitative services provided along with the corresponding skill development should be linked to the needs identified in the profile and assessments. Home and Community Based (HCB) Waiver and Grant Funded habilitative services require specific learning or habilitation skills that are addressed through the goals and objectives in this section. Goals should have distinct methodology/procedures described, including parties responsible for implementation. One goal may be implemented across other services to assure continuity of services. The objectives must be measurable. Data collected, and how objectives will be measured, must be clearly described and made available for review upon request.

NOTE: These services should clearly and concisely communicate the strengths, needs, desires and plans for the recipient in such a manner that a provider could pick up the document and use it as a working tool to provide uninterrupted services.

Refer to the definition of habilitative services when writing narrative.

Definition: Habilitative services support the person to acquire, build or retain skills in the following areas, including but not limited to: Mobility/Motor skills, Self care/ Personal Living, Communication, Learning, Self direction/Social skills, Living skills/ Community Living, Economic self-sufficiency/ Vocational skills. Habilitative services support self-help, socialization and adaptive skills aimed at raising the level of physical, mental, and social functioning of an individual.

Habilitative Services (Copy & paste additional table rows needed for each service requested)

Service	Provider Agency & Contact Phone#	Specific Service Frequency (Minimum of weekly unit average)	Total Service Duration (State exact # of weeks)
Residential Habilitation Group Home	*Best Agency Inc 907-222-1234*	*Daily, 24 hours, 7 days a week*	*07.01.2013 – 06.30.2014*

Description/justification of service that will meet recipient needs identified in Section III:

This must relate to factual information in Section III and to assessment findings.

- *Why does this person need this particular service?*
- *What is it about this service that is necessary for health and safety?*
- *What is it about the supports that will be given through this service that relate to the person's desired outcome or goal?*

Do any providers for the service listed reside with the recipient? ☐ **Yes** ☐ **No**

Are any of the providers for this service related to the recipient? ☐ **Yes** ☐ **No**

If yes to either question, identify by name & describe:

Goal *(habilitative services)* related to this service:

Is this goal: ☐**New** ☐**Revised** ☐**Continued**

List objectives (steps of skill development or maintenance) which the person will use to reach the goal above.
Objective 1:

a) **List methodology/intervention for each objective. Indicate how supports will teach the skill(s).**

b) **Indicate how data will be recorded and measured for each objective.**

c) **Indicate how the objective(s) will be reviewed and evaluated, including frequency and duration of evaluation.**

What position(s) within the agency will be responsible for providing the supports for the above objectives?

Objective 2:

a) **List methodology/intervention for each objective. Indicate how supports will teach the skill(s).**

b) **Indicate how data will be recorded and measured for each objective.**

c) **Indicate how the objective(s) will be reviewed and evaluated, including frequency and duration of evaluation.**

"COPY AND PASTE ADDITIONAL SERVICE BLOCKS TO INDICATE ALL HABILITATIVE SERVICES REQUESTED"

☐**Providing agency certifies that the group home site is not requesting separate reimbursement for day habilitation service or any service provided by another resident of the group home.**

☐**Providing family home habilitation site is not requesting reimbursement for any other waiver services.**

☐**Providing agency certifies that the services of in home support habilitation or supported living habilitation are provided on a one to one basis.**

☐**Providing in home support agency is not requesting reimbursement for any other waiver service provided by another resident of the home or by the primary unpaid caregiver.**

Please note: the Care Coordinator will list ALL habilitative services requested, by cutting and pasting service blocks in this section. Plans of Care will not request every service available. The Plan of Care will request services based on information in the assessment, consultation with the person, availability of services in the home community, and regulations.

Complete for all recipients residing in a licensed home (full or part time) with date of admission included. Fill out all sections using NA for not applicable. Ensure that regulatory requirements for placement in this licensed home match the needs/age of person served - check box.

Contact information is required for the actual home's administrator/provider, not the main managing agency.

The staffing pattern should be described as shift staff or live in, 1 staff, 2 staff, etc, or occasional supplemental staff during a specific time period.

Section V ~ Out-of-Home Residential Services

Any recipient receiving waiver or grant funded out-of-home residential services (including residential supported living, group home, or family habilitation) must complete this section. The description of services and expected outcomes must be based on the recipient's needs identified in Section III.

Name of residential facility or family habilitation provider:

Administrator: **Cell-Phone:**
Office-Phone: **Fax#:**
Email:
Physical Address:
City: **State:** **Zip:**

Admission Date*:*

Description of staffing pattern, including how live-in and shift staff are scheduled:

Is this a state licensed home and is the license current as of the POC Start Date? **Yes** ☐ **No** ☐

Does this recipient's placement meet regulatory requirements for this licensed home? Yes ☐ **No** ☐
(i.e.: maximum number of persons in home, receiving care, child versus adult license, waiver type eligible for this service etc.)

Need	Service Provided by Residential Provider Include frequency & duration	Expected Outcome (If item covered in goal/objective, indicate)
Nutrition, Eating, Feeding	*3 meals a day/ one hour preparation and clean up. 1 to 2 snacks a day with 20 minute preparation and clean up.*	*Mr. Jones will eat a balanced low salt diet as indicated by his physician.*
Bathing/Hygiene, Grooming	*1 hour per day to assist with completing daily hygiene tasks as well as continual grooming throughout the day.* *Shower or bath once daily per direction of Mr. Jones.*	*Mr. Jones will remain healthy and safe in the home environment.*
Toileting/Incontinence	*Reminders, once a day 10 minutes after eating. Direct assistance when needed after BM.*	*Mr. Jones will keep his current independence skills in self care re: hygiene as long as possible*
Skin Care	*10 minutes a day to apply needed ointment*	*Mr. Jones will care for his face by using prescribed skin care regimen*
Dressing	*Reminders, twice a day, 10 minutes*	*Mr. Jones will choose clothing appropriate to the weather*
Mental Status, orientation, memory, behaviors	*Continual supervision throughout the day.*	*Mr. Jones will experience safety and a routine at home with which he feels comfortable.*
Medication Management/ Supervision/Assistance	*Staff will place medication for Mr. Jones, and remind him to take his medication.* *2 times daily for 10 minutes.*	*Mr. Jones will remain in optimal health by following his medication prescription.*
Laundry/Chores	*3 hours per week for laundry tasks, completed by staff.*	*Mr. Jones will live in a safe and clean environment*
Mobility/Ambulation, Safety	*Continual Supervision and support throughout the day.*	*Mr. Jones will receive residential service in a safe environment.*
Socialization	*1 hour per day and supports as needed.*	*Mr. Jones will maintain family ties and friendships. Mr. Jones will have the opportunity to socialize with others at the home.*
Other Needs (e.g.: weight, vital signs, treatments, skin/wound care, etc.)	*Support as needed and directed by physician/nurse*	*Mr. Jones will remain in a safe environment and experience the best possible health.*
Other Needs (e.g.: monitor seizure activity, chest pain, etc.)	*N/A*	*N/A*
Transportation/Medical Appointments	*As needed and scheduled.*	*Mr. Jones will receive transportation to participate in activities and to attend medical appointments as scheduled.*
Communication with other caregivers	***The care coordinator, team members, and physician are kept informed of changes in Mr. Jones' condition. The residential provider, caregivers, and family will provide needed information.***	***Care coordinator, team members, and physician are able to respond to changes in client condition.***

Section VI ~ Planning Team

List all members of the planning team. The planning team must include the recipient, the recipient's legal representative if applicable, the certified Care Coordinator, and representative of each certified provider that is expected to provide services, excluding transportation, environmental modification and specialized medical equipment providers (per 7 AAC 130.217). Each planning team member must sign the Plan of Care.

Name	Role/ Agency	Phone	Consulted by			
			In-person	email	phone	videoconference
	Recipient					
	Legal Representative					
	Care Coordinator					
	Natural Support					
	NOCM Nurse (if applicable)					
	HCB Agency Name:					
	HCB Agency Name:					
	HCB Agency Name:					
	HCB Agency Name:					
	HCB Agency Name:					
	HCB Agency Name:					

Type in the name of the HCB provider agency

Please note Transportation, SME and EMOD providers are not required to attend the planning meeting.

However the Transportation providers must sign the Plan of Care acknowledging their capacity to serve. SME, EMOD and IAT providers must submit to the CC a signed document that includes detailed information (including costs) of the services they intend to provide. This must be included with the POC for approval.

Most often the grant POC is filled out by the case manager at the agency providing the grant funded services.

- CCs may complete a grant POC.
- This section is Not Applicable for waiver POC.
- If applicable, Recipient/guardian signature required.
- **Grant plans stop here.**

Section VII ~ Grant Funded Agreement

To be completed if this Plan of Care is for GRANT FUNDED SERVICES ONLY. All others continue to Section IX, Recipient Choice of Service.

This Individualized Plan of Care has been carefully planned and coordinated with the active involvement of the recipient served. Necessary personnel and the recipient served will be involved in the evaluation of this plan's continuing appropriateness.

I, or any member of my team, may request another meeting at any time during the next 12 months to make changes to this plan. Unless otherwise stated, I am in agreement with this Plan of Care as written.

Recipient Signature	Date	Parent or Legal Representative	Date
Care Coordinator	Date	DD Grantee Agency Representative	Date

Section VIII ~ Recipient Choice of Service: **To be completed by Waiver Recipient. Please read, check each statement indicating understanding, and select your service choice.**

Having a completed or approved Plan of Care does not guarantee eligibility for Medicaid Services. HCB Waiver Recipients must continue to meet Division of Public Assistance annual financial eligibility requirement. In addition, certified and enrolled providers must be available to provide services.

I understand that:

___This is an application process to find out if Medicaid will pay the cost of my long-term care services.

___If I am found eligible, and if services are available to me in my community, I may choose to receive:

The services described in this Plan of Care, OR
Care in an institutional facility, OR
Community services only, OR
No Medicaid or community services at all.

___If I choose to receive institutional care, my care coordinator will help me select a facility to meet my needs.

___If I chose to receive Medicaid Home and Community Based Waiver services, my care coordinator has given me a brochure describing what waiver services are.

___If I chose to receive Medicaid Home and Community Based Waiver services, my care coordinator has given me a list of certified providers in my community that I may choose to deliver my services.

___If I choose to receive Medicaid Home and Community Based Waiver services, the Division of Senior & Disabilities Services staff will review my case annually to see if I meet the Level of Care eligibility requirements. They will also evaluate the services requested in my Plan of Care each year to be sure they are appropriate to meet my needs.

___ If I choose to have no Medicaid Home and Community Based Waiver services, but do want to have Community services that are available where I live, my care coordinator, DSDS grantee agency, or DSDS staff will assist me to find participating agencies.

___I have the right to consult with whomever I choose before making this decision, including friends, relatives, and advocacy organizations, and that I may authorize any of these people to contact the care coordinator or DSDS staff to provide information in helping me make this decision.

___ If I choose Medicaid Home and Community Based Waiver services, but I am denied services, I may still be eligible for care in an institutional facility.

I choose to receive (Check only one):

___ **Medicaid Home and Community Based Waiver Services**

___ **Services in an institution or nursing facility**

___ **Non-Medicaid Waiver Community services only**

___ **No Medicaid or community services**

The recipient can either check or initial each line. Initials are preferred.

Section IX ~ Signatures:

This Individualized Plan of Care has been carefully planned and coordinated with the active involvement of the recipient served. It has been explained that the intended purpose of this plan is to help the recipient maximize his/her independence and lead a fulfilling life. Necessary personnel, and the recipient served, will be involved in the evaluation of this plan's continuing appropriateness. It has been explained that each member of the planning team will receive, or have access to, a copy of the final Plan of Care.

By signing below, I certify that the information included in this Plan of Care is true and accurate to the best of my knowledge. I have been informed of any familial or business relationship between the care coordinator and any HCB provider.

Recipient Signature	Date	Parent or Legal Representative	Date
Care Coordinator	Date	Other Natural Support	Date
NOCM Nurse (if applicable)	Date	Printed Name	
HCB Agency Representative	Date	Printed Name	Agency Name
HCB Agency Representative	Date	Printed Name	Agency Name

Two witnesses are required if recipient signs with an X or a stamp. The Care Coordinator may not serve as a witness.

Witness Printed Name	Signature	Relationship	Date
Witness Printed Name	Signature	Relationship	Date

STATE OF ALASKA USE ONLY

This plan has been processed for prior authorization.

DSDS Representative	Position	Date

The Plan of Care is a communication tool betwee**n individuals and providers, facilitated by the Care Coordinator**. All service providers must sign the Plan of Care.

The purpose of signing the plan of care is to agree to provide the service as indicated in the plan (frequency, scope and duration).

Providers who indicate this on documents outside the plan of care are:

- Intensive Active Treatment: 7 AAC 130.275
- SME: 7 AAC 130.305
- EMOD: 7 AAC 130.300

The signature for these providers only may appear on the work order, contract, treatment plan, or service agreement which indicates the specific service/product they are going to provide.

These documents are required in regulation under each service as part of the service request.

