

CARE COORDINATION GUIDE

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Table of Contents

UNIT 1- Long Terms Support Services.....	7
Common Acronyms, Terms and Definitions:.....	8
Senior and Disability Services Webpage & Other Web Resources.....	10
ADRC: Person Centered Intake Interview.....	10
SDS MISSION	11
What is a “Waiver” and why do we have them in Alaska?.....	11
Senior and Disabilities Services offers 5 waivers:.....	13
UNIT 2- Becoming a Care Coordinator.....	14
Individual Care Coordinator and Agency Certification.....	15
Qualifications and Experience:.....	16
Care Coordination Training.....	18
Updating your Care Coordination training:.....	19
Documents needed to certify an additional CC are:.....	19
Initial Agency Certification Application.....	20
Background Check Program	22
Enrollment with Conduent.....	23
Connect to the SDS Harmony data system.....	23
Renewing Certification.....	24
Reimbursement for services.....	24
What happens when a Care Coordinator wants to discontinue his or her certification and enrollment?	25
What happens when a Care Coordinator wants to change CC Agencies?.....	25
Can a Care Coordination agency be sold or transferred?.....	25
Suspension or Denial of Certification Application, Decertification, and Appeal.....	26
UNIT 3 -Regulations & Responsibilities.....	27
REGULATORY ORDER OF CONSIDERATION.....	27
Federal Regulations all Providers Must Follow.....	28
CMS Regulation – Federal Code of Regulations (CFR)	28
Six Assurances to Centers for Medicare & Medicaid Federal Authority	29
Alaska’s application to operate HCB Waivers.....	30
Alaska Statutes for Medicaid Participation.....	31
Alaska Statues for Home and Community-Based Waiver & other SDS Services.....	31
Ethics & Boundaries: Some Basic Best Practices.....	33
Understanding Guardianship.....	35
What is a Power of Attorney?.....	36
Responsibilities of a Care Coordinator.....	37
On-going Care Coordination visits.....	38
Care Coordinators gather the planning team.....	39
Report changes in recipient basic information.....	39

Adult Protective Services Mandatory Reporters 40

Protect against Conflict of Interest 41

Use Releases of Information when working with PHI- protected health information..... 41

Follow (HIPAA) Health Insurance Portability and Accountability Act requirements 42

Establishing a Direct Secure Messaging account: 42

Critical Incident Reports..... 43

Report Medicaid Fraud..... 44

Case Notes of Care Coordination Service..... 45

 Records Retention schedule for the Alaska Medicaid Long Term Services and Supports..... 49

UNIT 4 - Eligibility 50

 Medicaid Eligibility..... 51

 Medicaid Ethics & Boundaries..... 52

 Applicant already on Medicaid? 53

 TEFRA/ Katie Beckett Waiver..... 54

 Cost of Care (Cost of Care Co- Pay) 55

Developmental Disabilities Eligibility 56

 Determining Level of Care..... 56

 Developmental Disability Registry..... 57

IDD/ISW Waiver Eligibility: diagnosis..... 58

 ICAP Assessment and ICF/IID Level of Care..... 59

 Applying for the IDD/ISW Waiver 60

 Interim year Assessment (the years between the ICAP cycles)..... 64

Nursing Facility LOC..... 64

 ADRC Person Centered Intake Requirement..... 64

 ALI/APDD/CCMC/CFC Application..... 65

 Determining (NFLOC) Nursing Facility Level of Care 69

 Table of Nursing Facility Level of Care, skilled services & intermediate services..... 70

 CAT (Consumer Assessment Tool) 76

 Admission to a Skilled Nursing Facility 76

 Preparing for the Assessment..... 77

 Assessments in a Nursing Facility or Long Term Care Hospital 77

UNIT 5 – HCB Services..... 79

 Community First Choice Services 80

 Waiver Service Definitions, Regulations, and Basic Exclusions..... 81

 Requesting Safeguard Funding for the ISW Waiver 87

 Services through Grants..... 88

 Senior Grants for Home & Community Based Services..... 88

 Other Resources For Individuals with Developmental Disabilities..... 89

 Nursing Home transitional services..... 90

HCBS Settings Compliance..... 91

 Requesting Services during temporary absence..... 93

 Out of Home Residential Services..... 94

 Waiver Transportation Services..... 95

 Duplications with Personal Care Services (PCS) or CFC-PCS Services..... 96

 Environmental Modifications (E-Mods)..... 97

 Specialized Medical Equipment..... 104

 Nursing Oversight and Care Management..... 105

 Supported Employment..... 107

 Acuity Rate for Out of Home Residential Services..... 108

Unit 6 - Writing a Person Directed Plan for Supports..... 109

 People get the support they need from many resources..... 109

 Person Centered Approach..... 110

 Each Support Plan is Individualized..... 111

 Personal Goals in the Support Plan..... 112

 Some Resources for Person Centered Planning 113

Developmental Disabilities Shared Vision 114

 Writing Narrative in the Support Plan..... 115

 Use person first language to accurately describe disability..... 115

 Be clear and precise..... 115

 Identify strengths..... 116

 Identify Barriers 116

 Refer to the assessment and other documents 117

 Collect ongoing supporting information when you visit 117

..... 118

 What Are Habilitation Services?..... 118

 Developing Goals & Objectives for Habilitation Services..... 121

 Habilitation Services Goals..... 121

 Assessing risks for habilitation services..... 122

 Providing support for habilitation goals 123

 Goals for habilitation services 123

 What is an objective? 123

 What does “measurable” mean?..... 124

 Please note that narrative progress is required in addition to any quantitative data. The care coordinator needs this info when planning services or renewal 125