Provider signature (to include transportation) on the plan is 7 AAC 130.217 (4)(B)

Service Overview Sheets

Waiver Service Overview sheets function as a comprehensive list of all services requested in the Plan of Care- or the Amendment. The codes listed are billing codes for that service. The unit value column shows how that service is divided into units. The unit rate is current according to the DHSS, Office of Rate Review. You must enter the exact amount of units as they are being requested on the Plan of Care or Amendment.

Overview sheets are always included as an attachment to the Plan of Care or Amendment. You can find the most current overview sheet at http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx . It is highly recommended to begin with a new sheet at each POC year.

Recipient Name:		Medicaid#	Waiver Type:	Initial POC
Address:		SDS ID#	POC Start Date:	Renewal POC
City, State, Zip:		**HCBW Services Overview & Cost Sheet**		Amendment POC
Date of Birth:		Department of Health & Social Services - Senior & Disabilities Services		

List Only Certified/Enrolled HCBW Agencies	Enterprise Billing #	POC Service Start Date:	POC Service End Date:	TYPE OF HCBW SERVICE	BILLING CODE	UNIT VALUE	Unit Rate	Units	TOTAL COST
				Care Coordination Monthly Case Management	T2022	1 Monthly	$240.77		
				Screening	T1023	1 Initial	$90.33		
				Plan of Care Development	T2024 U2	1 Annual	$384.81		
				Nursing Oversight & Care Management < 200 miles	T1016 CG	15 Minute	$22.38		
				Nursing Oversight & Care Management > 200 miles	T1016 TN	15 Minute	$88.95		
				Assisted Living Home (RSL)	T2031	1 Day			
				Assisted Living Home Acuity Rate Add-on (RSL)	T2031 TG	1 Day	$350.81		
				Family Home Habilitation ~ Adult *(18 & older)*	S5140	1 Day	$119.93		
				Family Home Habilitation ~ Child *(17 & under)*	S5145	1 Day	$150.01		
				Group Home *(18 & older)*	T2016	1 Day	$316.86		
				Group Home Acuity Rate Add-on *(18 & older)*	T2016 TG	1 Day	$350.81		
				Supported Living *(18 & older)*	T2017	15 Minute	$10.66		
				In-home Supports *(17 & under)*	T2017 U4	15 Minute	$10.66		
				Intensive Active Treatment (IAT) < 200 miles	H2011 CG	15 Minute	$22.38		
				Day Habilitation *(one-on-one support, age 3 and up)*	T2021	15 Minute	$10.71		
				Day Habilitation *(group of 2 or more, age 3 and up)*	T2021 HQ	15 Minute	$7.50		
				Supported Employment *(one-on-one support)*	T2019	15 Minute	$12.12		
				Supported Employment *(group of 2 or more)*	T2019 HQ	15 Minute	$8.49		
				Pre-Employment *(one-on-one support)*	T2019 CG	15 Minute	$12.12		
				Pre-Employment *(group of 2 or more)*	T2019 TT	15 Minute	$8.49		
				Chore Services (10-hours per week max)	S5120	15 Minute	$6.70		
				Adult Day Services, 1-4 hours *(must be billed first)*	S5101	Half-Day	$84.11		
				Adult Day Services (time exceeding 4-hour half-day)	S5100	15 Minute	$5.25		
				Meal, Home Delivered (limit x2 per day)	S5170	Per Meal	$21.77		
				Meal, Congregate (limit x2 per day)	T2025	Per Meal	$21.15		
				Escort *(travel companion for the recipient)*	T2001 SE	1 Way Trip	$14.74		
				Transportation < 20 miles one way	T2003	1 Way Trip	$14.74		
				Transportation > 20 miles one way	T2003 TN	1 Way Trip	$29.48		
				Transportation (Paratransit) one way	T2003 CG	1 Way Trip	$29.48		
				Specialized Private Duty Nursing (RN)	T1002 U2	15 Minute	$20.00		
				Specialized Private Duty Nursing (LPN/LVN)	T1003 U2	15 Minute	$18.75		
				Agency Based Respite	S5150	15 Minute	$6.26		
				Family Directed Respite	S5150 U2	15 Minute	$4.22		
				Agency Based Daily Respite	S5151	1 Day	$299.78		
				Family Directed Daily Respite	S5151 U2	1 Day	$202.68		
				Environmental Modification *(EMOD)*	S5165	As Approved			
				EMOD Administration Fee *(only when applicable)*	S5165 U2	As Approved			
				SME *(list individually from approved SME schedule)*	See Schedule	As Approved			
						Waiver Subtotal			$0
Regional Rates: Find the applicable agency region location below & enter the percentage factor provided here >>>>>>>>>>>>>>>>>>>>						Regional Factor			
						Grand Total			$0

Fairbanks (1.03)	Kodiak (1.12)	Anchorage/Wasilla/Palmer (1.0)
Delta Junction/Tok Region (1.04)	Arctic Region (1.48)	Ketchikan/Sitka/Juneau (1.09)
Roadless Interior (1.31)	Bethel/Dillingham (1.49)	S.E. Mid-Size/Small Communities (1.09)
Kenai Peninsula (1.01)	Aleutian Region (1.50)	
Prince William Sound (1.08)	S.W. Small Communities (1.44)	

1. Start by filling out the top section.
2. Then indicate the services the person is requesting on the Plan of Care by:
    a. listing the provider on the left column
    b. their Xerox billing ID# (you can find this in "Search for a Provider" on the SDS Webpage)
    c. enter the service start & end date
    d. Enter the total units requested on the Plan of Care
3. Then calculate the units by the unit rate in the total cost column.
    a. To increase the functionality of the sheet, enter =I7*K9 in the CC Monthly row
    b. Then copy to all the other lines in the total cost column
        i. STOP before you reach the Waiver Subtotal row
4. If your client is requesting RSL please enter the rate; double check with the home

5. The Waiver Subtotal line should auto calculate
6. If you have a regional rate adjustment, enter the factor and it should auto calculate

Care Coordinators may add blocks to this list, for example if a person is requesting to receive one service from 2 different providers.

1. Copy the entire line of the service being provided by a 2nd agency
2. Paste it directly below the 1st agency

Services not requested may be deleted from the Overview form.

Overview sheets MUST match the services & units requested on the POC!!!

Become familiar with the unit size of the service you are requesting. For example, day habilitation is a 15 minute unit. If the person will have one hour of day habilitation- that means he or she will be requesting 4 units of day habilitation.

Please include each provider's Medicaid billing ID#

Be aware of group vs. individual services- make sure your request them appropriately

You can consider using a calculation website such as http://www.timeanddate.com/ to calculate the exact number of units and how they are planned to be used across the level of care duration.

Remember that a POC or Amendment cannot be submitted without an overview sheet…

Helpful Reviewer hint: Match the order of services on the overview sheet to the POC.

Plan of Care submission guidelines

If the person is found to meet Level of Care the Care Coordinator will receive a notice (letter) of a current Level of Care determination and a copy of the Assessment summary from SDS. This LOC will be active for up to one year from the date of issue –refer to the letter.

The Care Coordinator develops and submits a Plan of Care within 60 days of initial Level of Care determination per regulation **7 AAC 130.217 Plan of care development and amendment.** Annually re-newed POCs are due to SDS 45 days prior to current POC expiration.

Plan of Care Start and End Dates

The Plan of Care start date is the date of the initial Level of Care determination date, and ends 365 days later.

Contents for an IDD submissions:

Form #	Form or document	IDD Initial- LOC	IDD POC	IDD Reapply
Uni-01	Plan of Care All Waivers		X	
Uni-05	Appointment for CC Services	X	X if diff	X if diff
Uni-07	Recipient Rights and Responsibilities		X	
Uni-10	Care Coordination Request for Visit Exception		X If	
HSS-06-5870	ROI- CC releasing info to SDS	X		X
IDD-03	ICAP Assessment Info and Consent	X per age		X per age
Uni-14	Services Overview		X	
IDD-10	Interim ICF/IID Level of Care Determination	X per age		X per age
IDD-13	QDC Qualifying Diagnosis Certification	X		X
Legal Rep documents	POA for healthcare (not just "PCA") Signed. Guardian= judge's seal	X	X if diff	X if diff
Medical information	Per waiver type	X	X if diff	X if diff
Diagnostic evaluation	Per waiver type	X	X if diff	X if diff
Documents for services	EMOD, SME,day hab res exclusion		X	
IDD unit request	Most recent LOC letter		Best practice	

starting July 1, 2016 - include UNI - 15 Plan of Care Questionnaire

Scan completed POC with attached documents through DSM to:

'IDD Anchorage' or ***outside of Anchorage & MSSCA*** **to 'IDD Fairbanks'**

In the event that a person chooses to receive services in an ICF/IID (also known as an Intermediate Care Facility for Individuals with Intellectual or Developmental Disability) he or she will eventually transfer to an SDS Care Coordinator. During the planning stages to receive services outside the state of Alaska, the current CC and the State CC will work together per the policy **ICF/MR Placement** http://dhss.alaska.gov/dsds/Documents/policies/ICFMRPlacement.pdf .

Contents for an ALI or APDD submissions:

Form #	Form or document	ALI Initial-	ALI POC	ALI Reapply	APDD Initial-	APDD POC	APDD Reapply
Uni-01	Plan of Care All Waivers		X			X	
Uni-04	Waiver Application for Ali/APDD/CCMC	X		X	X		X
Uni-05	Appointment for CC Services	X		X if diff	X		X if diff
Uni-07	Recipient Rights and Responsibilities	X		X	X		X
Uni-09	Verification of Diagnosis	X		X	X		X
Uni-10	Care Coordination Request for Visit Exception		X			X	
HSS-06-5870	ROI releasing gathered info TO SDS	X		X	X		X
HSS-06-5870	ROI releasing info FROM primary physician TO SDS	X		X	X		X
Uni-14	Services Overview		X			X	
Legal Rep documents	POA for healthcare (not just "PCA") Signed Guardian= judge's seal	X if any	X if diff	X if diff	X if any	X if diff	X if diff
Medical information	Per waiver type	X	X if diff	X			
Diagnostic evaluation	Per waiver type				X	X if diff	X
Documents for services	EMOD, SME,day hab res exclusion		X			X	

Starting July 1, 2016, include UNI - 15 Plan of Care Questionnaire

Scan completed documents through DSM to: **NFLOC- initial**

If you are completing a renewal scan & DSM to: **NFLOC- renewal**

ALI and APDD information can also be faxed to 269-6246

Contents for a CCMC submissions:

Form #	Form or document	CCMC	ALI	ALI
		Initial-	POC	Reapply
Uni-01	Plan of Care All Waivers		X	
Uni-04	Waiver Application for Ali/APDD/CCMC			X
Uni-05	Appointment for CC Services		X	X if diff
Uni-07	Recipient Rights and Responsibilities		X	X
Uni-09	Verification of Diagnosis		X	X
Uni-10	Care Coordination Request for Visit Exception		X	
HSS-06-5870	ROI releasing gathered info TO SDS	X		X
HSS-06-5870	ROI releasing info FROM primary physician TO SDS	X		X
Uni-14	Services Overview		X	
Legal Rep documents	POA for healthcare (not just "PCA") Signed Guardian= judge's seal	X if any	X if diff	X if diff
Medical information	Per waiver type	X	X if diff	X
Diagnostic evaluation	Per waiver type		X	X
Documents for services	EMOD, SME,day hab res exclusion		X	

Starting July 1, 2016 include UNI - 15 Plan of Care Questionnaire

Scan completed documents through DSM to: **NFLOC- initial**

If you are completing a renewal scan & DSM to: **NFLOC- renewal**

CCMC information can also be faxed to 269-6246

UNIT 10

Amendments
Annually Renewing the Waiver
Material Improvement Review Process
Closing a Waiver
Ending Association with a Client
Fair Hearing Rights

The Amendment Document

If an individual wants to make a change to his/her service provider, type of service, or amount of service, The Care Coordinator will prepare an Amendment to the Plan of Care.

The Amendment plan of Care form is found at http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx
Use this form to request changes to the services, vendors (providers), or amounts of services in a current approved Plan of Care. The Amendment form is very much like the Plan of Care form. It asks for a summary of changes first, then a description of services with service blocks as seen on the Plan of Care itself.

An Amendment also requires the Service overview sheet. The Service Overview sheet needs to include all current services which are ending, new services that are starting, and any ongoing services that are not changing. Start and end dates as applicable will be included on the Service Overview sheet.

An Amendment is created for any requested change in provider, type of service, or frequency amount and duration of a service. Submit only one Amendment when multiple changes are requested (as long as the Care Coordinator knows about the person's desire to request the change). It is not necessary to submit a separate Amendment for each change requested.

Per 7 AAC 130.217 Plan of Care Development and Amendment:

Amendments are required within 10 business days of the change

- if a change is needed to meet needs due to change of circumstances related to health safety and welfare
- Or -/+ amount of existing services is needed

- CC uses POCA (plan of care amendment form)
- Recipient/legal rep signs the form
- Any providers listed on the POCA must also sign
- If there are unusual circumstances that mean a delay of +10 days they must be documented and provided to SDS

Here are some questions that Care Coordinators should consider for portrayal in an amendment (or renewal) Plan of Care:
(Except transportation and respite- these services are delivered as needed)

Did the person receive all the services on the plan, in the amount and frequency that was previously planned? If not, what circumstances prevented the service being delivered as originally planned? (e.g. changes in recipient health, lack of direct service workers, etc.)

If services were not utilized during the past plan year and these services remain on the new plan, the Care Coordinator should address choice and what actions can be done to advocate utilization of wanted/needed services. There should be grounded reasons to keep the services on the new plan.

Portraying changes for amendments and renewals

TIP: If a person is not using services, end them with an Amendment. When should services end? For services used frequently such as Group Home: as soon as the Care Coordinator is aware of the change, an amendment should be started and submitted. Within 2-3 months is a good guideline for submitting an amendment for ending an intermittent service. The Care Coordinator can trouble shoot to help service be delivered, and can help the person understand considering a reduction in the amount. The person can always request to add the service again later. Also, the Care Coordinator should let providers know that services are changing. For example, personal emergency response system providers- people may move and not use the service- and the provider cannot bill for it even thought they were unaware it was not being used. Check on monthly visits to see if person has added new programs that are helpful- such as PCA services, or even unpaid family or community members who are helping the person. Remember that HCBW cannot duplicate other services regardless of source.

For increasing services requested, relate the request to the assessment and actual circumstances the person is facing. What has changed in his/her health that would create this need? What has changed in regards to previous supports? Be specific. What has created the need for the increase?

Also, portray the reasons for requesting changes. State what the team has discussed and why the changes are requested. Relate the request to factual information. It needs to be stated why the request is being made, giving reasons.
Example: **"Because of (problem or circumstance), we are adding, reducing, increasing, etc."**

Remember, the waiver reviewer has only the information you provide in the Plan of Care and associated documents in order to understand what level of service is being requested. The Care Coordinator will need to clearly and concisely portray these factors.

Your narrative should remain person-centered. You may need to take into account cultural considerations. For example the use of pronouns such as he/she, or the repetition of an individual's name may feel disrespectful to the individual/family/legal rep. it is fine to acknowledge in the Plan of Care how the person would like to be represented in the plan's narrative.

From Section III:

Here is an example which portrays reasons for service changes in the Plan of Care:

Information in regard to changes in service hours for this POC:
Jamie has decided that she would like to have a job in the community. She realized she needed to change her schedule. She would like to participate in day habilitation three mornings a week, and pursue job training skills in the afternoons. For this POC duration, she will continue to work 5 days a week, unless she is participating in a job search activity. Also, during the afternoon work time, she will participate in several job exploration activities in the community.

As a result of these changes in her schedule, her work hours are being maintained, and her day habilitation units reduced. Therefore, the amount of day habilitation units requested have changed.

This is also reflected in the service request block and on the overview sheet.

Here is an example which described progress toward previous goals and objectives.

- **Summary of progress toward previous goals & objectives**

Care Coordinator: As stated in the "desirable future outcomes" section from last years' POC, increased independence in doing her own laundry at home is important to Jamie. Jamie wants to make sure she has her clothing folded and hung up in the way she prefers. Jamie likes her pants to be neat and wrinkle free. She likes to place them on hangers in the closet rather than waiting for help with the clothes iron. Jamie's goal and objective for the group home service have changed.

Here is an example for discontinuing a goal that is no longer relevant to the person:

Group Home:

Over the last year, Jamie has made considerable progress towards goals and objectives. Although she sometimes does not want to place her dishes in the dishwasher after a meal, it is observed that she knows how to complete this task. Staff can redirect Jamie and use encouragement to remind her. Sometimes Jamie will state No and will not complete this task. Jamie and her team feel that loading the dishwasher no longer needs to be a goal for the next waiver year.

Environmental modifications are most commonly requested as an amendment, which gives time for the process. Specialized Medical Equipment can also be requested on an amendment. Respite is most commonly requested on the Plan of Care.

Waiver Service Overview sheets for Amendments

The overview sheet from the current POC is updated to reflect the change in providers or services. The updated sheet must be included with the Amendment request.

The Waiver Services Overview sheet is simply a list of what the person is requesting- in this case- the amendment- they are requesting one of the following things to happen:

Change in service amount

New service, change in existing service- requesting ADDITIONAL units
Ending a service or requesting LESS units

Change in service provider

Going from one service provider to another, for a service already approved

Adding a provider for a prior authorized service

such as deciding to use 2 separate providers for the same service

Annually Renewing the Waiver

SDS requires the Care Coordinator to submit a complete renewal application 90 days before the current Plan of Care expires. Submitting these documents allows the recipient to acknowledge their choice to continue with the waiver and the State of Alaska assessor time to review the current information and documents. If the recipient's condition changes after the renewal application is submitted the SDS office will accept updated documents to reflect the most recent condition.

The CC MUST include updated medical and functional information with each re-application.

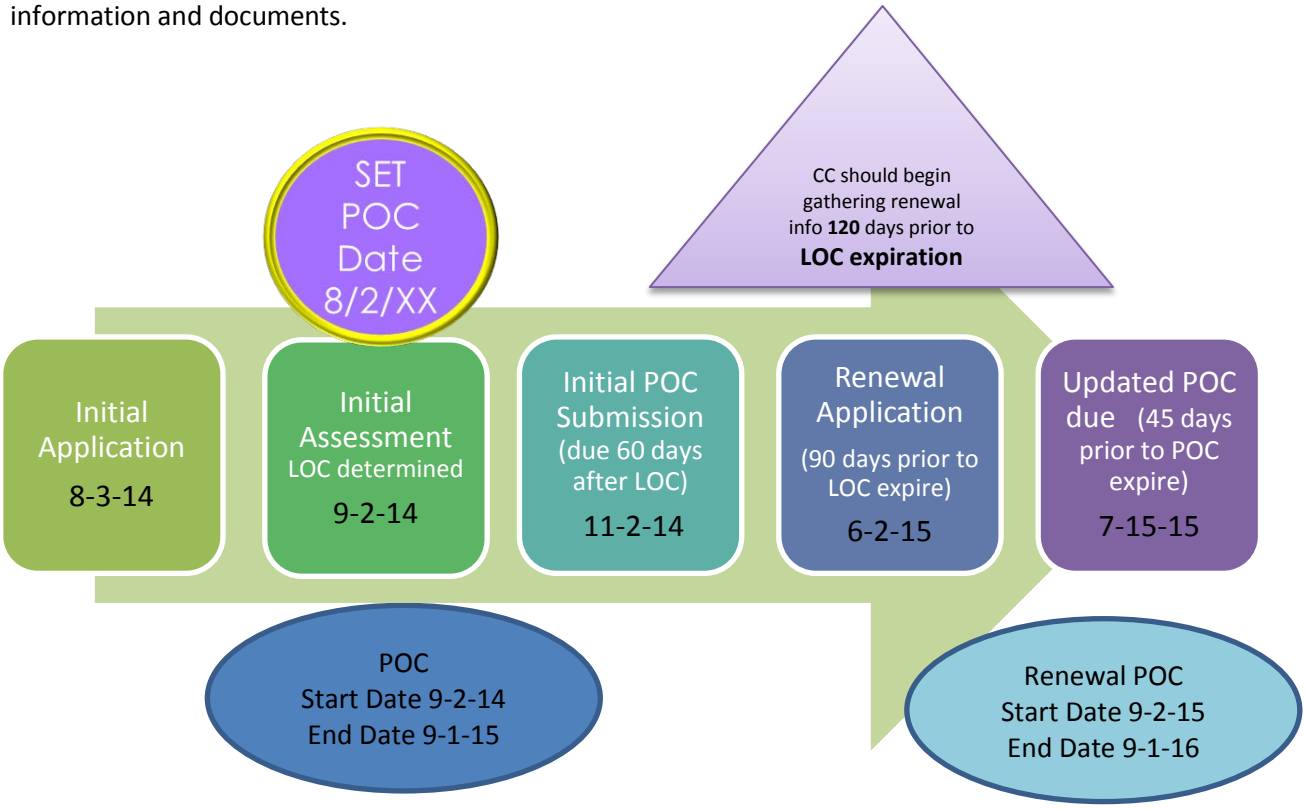
Here is a list documents and information to consider submitting when updating current information in the renewal application to prepare for the annual assessment.

- Documentation including new diagnosis or treatments from medical specialists the recipient has consulted
- The treatment schedule and provider for any physical, occupational or speech therapy the client is receiving
- The reason and outcome for any emergency room visits or hospitalizations
- The reason for and usage of any new equipment the client has received
- List of current medications, including reason prescribed
- Any changes in living situation or natural supports from previous year assessment
- Current Individualized Educational Plan (IEP) if receiving Special Education Services
- Any additional documentation that supports the diagnosis

Participants need to reapply annually for continued HCB Waiver services. They must sign the renewal Application and associated forms to show their choice to continue on the HCB Waiver.

- IDD Waivers will complete ICAP Info & Consent or the Interim ICF IDD LOC depending on the ICAP cycle
- ALI, CCMC & APDD Waivers must complete the Waiver Application form UNI-04

Submit these documents in the required timeframes, 120 days prior to and not later than 90 days before the EXPIRATION of the current approved **Level of Care**. This allows the SDS assessor time to review the current information and documents.



Re-Assessment of the ALI, APDD and CCMC Level of Care (NFLOC)

The SDS Assessor will visit the person and use the CAT to conduct the assessment. The Assessor will consider other kinds of information about the person's health care needs and outcome of the Waiver service, such as medical records, and the feedback of the person's supportive team.

* Please note the assessment may occur anytime and will not coincide with the current Plan of Care dates.

CC should refer to their monthly status report to verify the set POC date and the last LOC or assessment date.

You will have 2 dates to track for renewal of each client.

1. Level of Care- good for one year from the date it is approved
2. Plan of Care- good for one year. The Plan year is "set" by SDS.

Update the Plan of Care

Renewed POCs are due to SDS 45 days prior to POC Expiration so they can be reviewed prior to expiration, to maintain the services. The Start and End dates of a POC are "Set" even though the LOC date may change through years of waiver service.

<u>Most common issues with incomplete POCs</u>

- incorrect signatures
- missing the cost overview sheet
- cost sheets filled out incorrectly or not matching the units listed/requested within the plan of care., dates are wrong, missing enterprise number- forgetting to add services or putting services on the overview that are not in the POC
- checks on the choice of service page are blank
- the final signature page is blank
- recipient's rights and responsibilities form missing (IDD waivers)
- hard to read faxed plans, USE DSM whenever possible
- providers don't identify themselves on signature page – should be the same person on the planning team
- not sending complete packages (dribbling in signature pages, etc.)
- POC that do not take into account amendments that were requested- when requesting services
- Lack of updates and contemporaneous information or documentation (cutting and pasting last year's plan)
- Incomplete forms, including unmarked mandatory checkboxes
- Narrative content needs to match services requested in POC

Other

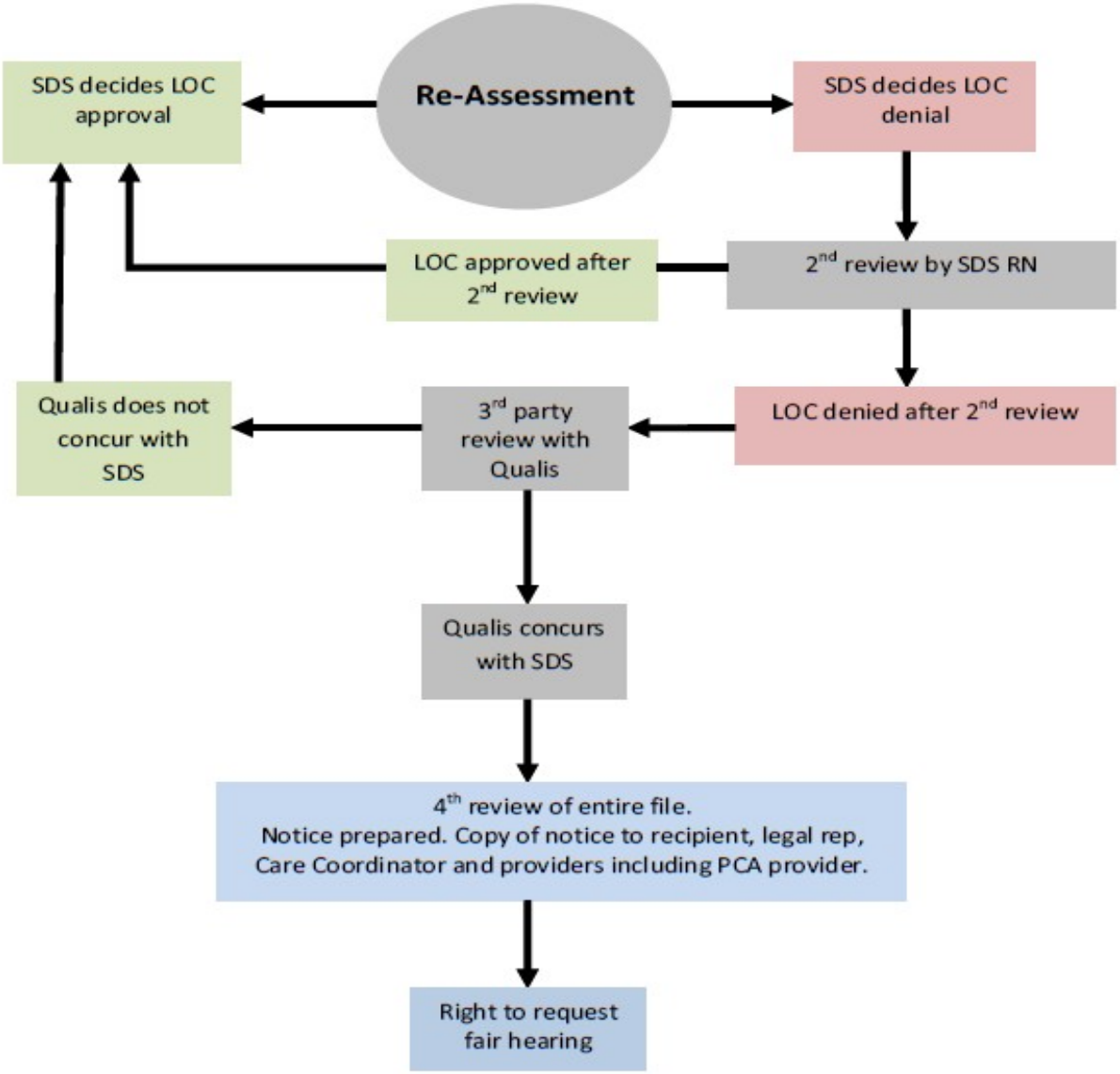
In general some care coordinators are very timely and responsive and just make a few minor errors occasionally. However, for those Care Coordinators who are continually unresponsive or do not follow up on things that SDS brings to their attention, the process is tedious. A courtesy notice is sent to the CC followed by a formal certified notice 7 days later if the requested info hasn't been submitted. Frequently, a CC will submit the info as soon as they receive the formal notice via DSM, which is sent the same day as the formal certified letter when costs the state funds.