 Habilitation services to help decrease behavior..... 125

 What are the “interventions”?..... 126

 What if goals change during the current Support Plan?..... 127

 Renewal planning for goals and objectives?..... 127

What is SDS looking for?..... 128

 Goals and the accompanying objectives must be:..... 128

 Be Cautious of these types of goals: 128

Writing in Plain Language..... 130

 What are the main elements of plain language?..... 130

 Goals of Plain Language..... 131

 Apply plain language to your writing?..... 131

Support Plan Questionnaire..... 135

Unit 7 - Renewing CFC and Waiver Services..... 136

 LOC Reapplication..... 136

 Material Improvement Review Process (MIRP)..... 137

 Fair Hearing & Hearing Process Rights 138

 Mediation -1st Step..... 138

 Fair Hearing – 2nd Step..... 139

Transfer of Care Coordination..... 139

Closing a Waiver..... 140

 Community First Choice (CFC). 141

 141

Other Resources..... 153

 Medicaid (PCS) Personal Care Services Eligibility 153

Current SDS Contacts 157

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.

Welcome!

We're glad you've chosen to study the profession of Care Coordination with Senior and Disabilities Services. Alaska needs you and your skills to help seniors and individuals experiencing a disability live full lives within our community. This guide is designed to provide you with basic information and procedures on accessing Home and Community Based Waiver Services for Alaskans. Mastering the information of this guide alone will not qualify you as a Care Coordinator. There are specific educational and professional experience qualifications required to become a Care Coordinator. (See Unit 2 of the guide.) You must become certified with SDS, and enrolled with Alaska Medicaid; or become certified and work for a care coordination agency which is enrolled. Even with the basic qualifications, the best practice for a new Care Coordinator is to spend a lot of time with a mentor. You may consider contacting a local Care Coordinator about mentorship possibilities. You may also choose to join your local Care Coordination Network association.

Stay informed:

- 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.¹ Training materials will be updated to reflect changes as they progress.
- Join the [SDS E-Alert System](#). SDS emails updates for all its' programs to providers.²

About Critical Incident Report (CIR) Training

SDS requires Critical Incident Report Training prior to Certification and verification again at Recertification. This guide gives an introduction to Critical Incident Reporting. To receive the required certificate of attendance for Critical Incident Report Training you must either enroll in the [SDS Critical Incident Reporting Webinar](#) or participate in Critical Incident Report training facilitated by your employer agency.³ You may also register for an SDS lead Critical Incident Report training webinar through the SDS webpage under **Provider Training**.

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

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¹Alaska's Seniors and Disabilities Services Website: <http://dhss.alaska.gov/dsds/Pages/default.aspx>.

² SDS E-Alert ListServe sign up: <http://list.state.ak.us/mailman/listinfo/SDS-E-News>

³ SDS Critical Incident Reporting Training Video & Quiz:

<https://docs.google.com/forms/d/e/1FAIpQLScfX4y1ExbOfXCPyWs1tMGrpiZVTavTjwCWcLHBDH1O0aReWg/viewform>

Why should I find a mentor?

A beginning Care Coordinator should try to find a mentor- an a currently certified Care Coordinator who can share his or her knowledge and experience. Training can bring you technical information and updates, but you will gain more through on the job experience. 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. However, as a trainee you can become familiar with the daily work of a Care Coordinator through the process of shadowing. This will allow for you to practice interacting with people, learn the processes and work with sample documents.

You may wish to connect with a local Care Coordinator Association to find a mentor. The [Alaska Care Coordination Network](#) is a good place to start.⁴ They have contacts in various regions of the State. Some Care Coordinator Agencies pair experienced Care Coordinators with new ones in a training plan.

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

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

UNIT 1- Long Terms Support Services

Terms and Definitions

Senior and Disabilities Services Webpage

Mission & Service Principles

What is a Waiver?