- Misunderstanding of reapplication process. Many reapps are submitted too early – should be no more than 90 days and no less than 30 days prior to Level of Care expiration date

Material Improvement Review

Material Improvement Review applies ONLY to re-assessment at WAIVER RENEWAL.
Material improvement Review and 3rd Party Review are NOT additional assessments that the person would have to undergo. They are document review processes.

The purpose of the Material Improvement Review process is to find eligibility for the waiver. For re-assessment at renewal only, if an individual does not to meet level of care for the HCB Waiver, the assessment results undergo Material Improvement Review. The assessment findings are first reviewed by SDS Assessment unit staff. The Assessment Unit may ask the Care Coordinator for additional documentation related to the person's health conditions or other recent health related information (within the last level of care duration). 7 AAC.207 (c) (3) allows SDS 30 additional days (total of 60 days) to notify the applicant and care coordinator of the level of care determination, if the applicant is in the Material Improvement Review Process.



If, after the initial Material Improvement Review, the individual does not meet Nursing Facility Level of Care (or ICF/IID Level of Care), these findings and associated documentation would undergo 3rd Party Review with the SDS contracted agency.

Care Coordinators can help by:

- Calling SDS regarding questions on timeline for specific cases
- Check with the recipient about the hearing conference
- Checking in with SDS if there are any questions
- Collecting medical and functional information
- Ensuring there is updated contact information

Please note: Prior authorizations (meaning that providers are prior authorized to provide the approved service to the person) are continued throughout the process.

Closing a Waiver

Individuals you serve have the choice to participate with Waiver services or not. There are many reasons why people would no longer participate in the Waiver.

- People may choose to be served in the nursing home or institution.
- People sometimes no longer meet financial limitations for Medicaid due to a change in income.
- People may also experience changes in their living arrangements that mean they no longer need services.
- An example would be a person whose family members move in to care for him or her on a long term natural support basis.
- A person's health may have improved so that he or she does not need services to the level of the HCB Waiver (level of care).
- Participation may end due to the person moving out of Alaska.
- At times those you serve will die, whether this is expected or unexpected.

In the event that a person no longer engages in the Waiver, he or she may still choose to receive Personal Care Assistance services if eligible, or grant funded services. The person may re-apply for the Waiver in Alaska at a future date if there are significant changes in their service needs.

Follow these processes depending on the circumstances:

1. **Death-** **Submit a Critical Incident Report**
   Submit a Waiver Overview sheet portraying the last known units used-
   SDS will verify the death and units used prior to death
2. **Admitted to a long term care facility-** **Submit a Change of Status**
3. **Declining waiver services or moving away-** **Submit an Amendment**

FOR ANY WAIVER CLOSURE OTHER THAN DEATH:

- Give the person a letter stating that you are terminating Care Coordination services to them (as appropriate- for example in the event of declining the Waiver or choosing to be served in the nursing home).
  - Follow the standard for this notice as seen in the Appt. for Care Coordination Services (30 days' notice).
- Update the Waiver Services Overview form indicating the last known dates of service(s)
- Submit the information to SDS
- Convey the closure information to DPA by DSM.
- Convey the closure information to the providers on the person's (ending) plan of care.

After SDS receives the closure request, the person and/or legal rep, and the Care Coordinator, will receive a letter acknowledging that SDS is closing the waiver. The letter states the person has 30 days to rescind the request (in the event of closure due to circumstances OTHER than death).

PLEASE NOTE: If the person you serve becomes **incarcerated,** he or she will not be receiving Waiver services during this time period. Complete and submit a Critical Incident form. The person will not "terminate" from their Waiver but the services will be inactive and in a suspended status until more is known about when the person will choose to re-engage in community living with Waiver supports. The Care Coordinator will not be doing Care Coordination visits and follow up during that time. It is likely that the plan for re-entry into community life will include the Care Coordinator on the planning team. The correctional facility usually assembles this team. It is not necessary for those with the IDD Waiver to return to a "wait" period once community life recommences after the incarceration period. Contact SDS for technical assistance.

Fair Hearing and Hearing Process Rights

If eligibility, level of care, services, or units of services are denied:

All systems of support that are based on financial eligibility and public funding, such as Medicaid, have a system of appeal in the event that eligibility or ongoing participation is denied. The person and/or legal representative can use the procedure found on the Notice of Adverse Actions and Fair Hearing Rights, which is sent to the person upon denial.

For example, a person may decide to exercise his or her fair hearing rights in the event of:

- Denial of eligibility for Medicaid
- Denial of eligibility for the Waiver program (not meeting Level of Care)
- Denial of some or all services requested on a Plan of Care

How do people know about their fair hearing rights?

When a person receives a notice (letter) of denial from SDS, a copy of the Notice of Adverse Actions and Fair Hearing Rights is included. *Waiver recipients should have already received a copy of this notice when the initial application was completed with the CC.*

It's important for the CC to help the person understand they do not give up rights when becoming a recipient with the Waiver program, and to understand the right to fair hearing when participating in the Waiver program.

When services or eligibility are denied, Senior and Disabilities Services will notify the Division of Healthcare Services, who then refers the case to the Office of Administrative Hearings (OAH). The OAH will send the person a letter offering information about the fair hearing containing:

- A brief overview of the reason for the hearing
- A list of legal authorities (state regulations)
- A copy of the hearing request
- A copy of the denial letter
- Copies of documentation used in making the decision

AAC 49.10-49.900
Hearing Process Rights

The letter will also contain:

- Info about options to attend the hearing (by phone, in person)
- The name of the assigned judge
- What statutes and regulations apply to the case
- How to submit additional documentation
- How to file and deliver documents, where to direct questions
- The date of the hearing
- Actions made by the judge
- How to resolve before the hearing, and how to withdraw from the process
- A list of rights

Ending Association with a Client- Transfer of Care Coordination

According to the Appt. for Care Coordination Services document, you may end association with a client by giving him or her 30 days' notice, informing SDS, and helping the client find a new Care Coordinator.

In rare cases and with proper documentation you may end services sooner. Refer to regulations and COPs

1. Give your client notice in writing.
2. Write an email to the SDS unit that oversees your client's waiver to inform of the change, include your notice to the person.
3. Assist your client in choosing a new Care Coordinator.
    a. Give your client names and contact info of care coordinators in the area who work with that waiver type.
4. Follow the process in the Appointment for Care Coordination Services document to transfer care coordination to someone else.

If you are ending association with an agency and going to work at another agency, you must still give your client options to choose a Care Coordinator. Follow the guidelines found in the Anti-Solicitation letter, issued by SDS, June 2, 2015. A copy is included in the attachments to this guide.

According to 7 AAC 130.219(e)(8), your client risks disenrollment if he or she does not take action to choose another care coordinator after getting your notice of termination of services, or provide documentation for the waiver program. In some cases people are ending the waiver program by choice. In other cases you may need to file a report with Adult Protective Services or Office of Children's Services if you know or reasonably suspect circumstances that would require a report.

Remember: The waiver programs serve people who would otherwise require care in a nursing facility or institution.

UNIT 11

Resources outside the Waiver

Alaska Regulations

- Personal Care Assistance Regulations
- Nursing Regulations
- Assisted Living Licensing Regulations

Contacts at SDS

Senior and Disabilities Services, Resources outside the Home and Community Based Waiver

As stated previously, the Plan of Care is a complete picture of supports regardless of funding source. Here are some links to several resources that Care Coordinators can use to assist those they serve outside of waiver supports. Care Coordinators should know local resources that are available in their community in order to help the people they serve get connected with person centered supports.

Personal Care Assistance (PCA)
PCA is a Medicaid funded service, but it is not a Waiver service. PCA offers hands on help at home (and sometimes at a place of employment) with the activities of daily living, such as dressing, bathing and eating, and instrumental activities of daily living such as laundry and shopping. To receive PCA, a person must have Medicaid and an Assessment for PCA. PCA does not require Nursing Facility Level of Care, however it does require verification of diagnosis indicating the need for hands on help with ADL/s and IADLs, and the PCA Assessment.

Senior and Disabilities Services PCA website: http://dhss.alaska.gov/dsds/Pages/pca/default.aspx

Nursing Facility Transition Program
The funds from the Nursing Facility Transition Program can be used to help an elderly person or individual with a disability transition from a nursing facility back into the community.

Senior and Disabilities Services website: http://dhss.alaska.gov/dsds/Pages/nursing/default.aspx

Grant Services, including Mini-grant information
Grant funded services are available to both seniors and persons who experience physical and/or developmental or intellectual disabilities. Senior and Disabilities services works with community grantees who administer the grant funds to provide these services.
Senior and Disabilities Services website: http://dhss.alaska.gov/dsds/Pages/grantservices/default.aspx

Aging and Disability Resource Centers (ADRCs)
ADRCs are part of a federal effort to help people more easily access the long-term supports available in their communities. That might include transportation, assistive technology, or in-home care.
The ADRC goal is to be a trusted resource. ADRC specialists counsel callers and visitors on long-term supports that fit their circumstances. People choose which services they'd like, then the ADRC specialists help people access those services.

Senior and Disabilities Services website: http://dhss.alaska.gov/dsds/Pages/adrc/default.aspx

Alaska 211
2-1-1 is an easy-to-remember telephone number that connects callers, at no cost, to information about critical health and human services available in communities around Alaska.

Alaska 211 website: http://www.alaska211.org/

HIPAA information, State of Alaska Health Care Services

http://hss.state.ak.us/dhcs/HIPAA/

***H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct*

The Health Insurance Portability and Accountability Act (HIPAA) generally requires covered entities to receive authorization from an individual before using or making disclosures to others about protected health information (PHI). An authorization is required if a use or disclosure of PHI is for purposes that are unrelated to treatment, payment, health care operations, unless disclosure is otherwise required or permitted by HIPAA (for instance it is a requirement of law).

DHSS has created a HIPAA compliant authorization form for use by DHSS agencies to ensure any use or disclosures of PHI is completed in compliance with HIPAA.

Office of Rate Review

The Office of Rate Review (ORR) establishes Medicaid payment rates for hospitals, nursing facilities, home health agencies, ambulatory surgical centers, rural health clinics, and federally qualified health centers. ORR also works with tribal providers and various divisions and units throughout the Alaska Department of Health and Social Services on rate setting and accounting issues.

http://dhss.alaska.gov/Commissioner/Pages/RateReview/default.aspx

PERM Medicaid Review

Each year, Medicaid pays more than $1 billion in medical costs for low-income and vulnerable Alaskans. From children's dental care to elders' medical care, the joint state and federal medical assistance program provides all kinds of needed equipment and services.

Payment Error Rate Measurement, or PERM, is a review of each state's Medicaid payments to measure billing and eligibility related errors.