Six Assurances to CMS

⁴ Alaska Care Coordination Network: <http://www.alaskaccn.com/index.html>

Common Acronyms, Terms and Definitions:

A&G	Administrative and General
AAC	Alaska Administrative Code
ABPCA	Agency Based Personal Care Agency
ACoA	Alaska Commission on Aging
ADL	Activities of Daily Living: walking, eating, dressing, bathing, toileting and transferring
ADRC	Aging and Disability Resource Center
ADRD	Alzheimer's Disease and Related Disorders
ADS	Adult Day Services: programs providing adults with various social and some health-oriented services in a supervised outpatient group setting
AFDC	Aid to Families with Dependent Children
Alaska 211	Dial 211 for general information and resources for publicly funded assistance by the United Way
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
ALI	Alaskans Living Independently: a Waiver authorized in Alaska, for adults 22 & over with significant needs for daily living supports. (formerly Older Alaskans OA and Adults with Physical Disability APD)
ALL	Assisted Living Licensing (DHCS)
ANP	Advanced Nurse Practitioner
APDD	Adults with Physical & Developmental Disabilities: a Waiver authorized in Alaska for people 21 and over who experience significant Physical and developmental limitations
APS	Adult Protective Services (SDS)
AS	Alaska Statute
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 Support Plan.
CAT	Consumer Assessment Tool
CC	Care Coordinator
CFC	Community First Choice: an option (NOT a Waiver) for people who meet level of care for a facility: NFLOC, ICFIID, or IMD
CCMC	Children with Complex Medical Conditions: a Waiver authorized in Alaska, for children and young adults under the age of 22 years, who require a level of care ordinarily provided in a nursing facility.
CDPCA	Consumer Directed Personal Care Agency
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.
Conduent	Alaska's Fiscal agent for Medicaid
DHCS	Division of Health Care Services – State office which administers Alaska Medicaid
EMT	Emergency Medical Technician
Enrollment	Providers certified by SDS apply for enrollment through Conduent to bill for services provided to Medicaid clients.
Enterprise system	Fiscal interface for provider billing
EPSDT	Early and Periodic Screening Diagnostic Treatment ("regular" Medicaid for individuals up to age 21.)
GR	General Relief: a program that provides temporary funding for housing accommodations outside of an institutional environment.
Harmony	Harmony Data System is a secure electronic filing system that providers submit required documentation to SDS on behalf of their clients. This is a new system and providers are being systematically onboarded in 2019.
HCB	Home and Community Based
HCBS	Home and Community Based Services
HCBS Settings	All Medicaid-funded services must be provided in settings that exhibit home and community based characteristics and do not isolate recipients. All providers must ensure that all settings owned, rented, leased, and/or contracted must be in compliance.

HCBW	Home and Community Based Waivers: a choice to receive home and community based care rather than care in a nursing facility or institution. Established through 1915(c) Social Security Act and regulated in Alaska under 7AAC 130.200-7AAC 130.319.
I&R	Information and Referral
IADL	Instrumental Activities of Daily Living: laundry, housework, food preparation, managing finances, obtaining appointments, using the telephone, and engaging in recreational, leisure, or social activities.
IAT	Intensive Active Treatment
ICAP	Inventory for Client and Agency Planning
ICF	Intermediate Care Facility
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
IDD	Intellectual/Developmental Disability
IEP	Individualized Education Program
IMD	Institution for Mental Disease (level of care)
ISW	Individual Supports Waiver: A Waiver for people experiencing IDD that allows for choice in the use of specific services up to \$17,500 a year, including equivalent geographic differential. Can stay on the DD registry.
LOC	Level of Care
LTC	Long Term Care
LTCO	Long Term Care Ombudsman
MHTA	Mental Health Trust Authority
MIRP	Material Improvement Review Process
MMIS	Medicaid Management Information System
MOA	Memorandum of Agreement
NFLOC	Nursing Facility Level of Care
NOCM	Nursing Oversight and Care Management
OCS	Office of Children's Services
OT	Occupational Therapy
PA	Physician's Assistant

Senior and Disability Services [Webpage](#)⁵ & Other Web Resources

A critical skill for a Care Coordinator is to research solutions and be up to date on the latest developments in Home and Community Based Waiver and Personal Care Services. Take the time to explore all sections of our website to gain information on services, processes, and resources

Also consider visiting:

[Alaska's Governor's Council on Disability & Special Education](#)⁶

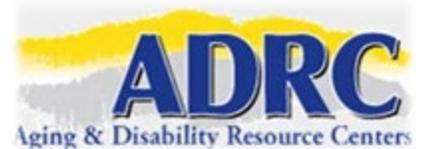
[Center for Medicaid and Medicare \(CMS\)](#)⁷

[Division of Public Assistance \(DPA\)](#)⁸

[Medicaid Enrollment Information for Individuals](#)⁹

ADRC: Person Centered Intake Interview

All people interested in learning about services and seeing what may be available are encouraged to contact the ADRC to find out more.



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 ALI, CCMC, and APDD Waiver Recipients MUST contact the ADRC for a Person Centered Intake Interview, prior to submitting an application. The person will receive a person centered intake interview and become aware of service options.

⁵ SDS Website: <http://dhss.alaska.gov/dsds/Pages/default.aspx>

⁶ GCDSE Website: <http://dhss.alaska.gov/gcdse/Pages/default.aspx>

⁷ CMS Website: <https://www.cms.gov/>

⁸ DPA Website: <http://dhss.alaska.gov/dpa/Pages/default.aspx>

⁹ Medicaid Enrollment Website: <http://dhss.alaska.gov/HealthyAlaska/Pages/enrollment.aspx>

SDS 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.



What is a "Waiver" and why do we have them in Alaska?

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.
 - Congress described the isolation and segregation of individuals with disabilities as a **serious and pervasive form of discrimination**.
- 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 was created after the United States Supreme Court case *Olmstead v. L.C.* The court determined that unjustified segregation of persons with disabilities constitutes discrimination.

States must develop a system of community care options for people with long term Medicaid, as long as:

- such services are appropriate;
- the affected persons do not oppose community-based treatment

- community-based services can be reasonably accommodated

The case was decided based on evidence that:

1. Unnecessary institutionalization continues the stereotype that people facing disabilities are incapable or unworthy of participating in community life.
2. Confinement in an institution severely diminishes the everyday life activities of individuals: family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.

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.accessible.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

All services in the home and community which are reimbursed by Alaska Medicaid are part of Alaska's Long Term Services and Supports (LTSS) State Plan. This includes all waivers and personal care services.

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.

Long term services and supports or Home & Community Based 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.

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

Each state designs its' Medicaid Long Term Services and Supports 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.

People can also choose **NOT** to have any Home or Community Based Long Term Services and Supports at all!

Senior and Disabilities Services offers 5 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 (last day of 21st year).

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

ISW: Individual Supports Waiver

People of all ages who experience developmental or intellectual disabilities.

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

MEDICAID covers

Medical Services

Medical expenses

- doctors,
- medication
- hospital

Durable

Medical Equipment

Personal Care Services

Home Health

Nursing Home

Senior & Disabilities Services NF or ICF/IID- LOC

Community First Choice Option

*Training to help manage direct care staff

*Care Coordination

*Personal Care Services

*Self-care skills training

*Supervision & cueing

ISW Waiver (any age) limit up to \$17,500.00*/year

- Care Coordination
- In Home Supports
- Supported Living
- Transportation
- Supported Employment
- Day Habilitation
- Respite
- Intensive Active Treatment/Adults
- *geographic differential equivalent

APDD Waiver (age 21+) IDD Waiver (any age) CCMC Waiver (birth to last day of 21st year)

- Care Coordination
- In Home Supports
- Family Habilitation
- Supported Living
- Group Home
- Adult Intensive Active Treatment
- Transportation
- Escort
- Supported Employment
- Day Habilitation
- Chore Services
- Respite
- Meals
- Environmental Mods
- Specialized Medical Equipment
- Specialized Private Duty Nursing
- Nursing Oversight & Care Mgt

ALI Waiver (age 21+)

- Care Coordination
- Adult Day Services
- Residential Supported Living
- Transportation
- Escort
- Chore Services
- Respite
- Specialized Private Duty Nursing
- Meals
- Environmental Modifications
- Specialized Medical Equipment

UNIT 2- Becoming a Care Coordinator

Certification for an Individual or Agency Training Certification Application Reimbursement for services

Home and Community Based Services Certified by Senior and Disabilities Services. Each service in the table below requires a specific Service Declaration and policies & procedures that ensure a provider will meet the Conditions of Participation. Certain services focus on supporting a specific waiver type.

Which services are available to which Waiver type/Community First Choice?

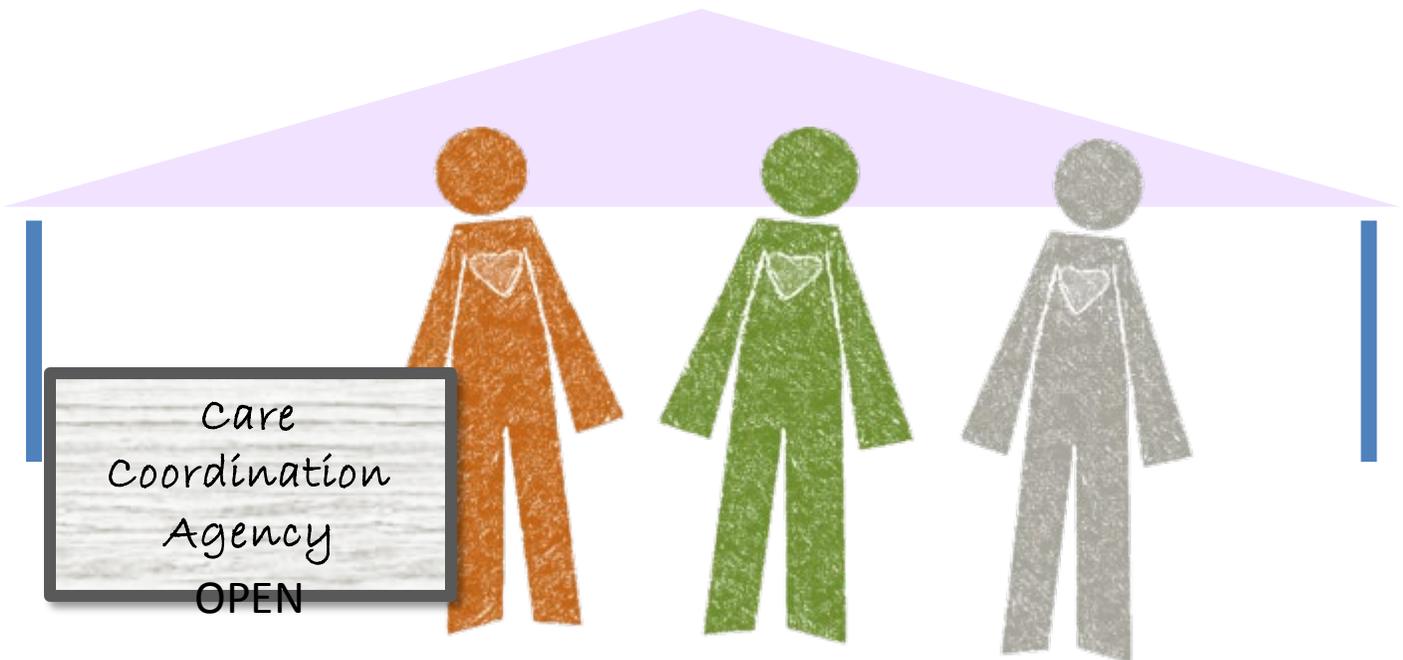
Home and Community Based Service	APDD	ALI	CCMC	IDD	PCS only*	ISW*	CFC*	TEFRA*
Nursing Oversight and Care Management								
Initial Application and Annual Support Plan for APDD, ALI, CCMC, IDD, ISW, and CFC								
Care Coordination/Targeted Case Mgmt (TCM)								
CFC Targeted case management for CFC only plan								
Care Coordination -Monthly ongoing								
TEFRA Coordination								
Chore								
Adult Day								
Residential Supported Living								
Day Habilitation								
Res Hab Family Home Habilitation								
Res Hab Supported Living Habilitation								
Res Hab Group Home Habilitation								
Res Hab In-home Support Habilitation								
Supported Employment								
Intensive Active Treatment								
Respite Care								
Family-directed Respite Care								
Transportation								
Congregate Meals								
Home-delivered Meals								
Environmental Modification								
PCS (Personal Care Services)								
Supervision and Cueing								
Skills training for self-care								
Training to manage own direct service staff								
Personal Emergency Response system (CFC only)								