Alaska Medicaid State Plan

http://dhss.alaska.gov/Commissioner/Pages/MedicaidStatePlan/default.aspx Alaska's plan for its Medical Assistance Program, Medicaid

Directory of Alaska Health Care Sites

http://dhss.alaska.gov/dph/HealthPlanning/Pages/SafetyNetDirectory.aspx

State of Alaska Background Check Program

http://dhss.alaska.gov/dhcs/Pages/cl/bgcheck/default.aspx

Disaster Preparedness For Families with children who experience Intellectual Disability:

http://dhss.alaska.gov/dph/wcfh/Documents/PDF/Prepared4HealthCare.pdf

Disaster Planning Guide For Assisted Living Homes

http://www.muni.org/Departments/OEM/Plans/Documents/AssistedLivingHomeAllHazardsPlanningGuide.pdf

For Anchorage area: Disaster Registry

http://www.muni.org/Departments/OEM/Prepared/Pages/DisasterRegistry.aspx

Division of Health Care Services http://hss.alaska.gov/dhcs/

Resource: Medicaid Handbook for Recipients:
http://hss.state.ak.us/dhcs/PDF/MedicaidRecipientHandbook.pdf

Article 2
Home and Community-Based Waiver Services; Nursing Facility and ICF/MR Level of Care

Personal Care Assistance Regulations
Title 7 Health and Social Services
Part 8 Medicaid Coverage and Payment
Chapter 125 Medicaid Coverage; Personal Care Services and Home Health Care Services

Article 1
Personal Care Services

State of Alaska Board of Nursing

https://www.commerce.alaska.gov/web/cbpl/professionallicensing/boardofnursing.aspx

Assisted Living Licensing Regulations
Title 7 Health and Social Services
Part 5 Services for Mental Health Clients, Seniors, and Persons with a Disability **Article 1**
Licensing of Assisted Living Homes

Office of Administrative Hearings
www.doa.alaska.gov/oah
550 W 7th Avenue, Suite 1940, Anchorage, AK99501
Tel: 907-269-8170 Fax: 907-269-8172

Fair Hearings Dept, Xerox State Healthcare, LLC
1835 S. Bragaw St, Suite 200, Anchorage, AK 99508
Tel: 907-644-6877 or 800-780-9972 Fax: 907-644-8126
E-mail: FairHearings@xerox.com

Alaska Legal Services Corporation
272-9431; 888-478-2572 (outside of Anchorage)

Disability Law Center: 800-478-1234

Appendices

Appendix A Common Forms

Care Coordinator Certification Application
Disclosure of Business and Familial Relationships
Change of Status: CC or Program Admin
Authorization for Release of Information
(blank and filled out examples)
Appointment for Care Coordination
Recipient Rights and Responsibilities
Qualifying Diagnosis Certification
Inventory for Client and Agency Planning (ICAP)
Interim ICF/IID Level of Care Information
Verification of Diagnosis
Request for Expedited Consideration
Recipient Change of Status
ALI/APDD Application, CCMC Reapplication
SDS Plan of Care Amendment

Appendix B Understanding Guardianship

Appendix C Current Contacts at SDS

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

Home and Community-based Waiver Services

Care Coordinator Certification Application

Applicant

Name _____

Physical Address/City/Zip _____

Mailing Address/City/Zip _____

Telephone Number _____ FAX Number _____

Cell Number _____ Email _____

Services: Care Coordination Services to be provided for the following waivers:

- ☐ Adults with Physical and Developmental Disabilities
- ☐ Alaskans Living Independently
- ☐ Children with Complex Medical Conditions
- ☐ People with Intellectual and Developmental Disabilities

Provider Agency Name _____ CMG Number _____

Physical Address/City/Zip _____

Back-Up Care CoordinatorName_____

Telephone Number _____ CM Number _____

Required attachments *Review the SDS certification website for instructions and content requirements.*

- ☐ Applicant's resume
- ☐ Documentation showing applicant's educational qualifications
- ☐ Certificate of completion of care coordination training
- ☐ *Disclosure of Business and Familial Relationships* form

Care Coordinator Assurances

I affirm that I will comply with the care coordination services regulations, 7 AAC 130.211 – 7 AAC 130.215 and 7 AAC 130.240, the Care Coordination Services Conditions of Participation, and all applicable federal, state, and local laws and regulations. I certify that the information provided in the attachments required for certification is true and complete.

_____

Applicant Signature

_____ _____

Print Name *Date*

Provider Assurances

I certify that the applicant meets and complies with the requirements of the Care Coordination Services Conditions of Participation, is employed by named provider agency, and meets the provider's employment and certification standards to provided care coordination services.

_____

Care Coordination Program Administrator Signature

_____ _____

Print name *Date*

CERT-02 (Rev. 5-2-13)

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

Home and Community-based Waiver Services

Care Coordinator Certification
Disclosure of Business and Familial Relationships

Name of care coordinator _____ CM# _____

Name of provider agency employer _____

Table 1 *List provider agencies in which you have an ownership, partnership, or equity interest equal to or greater than 5%.*		
Name of provider agency	Address	Telephone

Table 2 *List other businesses or commercial activities, in which you and another provider, owner, or administrator each have an ownership, partnership, or equity interest equal to or greater than 5%.*		
Name of business/commercial activity	Name of other agency/owner or administrator	Address

Table 3 *List any individual who is an owner, administrator, or employee of a provider agency or of a business/commercial activity who is your spouse, parent, sibling or child, or the spouse of a parent, sibling, or child.*		
Name of agency/business/commercial activity	Name of relative	Relationship

Care coordinator assurances
I certify that the information provided regarding my business and familial relationships is true, accurate, and complete.

Care coordinator signature _____ Date _____

CERT-20 (Rev 5-2-13)

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

Home and Community-based Waiver Services

Change of Status: Care Coordinator or Program Administrator

Instructions *Check box for type of reported change, and provide required information.*
Send completed form and attachments to DSDSCertification @alaska.gov, *or*
Fax to 907-269-3690, Attention: Provider Certification.

Name of Provider Agency _____

Provider Number _____

Person to Contact Regarding Change _____

Telephone Number _____ **Email** _____

Care Coordinator *Notification required 30 days prior to a planned change or within one business day of an unplanned change.*

☐ **Name Change** *Attach legal document showing name change.*

Name of Care Coordinator _____ CM# _____

Name Changed To _____

☐ **End/Change of Agency Affiliation**

Date Employment with Current Agency Ended _____

If Applicable:

Name of New Employer _____

CMG# _____ Beginning Date Of New Employment _____

Program Administrator *Notification required 30 days prior to a planned change or within one business day of an unplanned change.*

☐ **New/Interim Program Administrator** *If change of program administrator is for care coordination, chore, adult day, day habilitation, residential habilitation, supported employment, or respite services, attach* Notice of Appointment: Program Administrator *form and required attachments.*

Name of Program Administrator _____

Date of Employment with Agency _____

Program/Waiver Service Administered _____

☐ **End/Change of Agency Affiliation**

Name of Program Administrator _____

Date Employment with Agency Ended _____

Program/Waiver Service Administered _____

If Applicable:

Name of New Employer _____

CMG# _____ Beginning Date of New Employment _____

CERT-44 (Rev. 8-2-13)

State of Alaska
Department of Health and Social Services
Division of Senior & Disabilities Services
550 West 8th Ave ● Anchorage, Alaska 99501
(907) 269-3666 ● 1-800-478-9996

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: COMPLETE NAME

Record # or Other ID: MEDICAID NUMBER or SDS ID Date of Birth: _____

Other Names under which records might be filed: _____

Person/Organization Releasing Information: CC, CC AGENCY

Person/Organization Receiving Information: SDS

_____

Description of Information To Be Released: *(If substance abuse information is to be released from a federally assisted substance abuse treatment center, then this information must be included in the description)*

DESCRIBE IN THIS FIELD WHAT THE APPLICANT IS AUTHORIZING BE

RELEASED.

The purpose of the release of this information is: PROGRAM DETERMINATION

I hereby authorize the use or disclosure of my health care and/or other information as described above. I understand that this authorization is voluntary. I understand that my records *may* contain sensitive information. I understand that I may revoke this authorization at any time by signing the revocation section on the back of this release, or by notifying the individual(s) or organization releasing this information in writing, but if I do, it won't have any affect on actions taken on this authorization before my revocation was received. I understand that the individual(s) or organization releasing this information *may* condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

This authorization expires on the following date or event: 1 YEAR FROM DATE SIGNED

_____ _____

Signature of Client or Personal Representative
(Or Witness if signature is by mark)

Date

PRINT NAME

Printed Name of Personal Representative or Witness

POA, LEGAL GUARDIAN,SD

Description of Personal Representative's Authority

NOTE: This authorization was revoked on: _____ *(see reverse or attached revocation statement)*
Date

RECIPIENT INFORMATION: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL

REVOCATION SECTION

I do hereby request that this authorization to release the information of: _____
(Printed Name of Client)

described on the reverse side of this form, be rescinded, effective _____. I understand that any
(Date)

action taken on this authorization prior to the rescinded date is legal and binding.

_____ _____
Signature of Client or Personal Representative
(Or Witness if signature is by mark)
Date

_____ _____
Printed Name of Personal Representative or Witness
Description of Personal Representative's Authority

_____
Signature of Staff

* This Revocation Section must appear on the reverse side of DHSS Authorization for Release of Information 06-5870 (03/03) and is invalid if used separately. If a separate form is required, use DHSS Revocation of Authorization for Release of Information 06-5872 (03/03). If this revocation section has been completed and signed, please note the date of the revocation on the reverse side of this form in the space provided.

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

Appointment for Care Coordination Services

Recipient	*Care Coordinator*
Name:	Name:
CCAN:	CM Number:
Plan of Care Start Date:	Telephone Number:
Former Care Coordinator:	Care Coordination Agency:
Former Care Coordination Agency:	CMG Number:

I am a certified care coordinator authorized by the State of Alaska to assist you to obtain services funded by the Medicaid Home and Community Based Waiver Services program. If you are determined eligible and continue to meet eligibility requirements, you will qualify for services through the program.

As your care coordinator, I agree to:

- Assist with your initial application for and renewals of Medicaid eligibility, but it is your responsibility to complete the forms and submit them to the Division of Public Assistance with all required documentation.
- Explain your program rights and responsibilities, and to give you a copy of the *SDS Recipient Rights and Responsibilities* and the *Notice of Adverse Action & Fair Hearing Rights*.
- Inform you of any employment or family relationship I have to a certified provider agency (7 AAC 130.217 and 7 AAC 130.240).
- Assist you and/or your legal representative to develop a Plan of Care to meet your needs, to revise this plan when your needs change or are not being met, and to submit timely, on your behalf, all documents required by SDS.
- Submit a signed amendment to SDS within 10 days if your changing needs require a change of providers or an increase or decrease of services.
- Maintain case notes (available to you upon request) documenting visits, contacts, and other matters regarding your services.
- Evaluate whether your Plan of Care is meeting your needs and whether the services approved have been provided, (unless waived by SDS) through 2 contacts per month one of which must be face to face..
- Contact providers of services to monitor if services are being provided to meet your needs.
- Contact your providers when services are not provided to your satisfaction or in accordance with your Plan of Care.
- Provide you with contact information for another care coordinator for assistance whenever I will be unavailable for over 48 hours.
- Provide contact information as to where you can reach me, with the understanding that I cannot be available to you at all times and that you should call 911 when emergency care is needed.
- Provide you with 30 days notice, inform SDS, and help you to find another care coordinator if I exercise my right to terminate my services to you.
- Cooperate in the transfer of care coordination services to include transfer of documents if you exercise your right to change care coordinators at any time or for any reason.
- If this is a transfer of care coordination a payment agreement has been developed.
- Report abuse, neglect, self-neglect, and financial exploitation to Adult Protective Services at 1-800-478-9996, or to the Office of Children's Services at 1-800-478-4444.
- Report circumstances which might indicate Medicaid fraud, abuse or waste to the SDS Quality Assurance Unit at 1-800-478-9996.
- I understand that my Care Coordination responsibilities end when the approved Plan of Care (POC), Amendments (POCA) and all case notes for the past 12 months are sent to the new CC, and SDS is provided with a copy of this form

Signature of New Care Coordinator	Effective Date of Appointment
Signature of Applicant/Recipient or Legal Representative	Date
Signature of Transferring Care Coordinator	Date

UNI-05 (Rev. 9-25-13)

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Home and Community-Based Waiver • Personal Care Assistance

Recipient Rights and Responsibilities

Applicant/Recipient: _____ Medicaid Number: _____

Instructions: Initial below each section to indicate your agency representative or care coordinator has discussed the items with you.

I have the right:

- To withdraw from the application process at any time
- To make choices regarding my care
- To be treated with respect and dignity by my services providers
- To confidentiality regarding information about me in state and provider records
- To have information about me maintained as confidential by the state and by my service providers
- To a fair and comprehensive screening of my health and of my functional and cognitive abilities
- To my assessment results after eligibility determination has been made
- To participate in the planning of my eligibility services
- To request, as does any member of my comprehensive planning team, a meeting to amend my information that might effect my authorized service levels and/or plan of care at any time
- To know the fees for services before accepting care from a service provider
- To decline any service included in my plan of care and/or service level authorization
- To change service providers, including my care coordinator or service agency at any time
- To submit a complaint through a grievance procedure established by my service provider
- To written notification from my service provider regarding any change in, termination of, or discharge from services
- To appeal any decision that affects my care

_____ **Applicant/Recipient Initials**

I have been informed that

- The geographic location of my residence may limit my options for services to those made available by the service providers located in my community
- I should report abuse, neglect, self-neglect, and financial exploitation to Adult Protective Services at: 1-800-478-9996 (Alaska Relay System 800-770-8973) or to the Office of Children's Services at 1-800-478-4444
- I should report services that are not satisfactory or are not provided as outlined in my Plan of Care and/or authorized PCA service level to the SDS Quality Assurance Unit at 1-800-478-9996 (Alaska Relay System 800-770-8973)
- I should report circumstances that might indicate Medicaid fraud, abuse, or waste to the SDS Quality Assurance Unit at 1-800-478-9996 (Alaska Relay System 800-770-8973)

_____ **Applicant/Recipient Initials**

I am responsible for

- Working with my provider agency/care coordinator to submit a complete application packet according to timelines found in regulations at 7 AAC 130.207
- Obtaining a completed Verification of Diagnosis or Qualifying Diagnosis form from my licensed medical provider
- Cooperating with SDS in the scheduling and completion of my eligibility assessment
- Reporting to the provider agency/care coordinator within 15 days any change to my functional condition, residence, mailing address, telephone number, marital status, medical provider, provider agency, or legal representative.
- Providing only true and complete information and understand that to do otherwise could be an intentional program violation or program abuse
- Developing a contingency plan to ensure my health and welfare if PCA or HCB Waiver services are unable to be provided.