* PCS only is not waiver and does not require care coordination.
 * TEFRA Care Coordinators are certified through SDS although TEFRA is NOT Waiver care coordination and the duties are different.
 * Specialized Private Duty Nursing is a Waiver service. [7 AAC 110.520. Private-duty nursing agency enrollment requirements](#)
 *Specialized Medical equipment providers are certified through [7 AAC 105.200. Eligible Medicaid providers \(3\)\(C\)](#)

Individual Care Coordinator and Agency Certification

All Home and Community Based Waiver services are Medicaid services, all Medicaid services are authorized because they are **medically necessary**. To request reimbursement these services, providers must not only certify with SDS, they must also enroll as a State of Alaska Medicaid provider. This is done through the fiscal agent for the State of Alaska, Department of Health & Social Services - Conduent, Inc. The CC agency will need to attend training and enroll as an Alaskan Medicaid provider. See Alaska Medicaid Health Enterprise website for enrollment information: <http://medicaidalaska.com/>

Regulations (Waiver Regs, COPs): <http://dhss.alaska.gov/dsds/Pages/regulations/default.aspx>
 SDS Certification Application packet: <http://dhss.alaska.gov/dsds/Pages/provider/default.aspx>
 Conduent (Enrollment): <http://www.medicaidalaska.com/providers/Enrollment.shtml>
 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. (See [Cert-04 Notice of Appointment of Program Administrator](#))¹⁰

The Agency may also have additional Care Coordinators who work for the agency. They must also meet the individual Care Coordinator standards detailed in the [Conditions of Participation \(COP-02\)](#).¹¹ For certification, a potential individual or Care Coordinator agency must submit sufficient evidence that they have experience with the population type of each waiver they wish to serve.

Some agencies have only one Care Coordinator who is both the administrative CC and the working CC.—Some agencies have many CCs and one administrator. Either is fine as long as they are certified and providing only Care Coordination services.

¹⁰ Cert-04 Notice of Appointment or Change of Program Administrator: <http://dhss.alaska.gov/dsds/Documents/SDSforms/Cert-04%20Notice%20of%20Appointment%20Program%20Administrator.pdf>

¹¹ Care Coordination Conditions of Participation (COP-02): http://dhss.alaska.gov/dsds/Documents/SDSforms/CC_TCM_COP.pdf

Qualifications and Experience:

All Care Coordinators are qualified through education and experience:

(at least one of these ways)

- BA, BS, AA in social work, psych, rehabilitation, nursing or other closely related Human Services field **AND** 1 year of Full Time working experience with human services recipients
- 2 years course credit in the above **AND** 1 year of Full Time working experience with human services recipients
- 3 years Full Time working experience with human services recipients
- Certified as Rural Community Health Aide or practitioner **AND** 1 year Full Time working experience with human services recipients



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.

The care coordination knowledge base must include:

- the medical, behavioral, habilitative, and rehabilitative conditions and requirements of the population to be served by the care coordinator;
- the laws and policies related to Senior and Disabilities Services programs;
- the terminology commonly used in human services fields or settings;
- the elements of the care coordination process; and the resources available to meet the needs of recipients.

The care coordination skill set must include:

- the ability to develop and evaluate a Support Plan to meet the needs of the population to be served;
- the ability to organize, evaluate, and present information orally and in writing; and
- the ability to work with professional and support staff.

What qualifies a Care Coordinator Administrator?

In addition to the required education and experience of a care coordinator

- be 21+
- have one or more years' experience in a position with responsibility for planning, development, and management or operation of programs involving service delivery, fiscal management, needs assessment, program evaluation, or similar tasks

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 Training

Training is a requirement for initial and renewing certification. You need to complete *Basic Concepts of Care Coordination* before taking Care Coordination courses with SDS Training to start your training as a first-time applicant for certification or as a returning Care Coordination after ending your certification.. You must successfully complete, before applying for certification with SDS.

Please note: *If you are currently certified with SDS as a care coordinator, you may choose to take Basic Concepts of Care Coordination. However, completing this class alone will not qualify you to apply for recertification.*

Basic Concepts of Care Coordination:

Topics include but are not limited to: the care coordinator's role, ethics, how to serve people with disabilities, advocacy, and the skills of interaction with the people you serve and families. Class size is limited to 20. There is a \$35 fee for this class. This class is offered in a classroom and/or by webinar. Contact the Alaska Training Cooperative at <http://aktc.org/> for information and the schedule for Basic Concepts of Care Coordination.

Care Coordination Training Webinar Courses

A currently uncertified Care Coordinator (applicant) will need to complete one of the CC Core Course Options. You can take as little as one month to complete them, and up to one year to complete all the units. You can register for the units in any order you choose although it's recommended to take them in order. All Care Coordinator applicants must request and pass an exam prior to attending SDS Harmony training courses.

Choose one of the following two Beginning CC course options:

1. [Critical Incident Reporting Training-On-Demand](#)
 2. CCCORE-AKTC Basic Concepts of Care Coordination, presented by The Alaska Training Cooperative
 3. [CCCORE-01-TOD Training On Demand - What are Long Term Services and Supports?](#)
 4. [CCCORE-02-TOD Training On Demand – How do I Become a Care Coordinator?](#)
 5. CCCORE-03 live facilitated webinar – Care Coordinator Responsibilities
 6. CCCORE-04 live facilitated webinar – Eligibility for Waivers
 7. CCCORE-05 live facilitated webinar - Outcome Based Services and Settings
 8. CCCORE-06 live facilitated webinar – Habilitation Services and Settings
 9. CCCORE-07 live facilitated webinar – Designing a Plan of Support
- CCCORE-EXAM (score 80+) Given with webinar series
= Earn Beginning Care Coordination certificate of training completion
 (Send this with the SDS Certification Application)

CC CORE Course Option 2

1. Critical Incident Reporting Training-On-Demand
2. CCCORE-AKTC Basic Concepts of Care Coordination, presented by The Alaska Training Cooperative
3. CCCORE-01-TOD Training On Demand - What are Long Term Services and Supports?
4. CCCORE-02-TOD Training On Demand – How do I Become a Care Coordinator?
5. CCCORE-SELF Self - Paced Curriculum Equivalent for CORE-03 through CORE-07
6. CCCORE-EXAM (score 80+) Email SDSTraining@alaska.gov to request exam after completing steps 1 through 5.

= Earn Beginning Care Coordination certificate of training completion
 (Send this with the SDS Certification Application)

Further care coordinator training is available for recertification and continuing education hours requirements. Please check the Care Coordination Conditions of Participation for regulatory requirements for training: http://dhss.alaska.gov/dsds/Documents/SDSforms/CC_TCM_COP.pdf

Updating your Care Coordination training:

Your training must be updated before your renewal certification application can be approved. The CC must track training and renewal application dates to assure updated Care Coordination training is completed prior to applying for renewal certification. Please visit the [SDS Training Registration page](#) for current course registration.¹²

SDS Training attempts to offer a qualifying training course options monthly. Any CC renewal training that's been completed in the previous 12 months will be acceptable. There are multiple opportunities to achieve the renewal training requirements. They change regularly to enhance and focus your Professional Development as a Care Coordinator.

The renewing care coordinator can always choose Beginning CC CORE Course Option 2 (self-paced training) without a mentor. Then request a Renewing CC exam from SDS Training.

About Care Coordination Continuing Education Hours (CEH):

Per Care Coordination Services Conditions of Participation (COPS-02 (B)(3)), care coordinators must submit proof of attendance and successful completion of 16 annual hours of continuing education to apply for renewal of certification.¹³

SDS Training offers 16 optional continuing education hours (CEH), in specific topic areas. SDS training provider meetings, information sharing webinars, and self-paced training or exams are not available as CEH.