_____ **Applicant/Recipient Initials**

If receiving CDPCA services, I am also responsible for:

- Choosing a legal representative who is involved in my day-to-day care to manage and evaluate the PCA service as it occurs in my home for me, if determined that I cannot do so
- Managing my own care. This includes recruiting and scheduling my PCA
- Specifying training requirements for my PCA and assuring that the training has been received
- Developing a back-up plan about how PCA services are provided if the regularly scheduled PCA is unavailable.

_____ **Applicant/Recipient Initials**

Intentional Program Violation/Program Abuse

An "intentional program violation" occurs when an individual intentionally misrepresents, conceals, or withholds a material fact in order to establish or maintain eligibility for Medicaid benefits. "Program abuse" occurs when an individual misuses or overuses Medicaid benefits and causes unnecessary cost to the Medicaid program.

If Senior and Disabilities Services (SDS) has reason to believe that you have committed an intentional program violation or program abuse, the Department of Health and Social Services will conduct a full investigation in accordance with state and federal law. If, after a full investigation, the department finds that you have committed an intentional program violation or program abuse, the department may:

1. Deny your application for Medicaid, subject to a hearing under 7 AAC 49
2. Recover Medicaid expenditures made on your behalf in accordance with 7 AAC 100.910
3. Refer the matter to the Alaska Department of Law for civil or criminal action in a state or federal court.

Care Coordinator/PCA Agency Representative

I have discussed the Recipient Rights and Responsibilities with the applicant/recipient and/or legal representative.

_____ _____

Care Coordinator/PCA Agency Representative Signature and Printed Name — Date

Applicant/Recipient

I have discussed my rights and responsibilities with my care coordinator/PCA agency representative.

_____ _____

Applicant/Recipient Signature and Printed Name — Date

_____ _____

Legal Representative Signature, if applicable, and Printed Name — Date

_____ _____

Witness Signature and Printed Name — Relationship — Date

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services
Home and Community-based Services

Adults with Physical and Developmental Disabilities • Alaskans Living Independently
Children with Complex Medical Conditions • Individuals with Intellectual and Developmental Disabilities

Questionnaire for Initial and Renewal Plans of Care

Instructions: A planning process to develop, amend and renew plans of care for waiver services is required per federal regulations on person-centered planning. Prior to submitting an initial or renewal plan of care, discuss the topics below with the person you are serving and his/her representative (if applicable), and record the recipient's response. Provide an explanation if the recipient answers "No" to any of the questions. Initial plans of care can skip questions 1 and 2 and just address questions 3-5. **A completed Questionnaire must be submitted with each initial and renewal Plan of Care**.

RECIPIENT NAME:

CARE COORDINATOR NAME:

Renewal Plans of Care Only:

During the last year, did you receive the services identified in your current Plan of Care?

1. ☐ Yes
   ☐ No; there was an issue with:
   - ☐ Type (I did not receive all of the services on my plan)
   - ☐ Scope (The services I received did not do what I needed them to do)
   - ☐ Amount (I did not get enough of the services identified in my Plan of Care)
   - ☐ Duration (Direct care workers did not stay with me as long as they were supposed to)
   - ☐ Frequency (Direct care workers did not provide services as many times as they were supposed to)

If the response is No:

Care coordinator, please explain how the team plans to address or has already addressed the issues with type, scope, amount, duration or frequency of services (can check multiple boxes):

- ☐ Submit amendment to plan to redesign supports
- ☐ Convene a planning meeting to discuss what is not working, why, and remediate
- ☐ Offer a list of different provider(s) of the service
- ☐ File a formal complaint through provider grievance process
- ☐ File a formal complaint with Central Intake
- ☐ No action is required, please describe why:

2) Did the waiver services you received during your current Plan of Care year help you work towards your goals?

- ◯ Yes
- ◯ No

If the response is No:

Care coordinator, please explain how the team plans to address or has already addressed the issues with services not being helpful in working towards goals (can check multiple boxes):

- ☐ Submit amendment to plan to redesign supports
- ☐ Convene a planning meeting to discuss what is not working, why, and remediate
- ☐ Offer a list of different provider(s) of the service
- ☐ File a formal complaint through provider grievance process
- ☐ File a formal complaint with Central Intake
- ☐ No action is required, please describe why:

Initial and Renewal Plans of Care:

3) Did you get to choose who should be present at your planning meeting for your current Plan of Care?

- ◯ Yes
- ◯ No

If the response is No:

Care coordinator, please explain how you plan to allow for this aspect of recipient choice as part of the renewal Plan of Care process:

4) Did you get to choose where and when your planning meeting for your current Plan of Care took place?

- ◯ Yes
- ◯ No

If the response is No:

Care coordinator, please explain how you plan to allow for this aspect of recipient choice as part of the renewal Plan of Care process:

5) Did you have the choice to lead your own planning meeting for your current Plan of Care?

- ◯ Yes
- ◯ No

If the response is No:

Care coordinator, please explain how you plan to allow for this aspect of recipient choice as part of the renewal Plan of Care process:

Recipient/Legal representative signature_____Date_____

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

Qualifying Diagnosis Certification

Intellectual and Developmental Disabilities Waiver

Applicant/participant: _____

Date of birth:_____Medicaid number: _____

The information requested will assist SDS to determine if the applicant/participant qualifies for services. This is an annual requirement for Medicaid funded programs. Please return this form to the applicant, the care coordinator or agency representative at the Fax number or email address indicated:

Care Coordinator/representative:_____
Phone:_____ Fax: _____Email: _____

Diagnosis (Initial all that apply to the applicant/participant)

Failure to provide the ICD-10 code will result in this form being returned for correction.

ICD-10 code _____ Intellectual Disability (diagnosed by a licensed psychologist, psychological associate or developmental pediatrician)
Medical Provider's Initials:_____

ICD-10 code _____ Cerebral Palsy (diagnosed by a licensed physician)
Medical Provider's Initials:_____

ICD-10 code _____ Seizure disorder (diagnosed by a licensed physician)
Medical Provider's Initials:_____

ICD-10 code _____ Autistic Disorder (diagnosed by a clinical psychologist, child psychologist, or developmental pediatrician)
Medical Provider's Initials:_____

ICD-10 code _____ Condition *(other than mental illness, psychiatric impairment, or a serious emotional or behavioral disturbance)* that is closely related to intellectual disability that results in impairment of general intellectual functioning and adaptive behavior and that requires treatment or services similar to those required for individuals with intellectual disability (diagnosed by a licensed physician) Please specify diagnosis: _____
_____
Medical Provider's Initials:_____

ICD-10 code_____ Additional diagnoses (with comments)_____
_____
_____
Medical Provider's Initials:_____

Onset- please indicate the age of onset of the diagnosed condition:_____

To the best of my knowledge, the above information is true, accurate, and complete:

_____ _____ _____
Signature Date License #

_____ _____
Name (*please print*) Telephone number

Questions may be directed to Senior and Disabilities Services at 269-3666 or 1-800-478-9996.

This form may be completed by the following individuals licensed to practice in Alaska: Physician, Advanced Nurse Practitioner, Physician's assistant, Psychologist, Psychological Associate or Certified School Psychologist.

State of Alaska • Department of Health and Social Service • Senior and Disabilities Services

Inventory for Client and Agency Planning (ICAP) Assessment Information and Consent

Please refer to the *Guidelines for the ICAP Process* for assistance in providing the required information

Applicant/participant: _____

New ☐ OR ☐ Renewal IDD ☐ OR ☐ TEFRA

Physical address: _____
Street City State

Mailing address: _____
Street City State Zip

Telephone: _____ Medicaid number: _____

Agencies serving applicant/participant: _____

_____

Residential facility (if applicable): _____

Care Coordinator: _____ Agency: _____ Telephone: _____

☐ Legal Guardian ☐ Parent Name: _____ Telephone: _____

Current medications: Purpose:

***Respondents*:**

Name: _____ Telephone: _____

Relationship: _____ Needed accommodation: _____

Name: _____ Telephone: _____

Relationship: _____ Needed accommodation: _____

Name: _____ Telephone: _____

Relationship: _____ Needed accommodation: _____

***Attachments*:**
- ☐ Current release of information for each respondent
- ☐ Supportive diagnostic information (if not attached, date of future evaluation)
- ☐ Police reports/legal information
- ☐ Interdisciplinary Team *Evaluation Report*
- ☐ Current behavior management plan
- ☐ Other: _____

Comments/or alternate respondents: _____

_____

_____

IDD-03 (Rev. 9-30-13) Page 1 of 2

State of Alaska • Department of Health and Social Service • Senior and Disabilities Services

Inventory for Client and Agency Planning (ICAP) Assessment Information and Consent

Please refer to the *Guidelines for the ICAP Process* for assistance in providing the required information

Consent for Administration of the Inventory for Client and Agency Planning (ICAP)

Applicant/participant: _____

Initial each line and sign below

_____ My care coordinator has explained, and I understand the information provided in the *Guidelines for the ICAP Process*.

_____ I have received the *Guidelines for the ICAP Process*

_____ I understand that the responses provided by my ICAP Respondents must be accurate and will be used in assessing eligibility for a Medicaid waiver.

_____ I understand that the applicant listed above may or may not meet the eligibility criteria for a Medicaid waiver.

_____ I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

_____ I consent to a Senior and Disabilities Services representative conducting the ICAP assessment for the applicant/participant listed above.

_____ _____

Signature of applicant/participant or Representative Date

_____

Printed name of applicant/participant or Representative

IDD-03 (Rev. 9-30-13) Page 2 of 2

State of Alaska • Department of Health and Social Service • Senior and Disabilities Services

Interim ICF/IID Level of Care Information

To be completed by the participant's Care Coordinator

Participant: _____ Date form submitted: _____
Last name First name

DOB: _____ Medicaid #: _____ IDD Waiver ☐ TEFRA ☐

Plan of Care start date: _____

1. At the time of the last ICAP was the participant living in, or within three months of discharge from, an institution, (skilled nursing facility, rehabilitation center, ICF/IID) correctional facility (jail, halfway house) or other long-term care facility? Yes ☐ No ☐

   Name of facility: _____ Discharge date: _____

2. Primary diagnosis: _____ Secondary diagnosis: _____

3. Have there been significant changes in the participant's behavior or health in the last year? Yes ☐ No ☐
   Explain and attach supporting documentation to detail significant changes that may influence the qualifying diagnosis or change the level of services needed by the participant.

☐ *Qualifying Diagnosis Certification* form attached
The form must be completed by a qualified professional within the previous 12 months certifying that the participant continues to meet the diagnostic criteria for their qualifying diagnosis

Primary physician: _____ Phone: _____ Fax: _____

Address: _____
Street City State Zip

Care Coordinator: _____ Phone: _____ Email: _____

Agency: _____

E-Mail completed packets through DSM to akdhss.sds_iddanchorage@direct.alaskahie.com or
Fax completed forms and documentation to the Senior and Disabilities Services IDD Unit at (907) 269-3639

IDD-10 (Rev. 8/22/13)

Department of Health and Social Services • Senior and Disabilities Services

Verification of Diagnosis

• Children with Complex Medical Conditions (CCMC) • Alaskan's Living Independently (ALI)
• Personal Care Services (PCS) • Adults with Physical and Developmental Disabilities (APDD)

Section I

Applicant/Recipient:_____

Date of Birth:_____ **Medicaid Number**:_____

The information requested will assist SDS to determine if the applicant/recipient qualifies for services. Please complete and return this form to the care coordinator, agency representative or applicant, immediately or at the Fax number or email address indicated.

Care Coordinator or PCA Representative: _____

Phone:_____ Fax:_____ Email: _____

Section II - To be completed by a physician, a physician's assistant, or an advanced nurse practitioner licensed to practice in Alaska

The diagnostic information requested by this form will assist SDS in determining whether the applicant/ recipient is eligible for Medicaid services. The ICD-10 Code is required for claims processing.

ICD-10 Code: _____ Primary Diagnosis:_____

ICD-10 Code: _____ Secondary Diagnosis:_____

ICD-10 Code: _____ Additional Diagnosis:_____

ICD-10 Code: _____ Additional Diagnosis:_____

ICD-10 Code: _____ Additional Diagnosis:_____

Both ICD-10 Code and Diagnosis must be provided.

To the best of my knowledge, the above information is true, accurate, and complete.

_____	_____	_____
Physician, PA, or ANP Signature	Date	License #
_____	_____	_____
Printed Name	Telephone #	Fax #

Please send the completed form to the care coordinator or agency representative at the fax number or email address noted above. Questions may be directed to Senior and Disabilities Services at (907) 269-3666 or 1-800-478-9996.

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services

Home and Community-Based Services • Personal Care Services

Request for Expedited Consideration

Applicant/Recipient

Name Medicaid number

This request is for an ☐ Initial application/assessment ☐ Amendment of current service plan

for the following program: ☐ IDD ☐ CCMC ☐ APDD ☐ ALI ☐ PCS

For an initial application, provide the address of the location where an assessment can be performed:

Basis for expedited consideration

The recipient has no natural supports able to meet his /her needs, and qualifies for expedited consideration because of

- ☐ a diagnosis of terminal illness with a life expectancy of six months or less
- ☐ imminent/recent discharge on from an acute care or nursing facility
- ☐ unplanned absence of primary unpaid caregiver due to medical/family emergency or hospitalization
- ☐ declining health of his/her primary unpaid caregiver
- ☐ the death of his/her primary unpaid caregiver on
- ☐ Adult Protective Services/Office of Children's Services referral

For Personal Care Services only

- ☐ an immediate need for a time-limited increase in services related to functional capacity

Describe the circumstances that qualify the applicant/recipient for expedited consideration.

Required documentation *Attach documentation that supports expedited consideration.*

Provider agency requesting expedited consideration

Agency name Provider number

Agency contact Telephone number

DSM/encrypted Email address Agency FAX number

Agency representative signature Date

For SDS use only Date of review _____ Request ☐ approved ☐ denied

Reason for decision _____

☐ Follow-up on _____ Purpose _____

SDS reviewer signature Date

UNI-12 (Rev. 1/12/16)

Division of Senior and Disabilities Services Annual Application
ALI (Alaskans Living Independently), APDD (Adults with Physical and Developmental Disabilities) or Re-Application only: Children with Complex Medical Conditions Waiver
Legal Name (Last, First):

If Renewal: CCAN#: **POC Start Date:** **POC End Date:**

State of Alaska • Department of Health and Social Service • Senior and Disabilities Services

Recipient Change of Status

(Not for change in services. Use an Amendment form for Waiver or a Change of Information form (COI) for PCA to request change to service levels.)

This form is used to submit recipient status changes required to ensure program services and integrity. Only the care coordinator, recipient, or authorized agency representative recognized by SDS can submit for updates. All others please contact the care coordinator/agency for submission. Changes must be reported within 10 days per 7 AAC 100.900, Recipient obligation to report changes. A recipient eligible under 7 AAC 100.002(b), (d), (e) must report changes in accordance with 7 AAC 40.440. See also AS 47.05.010, AS 47.07.020, AS 47.07.040.

(1) Fill out the form completely. (2) Print the form. (3) Submit the form with any required documents
By fax: (Waiver) 907-269-3639 • (PCA) 907-269-8164 • (Fairbanks) 907-451-5046 • (LTC) 907-269-3688 • (Grants) 907-465-1170 • (GR) 907-269-3648
By DSM email or other encrypted email: Per your program
By mail: (Anchorage) 550 W 8th Avenue, Anchorage, AK 99501 • (Fairbanks) 751 Old Richardson Hwy., Suite 100a, Fairbanks, AK 99701

Recipient Name:_____ **Recipient ID:**_____
Date:_____ **Program:** ☐ Waiver ☐ PCA ☐ LTC ☐ Grants ☐ GR ☐ Unknown
Care Coordinator/Agency Rep:_____ **Email:**_____
Relationship of Person Submitting Form: Choose an item.

Change of Phone Number

New phone number
_____ Is this change of phone number also for the legal representative? ☐ Yes ☐ No

Change of Physical Address

Previous Physical Address | New Physical Address

Is this change of physical address also for the legal representative? ☐ Yes ☐ No

Change of Mailing Address

Previous Mailing Address | New Mailing Address

Is this change of mailing address also for the legal representative? ☐ Yes ☐ No

Is this change of address to or from a licensed home? ☐ Yes ☐ No

Change of Legal Representative/Custody (include copy of legal representative document)

Previous Legal representative | New Legal Representative/Address

Change of Recipient Name (include copy of legal document)

New Name | Reason for Change: Choose an item.

Admission or Discharge to or from a Hospital or Long-Term Care Facility

Hospital or Facility Name _____
☐Admit ☐Discharge Date of Admit or Discharge_____
Estimated length of time hospitalized or estimated discharge date _____
Recipient discharged to: ☐Home ☐ Other Location

UNI 11 (Rev. 5-16-13)

Date Stamp Here:

ANNUAL APPLICATION for ALI/APDD

CCMC *RE-APPLICATIONS Only*

Completed by Care Coordinator:

Recipient Name: *COMPLETE NAME*

CC Name: *COMPLETE NAME*

CC Agency Name: *COMPLETE NAME*

SELECT ONE

Waiver Type: ☐ **ALI - Alaskans Living Independently**

☐ **APDD - Adults with Physical & Developmental Disabilities**

☐ **CCMC - Children with Complex Medical Conditions**

New ☒ **Renewal** ☐

SELECT "NEW"

The ALI/APDD/CCMC Waiver re-application is required annually per 7AAC 130.213

Division of Senior and Disabilities Services Annual Application

ALI (Alaskans Living Independently), APDD (Adults with Physical and Developmental Disabilities) or Re-Application only: Children with Complex Medical Conditions Waiver

Legal Name (Last, First):

If Renewal: SDS ID#: **POC Start Date:** **POC End Date:**

COMPLETE NAME

Section I ~ Demographic Information

COMPLETE EACH FEILD

PROVIDE MEDICAID NUMBER. "PENDING' OR "AWAITING" IS NOT ACCEPTABLE.

POC Type (Select one): **ALI** ☐ **APDD** ☐ **CCMC** ☐

Medicaid#: **DOB:**

Male ☐ **Female** ☐ **Married** ☐ **Single** ☐ **Height:** _____**Weight:**_____

Primary Language:

If non-verbal-primary mode of Communication:

If a communication barrier exists, please provide an English speaking contact for scheduling:

IF THE APPLICANT IS DIFFICULT TO REACH, IDENTIFY A GOOD CONTACT PERSON TO SCHEDULE WITH

Contact name:_____**Contact Phone:**_____ **Relationship:**_____

Applicant's Physical Address or directions to home in rural areas (No P.O. Boxes)

Address:

City: **State:** **Zip:**

Work-Phone: **Home-Phone:** **Cell-Phone:**

Email:

Mailing address (if different than physical)

Address:

City: **State:** **Zip:**

Applicant's Legal Representative

Does the [illegible] ☐

Name:

ONLY COMPLETE IF THE LEGAL REP. IS SIGNING PAGE 5, SIGNING THE RR, ROI, ACC, AND NAME MATCHES THE LEGAL DOCUMENTATION THAT PERMITS THE AGENT TO MAKE "HEALTH CARE DECISIONS"

Mailing A[illegible]

C[illegible]

Work-Phone: **Home-Phone:** **Cell-Phone:**

E-Mail:

Care Coordinator

Name: **Cell-Phone:** **Email:**

Agency: **Work-Phone:** **Fax#:**

Address:

City: **State:** **Zip:**

Provider ID#: **Provider Group ID#:**

IF THE APPLICANT'S ADDRESS CHANGES AFTER SUBMISSION, SUBMIT COS FORM.

IF RESIDING IN A FACILITY, PROVIDE BOTH THE CURRENT ADDRESS AND THE ADDRESS THE APPLICANT WILL BE DISCHARGING TO. DON'T FORGET TO SUBMIT WITH THE DISCHARGE PLAN WITH THE TENTATIVE DATE.

Section II ~ Diagnosis & Medical

Primary Diagnosis from the Verification of Diagnosis (VOD):

COMPLETE EACH FIELD, ENTER N/A at least

Secondary Diagnosis(es) from the VOD:

Source(s) for diagnostic information (including the medical professional from the VOD):

Must provide information under each section of the Health summary

Health Summary- **Specify and attach appropriate supporting documentation.**
Summarize the applicant's health over the past 12 months.

Document emergency room visits, hospitalizations, surgeries/ or treatments:

Describe significant changes in the applicant's health or behavior in the last year.

If a renewal application:
Has the applicant received a new primary diagnosis?

Has the applicant been diagnosed with any new health problems, mental health issues, or other problems that might affect his/her functional abilities?

Section III ~ Current Medical Data

Medical and/or Psychiatric Contacts ***(Highlight, right-click & insert additional rows as needed)***

Include a fax number for a primary physician as well as a contact phone number for all providers listed.

Full Name	Address	Phone & Fax	Reason for visits and frequency

YOU MUST PROVIDE THE FIRST AND LAST NAME OF THE PROVIDER; THE PROVIDER'S TITLE (DR., ANP, DO, ECT); THE PHONE AND FAX NUMBER; THE REASON FOR THE VISITS AND HOW OFTEN.

Current Medications ***(Highlight, right-click & insert additional rows as needed)***

Medication	Dosage	Prescriber	Reason Prescribed	Administered how?

"SEE ATTACHED" IS NOT ACCEPTABLE. YOU MUST LIST ALL CURRENT MEDICATIONS. ***(Highlight, right-click & insert additional rows as needed)***

Adaptive Medical Equipment (DME/SME)

List all adaptive medical equipment currently in use/available to the applicant regardless of funding source:

☐ Bath Bench	☐ Gait Belt	☐ Lift/Hoyer
☐ Braces/AFOs	☐ Grab Bars	☐ Stair Glide
☐ Cane	☐ Hand Held Shower	☐ Wheelchair
☐ Commode	☐ Hospital Bed	☐ Walker
☐ Elevated Toilet	☐ P.E.R.S/Lifeline	
☐ Other:_____		

List adaptive medical equipment needed:

Environmental Modifications (EMOD's)

List all environmental modifications completed for this applicant regardless of funding source:

List environmental modifications needed:

Statement of Reasonable Expectation of the Need for Long Term Care

I believe that there is reasonable indication the applicant might need services at a level of care provided in a hospital, nursing facility, or ICF/MR in 30 or fewer days unless the applicant receives home and community-based waiver services under 7 AAC 130.211.

I have provided appropriate and contemporaneous documentation that addresses each medical and functional condition and indicates the applicant's need for home and community based waiver services.

7 AAC 130.217 and 7 AAC 130.240 protect you from conflict of interest by putting definitions around who can serve you as Care Coordinator. Has your Care Coordinator informed you of any employment or family relationship to a certified provider agency (per 7 AAC 130.217 (1)(A) ? ***Applicant please initial***

1 **Yes** _____ No _____(there are no known relationships)

MUST BE INITIALED

Section IV ~ Signatures:

INITIAL, SIGNATURES, AND DATES ARE REQUIRED

By signing below, I certify that the information included in this application is true and accurate to the best of my knowledge.

SIGNATURE OF APPLICANT & DATE		*SIGNATURE OF LEGAL REP & DATE* ***2***	
Recipient Signature	Date	Parent or Legal Representative	Date
SIGNATURE OF CC & DATE			
Care Coordinator	Date	Other Natural Support	Date

Two witnesses are required if recipient signs with an X or a stamp. The Care Coordinator may not serve as a witness.

Witness P

Witness P

1 ***THERE MUST BE AN INITIAL PRESENT IN THE "CONFLICT OF INTEREST" BOX. IF THERE IS AN "X", IT IS EXPECTED THAT A WITNESS, NOT THE CC, THAT WILL INITIAL NEXT TO THE APPLICANT'S "X"***

Rel

Rel

2 ***IF LEGAL REP. IS LISTED ON PAGE 2, SIGNING THE RR, ROI, ACC, AND NAME MATCHES THE LEGAL DOCUMENTATION THAT PERMITS THE AGENT TO MAKE "HEALTH CARE DECISIONS"***

Date Stamp Here:

SDS WAIVER PLAN OF CARE AMENDMENT

To be completed by Care Coordinator:

Recipient Name:_____

CC Name: _____

CC Agency Name: _____

POC Type: _____ALI - Alaskans Living Independently

_____APDD - Adults with Physical and Developmental Disabilities

_____CCMC - Children with Complex Medical Conditions

_____IDD - Individuals with Intellectual and Developmental Disabilities

_____Grant

Amendment Effective Date_____

Submitted within 10 business days of the requested change?_____Yes _____No*

This amendment must be used to modify services previously authorized on a Plan of Care (POC) because of a change of circumstances related to the health, safety, and welfare of the recipient; or the recipient needs an increase or decrease in the number of service units approved in the POC or a previous amendment.

Amendment Description

Describe the change in recipient's life that requires or justifies the need for the change of service(s) requested in this amendment:

Planning Team

List all members of the planning team consulted for this amendment.

Name	Role/ Agency	Phone	Consulted by			
			In-person	email	phone	videoconference
	Recipient					
	Care Coordinator					
	HCB Agency Name:					
	HCB Agency Name:					
	HCB Agency Name:					
	HCB Agency Name:					
	Natural Support					

Summary of Non-Habilitative Waiver Services

List and fully describe all ***changing*** non-habilitation services.