Documents needed to certify an additional CC are:

Cert-02 Care Coordinator Certification Application

- Applicant's resume
 - Documentation showing applicant's educational qualifications
 - Certificate of completion of SDS care coordination training within the prior 12 months
 - Disclosure of Business and Familial Relationships form (Cert-20)
- *** be sure to complete a Cert- 46 to keep on file with each Support Plan completed by this Care Coordinator

¹² SDS Training Registration Page: <http://dhss.alaska.gov/dsds/Pages/ops/senior-disabilities-service/training.aspx>

¹³ Care Coordinator Conditions of Participation (COP-02): <http://dhss.alaska.gov/dsds/Documents/regspackage/CareCoordinatorCOPs.pdf>

Initial Agency Certification Application

Guidance on the CC Certification Application Forms is available on [the SDS certification webpage](#).¹⁴ From the Main SDS Page look in the right side navigation for 'Provider Certification information'.

Instructions for Provider Certification

- [HCBS Waiver Certification FAQ's](#)
- [HCBS Waiver Certification Application Guidance](#)

First Time application for a Care Coordination Agency Certification packet

AGENCY OF ONE—A Care Coordination agency with one coordinator must have a care coordinator administrator. The sole care coordinator must meet the qualifications (required education and experience per conditions of participation) of the care coordinator administrator.

Go to the Certification section on the [Approved SDS Forms page](#) for current forms to apply for certification.¹⁵

What to turn in with application packet:	Purpose of form or document development	Develop, write, abide by and keep on file with agency:
Cert-01 Provider Certification Application	Apply to become certified as a provider.	
Cert-02 CC Certification Application	Shows your qualifications to be a certified CC.	
Cert-03 Worker Assurances	For Single Owner Agencies Tells SDS that you understand and agree to procedures regarding having no employees	
Cert- 04 Notice of Appointment of Program Administrator	State who the SDS point of Contact is.	
Cert-06 Service Declaration – Care Coordination	Declare which populations you are qualified for and will serve.	
Written Policies		<ul style="list-style-type: none"> • Critical Incident Reporting • Quality Improvement • Termination of Provider Services • Person-Centered Practice • Financial Accountability • Independence and Inclusion
Cert-37 Provider Policy Assurances		<ul style="list-style-type: none"> • Complaint Management Policy & Procedures • Confidentiality Policy & Procedures • Notice of Privacy Practices • Conflicts of Interest Policy & Procedures • Emergency Response Policy & Procedures • Evaluation of Employees Policy & Procedures
Cert-46 Conflict of Interest Attestation	No relations with other HCBS providers	

Providers

[Search for a provider](#)

[Care Coordination Agencies](#)

[Search for Public Notices](#)

[Provider Certification Information](#)

[SDS Policy Memo: Prohibition of Recipient Solicitation](#)

Of Interest

You should email a completed certification application to the SDS Provider Certification and Compliance unit.
dsdscertification@alaska.gov

¹⁴ Provider Certification Information: <http://dhss.alaska.gov/dsds/Pages/provider/default.aspx>

¹⁵ Approved SDS Forms: <http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx#cert>

Business Resources for Care Coordination Agency Applicants

Note: SDS does not provide guidance on your agency's business responsibilities.

If you need information about how to set up a business, how to write a policy, how to write an employee manual or other business related practices, you can contact the [Alaska Small Business Association](#) . .

Individual CCs are certified separately from the agency! The agency care coordinator administrator assists new care coordinators who are joining the agency to submit the packet for an individual care coordinator within the agency.

Certification tips:

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

- ❖ You may mail or hand deliver the *completed* certification application to the address on the application.
- ❖ Please give SDS at least 6 weeks to review a certification application.
 - If more information is needed, the application will be pended for 10 business days and e-mail guidance will be sent.
- ❖ Certification date will not be backdated!!!

Once the completed certification application is processed and no additional information is needed you will be sent a letter with instructions and a Provider Certification form. You **MUST** follow those directions to complete your enrollment with Conduent – Alaska's Medicaid fiscal agent.

Individual technical assistance for those applying for certification is available by appointment only. You can contact the Certification Unit by email dsdscertification@alaska.gov or by calling SDS at 907-269-3666 or 800-478-9996 and asking for Provider Certification and Compliance.

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 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).

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. This includes all people who will contact vulnerable individuals before working with recipients and/or their protected health information. Each agency must complete a background check for each employee. It is not possible to bring a background check from a previous place of employment and supply them to a new place of employment.

The BCP conducts an exhaustive background check before issuing a provisional clearance to an individual wishing to become a direct care service provider. This background check includes records from both Alaska and those states the individual has lived in for the past 10 years. Records searched are:

- Alaska Public Safety Information Network (APSIN) - APSIN serves as a central repository for Alaska criminal justice information. This information is also known as an “Interested Persons Report;”
- Alaska Court System/Court View and Name Index - Provides civil and criminal case information and is used to assist in determination of disposition for cases in APSIN;
- Juvenile Offender Management Information System (JOMIS) – JOMIS is the primary repository for juvenile offense history records for the State of Alaska, Division of Juvenile Justice;
- Centralized Registry (employee misconduct registry) - Includes those persons which have been investigated by a state investigator for abuse, neglect and/or exploitation, found guilty of abuse, neglect, and/or exploitation, and due process has been provided. Alaska and other states (birth and residence) as applicable;
- Certified Nurse’s Aide (CNA) Registry – Professional registry listing those individuals certified to perform duties as a CNA. In some states, this registry also serves an abuse registry. Alaska and other states (birth and residence) as applicable;
- National Sex Offender Registry (NSOR) - The NSOR provides centralized access to registries from all 50 states, Guam, Puerto Rico and the District of Columbia; and
- Office of Inspector General (OIG) - a database which provides information relating to parties excluded from participation in the Medicare, Medicaid and all Federal health care programs.
- And any other records/registries the Department deems are applicable.