NOTE: These services should clearly and concisely communicate the strengths, needs, desires and plans for the recipient in such a manner that a provider could pick up the document and use it as a working tool to provide uninterrupted services.

(Copy & paste additional blank service blocks as needed for each service requested and each service provider)

Non-Habilitative Services

Service	Provider Agency & Contact Phone#	Specific Service Frequency (Minimum of weekly unit average)	Total Service Duration (Exact # of weeks or date range)

Description/justification of service that will meet recipient needs identified in Section III:

Expected outcome(s):

Do any providers for this service reside with the recipient? ☐ **Yes** ☐ **No**

Are any of the providers for this service related to the recipient? ☐ **Yes** ☐ **No**

If yes to either question, identify by name & describe relationship:

Summary of Habilitative Waiver Services *(with Goals & Objectives)*

List and fully describe the ***changing*** services that will be provided to meet the needs of the individual. The habilitative services provided along with the corresponding skill development should be linked to the needs identified in the profile and assessments. Goals should have distinct methodology/procedures described, including parties responsible for implementation. One goal may be implemented across other services to assure continuity of services. The objectives must be measurable. Data collected, and how objectives will be measured, must be clearly described and made available for review upon request.

NOTE: These services should clearly and concisely communicate the strengths, needs, desires and plans for the recipient in such a manner that a provider could pick up the document and use it as a working tool to provide uninterrupted services.

Habilitative Services *(Copy & paste additional table rows as needed for each service requested)*

Service	Provider Agency & Contact Phone#	Specific Service Frequency (Minimum of weekly unit average)	Total Service Duration (State exact # of weeks)

Description/justification of service that will meet recipient needs identified in Section III:

Do any providers for the service listed reside with the recipient? ☐ **Yes** ☐ **No**

Are any of the providers for this service related to the recipient? ☐ **Yes** ☐ **No**

If yes to either question, identify by name & describe:

I. Goal *(habilitative services)* related to this service:

Is this goal: ☐**New** ☐**Revised** ☐**Continued**

List objectives (steps of skill development or maintenance) which the person will use to reach the goal above.

a) List methodology/intervention for each objective. Indicate how supports will teach the skill(s).

b) Indicate how data will be recorded and measured for each objective.

c) Indicate how the objective(s) will be reviewed and evaluated, including frequency and duration of evaluation.

What position(s) within the agency will be responsible for providing the supports for the above objectives?

☐**Providing agency certifies that the group home site is not requesting separate reimbursement for day habilitation service or any service provided by another resident of the group home.**

☐**Providing family home habilitation site is not requesting reimbursement for any other waiver services.**

☐**Providing agency certifies that the services of in home support habilitation or supported living habilitation are provided on a one to one basis.**

☐**Providing in home support agency is not requesting reimbursement for any other waiver service provided by another resident of the home or by the primary unpaid caregiver.**

Out-of-Home Residential Services

Any recipient receiving waiver or grant funded out-of-home residential services (including residential supported living, group home, or family habilitation) must complete this section. The description of services and expected outcomes must be based on the recipient's needs in the amendment description.

Name, phone, and email of residential facility or family habilitation provider:

Admission Date*:*

Description of staffing pattern, including how live-in and shift staff are scheduled:

Is this a state licensed home and is the license current as of the POC Start Date? **Yes** ☐ **No** ☐
Does this recipient's placement meet regulatory requirements for this licensed home? **Yes** ☐ **No** ☐
(i.e.: maximum number of persons in home, receiving care, child versus adult license, waiver type eligible for this service etc.)

Need	**Service Provided by Residential Provider** **Include frequency & duration**	**Expected Outcome** **(If item covered in goal/objective, indicate)**
Nutrition, Eating, Feeding		
Bathing/Hygiene, Grooming		
Toileting/Incontinence		
Skin Care		
Dressing		
Mental Status, orientation, memory, behaviors		
Medication Management/ Supervision/Assistance		
Laundry/Chores		
Mobility/Ambulation, Safety		
Socialization		
Other Needs (e.g.: weight, vital signs, treatments, skin/wound care, etc.)		
Other Needs (e.g.: monitor seizure activity, chest pain, etc.)		
Transportation/Medical Appointments		
Communication with other caregivers		

Signatures

This Plan of Care Amendment has been carefully coordinated with the active involvement of the recipient served. It has been explained that the intended purpose of this amendment to the plan of care is to help the recipient maximize his/her independence and lead a fulfilling life. Each person/agency signing this amendment will be provided with a copy of the approved amendment.

By signing below, I certify that the information included in this Plan of Care Amendment is true and accurate to the best of my knowledge. I have been informed of any familial or business relationship between the care coordinator and any HCB provider.

Recipient Signature	Date	Parent or Legal Representative	Date
Care Coordinator	Date	Other Natural Support	Date
HCB Agency Representative	Date	Printed Name	Agency Name
HCB Agency Representative	Date	Printed Name	Agency Name
HCB Agency Representative	Date	Printed Name	Agency Name
HCB Agency Representative	Date	Printed Name	Agency Name

Two witnesses are required if recipient signs with an X or a stamp. The Care Coordinator may not serve as a witness.

Witness Printed Name	Signature	Relationship	Date
Witness Printed Name	Signature	Relationship	Date

STATE OF ALASKA USE ONLY

This Plan of Care Amendment has been processed for prior authorization.

DSDS Representative	Position	Date

Appendix B

Understanding Guardianship and Power of Attorney

Guardianship takes away a person's rights so it is only done as a last resort. Guardianship is assigned by the court. Legal guardians receive a copy of the signed and sealed (with the judge's seal) guardianship decision.

When may a person need a guardian?

- Someone with an intellectual disability, who is turning 18.
- An elder who cannot manage medical decisions for him or herself.
- A person who experiences disabling mental illness, and who has no family or other supports.

What are the degrees of guardianship?

- Full guardianship. Responsible for person such as a parent for a child.
- Parents may not realize that they need to petition the court for guardianship when their child who experiences disability is 18
- Partial guardianship: as defined by the court order.

The person who a guardian is responsible for is called the "ward'. What does a guardian do?

- Decide where the ward lives.
- Ensure their ward has care and necessary services, in least restrictive setting.
- Ensure that the ward is treated fairly (civil rights, human rights)
- Manage or delegate management of their ward's money, to be spent for the ward's needs only.
- Give consent for medical treatment.

What are the limits of guardianship?

- Cannot place in an institution unless through a formal commitment procedure by the court.
- Cannot authorize surgical procedures re: reproduction (sterilization) or experimental procedures unless these are determined by a medical professional to be lifesaving or to prevent more serious impairment.
- Cannot withhold lifesaving medical procedures (independent of a Do-Not-Resuscitate order or Comfort One plan). A ward can oppose withholding of lifesaving medical procedures.
- Cannot terminate a ward's parental rights.
- Cannot withhold the ward's right to vote, get a driver's license, get married or divorced.

Order of preferences for appointment of guardianship:

- Someone nominated by the person.
- Their spouse.
- An adult child or parent.
- A relative, lived with person 6 months or more in last year.
- A relative or friend with sincere long standing interest in the person's welfare.
- Private guardian
- Public guardian

Filing a petition for guardianship with the court

- A Petitioner doesn't have to be the one who wants to be guardian.
- There is a $75.00 fee
- A court visitor is appointed, and a medical expert.
- The visitor sees the person and creates a report, adding the medical expert's info.
- The Petitioner must serve notice of proceedings to: Current guardian, caregiver, spouse, family, attorney, guardian ad litem (a temporary guardian).

At the guardianship court hearing:

- Judge will hear from the petitioner and the respondent.
- The court visitor's report will be considered.
- The judge will decide and assign the guardianship.

Guardianship can take different forms and duration. The Guardian must make a yearly report to the court. The guardian must respond to periodic guardianship review. People may choose mediation instead of guardianship procedures. A Conservator is assigned the responsibility for the ward's finances. A guardian is not always a conservator, and vice versa. The form and duties of guardianship and conservatorship will be clearly defined in the ward's guardianship decision, from the judge.

A guardian cannot be a public home care paid provider unless the guardianship documents outline this per AS 13.26.145. A conservator cannot be a public home care paid provider under AS 13.26.150(c) (6).

Resource for this information: Disability Law Center http://www.dlcak.org/

What is a Power of Attorney?

People make a variety of decisions every day. If a person signs a *Power of Attorney, they* give another person (the agent) the right to make decisions for them and the authority to carry the decisions out.

The Alaska Statute about Power of Attorney is (AS 13.26.332-335). Power of Attorney (POA) can be tailored to meet the person's specific needs. For instance, the person could grant the agent broad powers to do almost anything you could do for yourself (general power of attorney) or the person could pick and choose the powers to give an agent (specific power of attorney). People can choose to appoint an agent immediately or make the appointment effective only if they become disabled. They can limit the time the agent will have power to act on their behalf or can make the appointment "durable," which means the agent will have powers even if they become disabled. They can also state that the appointment will be revoked upon experiencing incapacity. POA for the waiver program must state "for general health care decisions" (rather than "PCA").

Please note, Alaska now has a separate law addressing health care advance directives. Issues addressed include the designation of a health care agent, end-of-life treatment decisions (living wills), mental health care treatment options, and organ donation (see AS 13.52). There is a separate pamphlet and form titled the Alaska Advance Health Care Directive that should be used for all health care related issues.

A Power of Attorney cannot be designated as a paid provider of public paid home care services per AS 13.26.358.

"public paid home care" is defined in AS 47.05.017 (c) as a person who is paid by the state, or by an entity that has contracted with the state or received a grant from state funds, to provide homemaker services, chore services, personal care services, home health care services, or similar services in or around a client's private residence or to provide respite care in either the client's residence or the caregiver's residence or facility.

http://touchngo.com/lglcntr/index.htm

Appendix C

Current Contacts and how to send information and documents to SDS

BY MAIL: If documents are:	Mail to:
All ALI, APDD eligibility, and CCMC documents ; or closure of these waivers	Senior and Disabilities Services Anchorage Office 550 W 8th Ave, Anchorage, AK, 99501
All DD Eligibility, TEFRA, and IDD Recipient LOC documents, and all DD Recipient POC/Amendment documents for recipients located *in* the Anchorage/Valley Area	Senior and Disabilities Services Anchorage Office 550 W 8th Ave, Anchorage, AK, 99501
IDD Recipient POC/Amendment documents for recipients located ***outside*** of the Anchorage/Valley Area go to the Fairbanks Office	Senior and Disabilities Services Fairbanks Office 751 Old Richardson Hwy., Suite 100a, Fairbanks, Alaska 99701

BY FAX: If document(s) are:	Fax to:
ALI, APDD and CCMC initial application packets & assessments; or closure of these waivers	907 269-6246
ALI, APDD & CCMC renewal waivers and amendments	907 269-3639
Verification of Diagnosis/Assessment	907 269-6246
Prior authorization	907 269-3688
All IDD documents	907 269-3639

BY EMAIL IF USING DIRECT SECURE MESSAGING (DSM2) (type the name in the "To:" box in DSM)

1. NFLOC-initial-application, DSDS (dsds.NFLOC-initial-application@direct.dhss.akhie.com) for ALI and APDD complete new application packet with supporting documents, CCMC screenings and INITIAL plans of care. This allows us to prioritize these plans and applications as these clients do not currently have services.
2. NFLOC-Reapplication, DSDS (DSDS.NFLOC-Reapplication@direct.dhss.akhie.com) for ALI, APDD and CCMC complete renewal reapplication packets packet with supporting documents, CCMC - this allows us to have one entry point to process complete applications so we can schedule assessments.
3. NFLOC Waiver, DSDS (DSDS.NFLOCWaiver@direct.dhss.akhie.com): for any ALI, APDD and CCMC complete renewal plan of care, amendment, Change of Status (COS), and Appointment of Care Coordination (ACC) document.
4. MIRP, DSDS (DSDS.MIRP@direct.dhss.akhie.com) This address should ONLY be used for medical documents when your client is in the MIRP process; otherwise please use the application or Waiver mailbox as appropriate.

For IDD Waivers IDD Anchorage

- ***ALL*** DD Eligibility, TEFRA, and IDD Recipient LOC documents go to the **Anchorage Office**
- IDD Recipient POC/Amendment documents for recipients located *in* the Anchorage/Valley Area (excluding MSSCA recipients)

For IDD Waivers out of Anchorage including MSSCA IDD Fairbanks

- POC/Amendment documents for recipients located *outside* of the Anchorage/Valley Area (and all MSSCA recipients)

For Quality Assurance, Critical Incident Reports and Reports of Harm to Vulnerable Adults-

on the SDS Webpage Or FAX to 907-269-3648

Please contact our SDS Transportation Coordinator for Medicaid rides to and from medical appointments. Sarah Bumpus 907-745-3500

For sending ROI's and Appt of CC to DPA:

DPA.LTC - managed by Marie Laroza, send ACC, ROI's
Or FAX to 907-269-5608

If you have any questions about training please email the training inbox at hss.dsdstraining@alaska.gov, or call the training unit at 907-269-3666, or 1-800-770-1672.