Fingerprints are good for 6 years; the background check is variable depending on factors such as, if an individual is charged with a barrier crime as defined under [7 AAC 10.905](#), etc. *Note: Fingerprints are good for 6 years, not background check itself.*¹⁶

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.

You must obtain and pass a background check per [AS 47.05.300– 47.05.390](#) to complete your certification.¹⁷

**See the Background Check Unit website for specifics:
<http://dhss.alaska.gov/dhcs/Pages/cl/bgcheck/default.aspx>**

The information is for educational purposes and not intended to authorize a person through a background check. Please consult the BCP website for current processes and fees.

¹⁶ 7 AAC 10.905: <http://www.akleg.gov/basis/aac.asp#7.10.905>

¹⁷ AS 47.05.300: <http://www.akleg.gov/basis/statutes.asp#47.05.300>

Enrollment with Conduent

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 Conduent—formally known as 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.¹⁸

Training is available to help you fill out the **enrollment application**. You can access [introductory training](#) about the enrollment process.¹⁹

You may also access the [Medicaid Enrollment Learning Portal](#).²⁰

Individual Care Coordinators are assigned an Individual Provider ID# (IP#). The Agency they work with is assigned a Provider Group ID# (Agency #).

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 Conduent (Alaska Medicaid). You will receive your provider billing ID numbers from Conduent.

Connect to the SDS Harmony data system

After your initial SDS certification is complete and you've received your Medicaid billing ID # from Conduent, all Care Coordinators must complete an Intro to Harmony review session and request SDS Harmony Access through a [Privacy and Security Agreement for Individual Provider User](#). After the Introductory session has been completed the SDS Harmony system administrators will open your access to the system. You may access the agreement forms and learn more about the Harmony system within the "Of Interest" section of the [SDS Website](#).²¹

Each certified agency will have a Harmony Access Coordinator this responsible for:

1. Ensure agency Harmony users have a need for access to the data system
2. Verify users have current Alaska Background checks complete
3. Monitor compliance of agency users to the individual user agreement
4. Report changes in name, position or affiliation to the agency for all of the individual agency users
5. Notify SDS of any suspected breaches of security, unauthorized access or disclosures of confidential consumer information.
6. Reporting to SDS that a CC or employee with Harmony access is no longer employed

If you have questions about gaining access to the SDS Harmony system please contact the SDS Training unit or send an email request to dsdsharmonyhelp@alaska.gov.

¹⁸ Conduent Website: <http://medicaidalaska.com/>

¹⁹ Conduent Introductory Training: <http://manuals.medicaidalaska.com/docs/akmedicaidtraining.htm>

²⁰ Medicaid Enrollment Learning Portal: <https://learn.medicaidalaska.com/>

²¹ SDS Website-Harmony Data System: <http://dhss.alaska.gov/dsds/Pages/harmony.aspx>

Renewing Certification

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

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

Individual Care Coordinator	Care Coordination Agency
Care Coordinator Certification Renewal Application (CERT-22)	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 Renewal Training certificate within the previous 12 months	Renewal Service Declaration: CC Services (CERT-24)
CIR Training Certificate (renewed)	State of Alaska Business License
	CC Agency Certification Conflict of Interest Attestation
	Certificate of Insurance
	Organization Chart or Personnel List if applicable
	Quality Improvement Report

Please visit the [SDS Training Schedules & Registration](#) page for the most current offerings.²²

Reimbursement for services

Rates of reimbursement are set by the DHSS, Office of the Commissioner Office of Rate Review. You can view current rates of reimbursement for Home and Community Based Waiver services, including Care Coordination, and Personal Care Assistance on SDS’s Cost Survey Page.²³

Please note: The recipient may have both a waiver and Community First Choice. When this occurs, the care coordinator is reimbursed only for the WAIVER CARE COORDINATION services and codes, NOT BOTH.

- Application for Waiver or Community First Choice One Initial (all 5 waiver types)
 - \$92.59 – Service Code: T1023 SE
- Initial Support Plan & Annual Renewal Support Plan for Waiver or CFC only
 - \$394.43 – Service Code: T2024 SE

Targeted Case Management – 7 AAC 128.010 & 7 AAC 145.290

- Case Management Monthly (Community First Choice Only)
 - \$121.98 - Service Code: T2022 TS

Care Coordination – 7 AAC 130.240 & 7 AAC 145.520 for Waivers:

- Care Coordination Monthly ALI, APDD, CCMC, IDD
 - \$246.79– Service code: T2022
- Care Coordination Monthly ISW
 - \$152.47 – Service code: T2022 CG

²² SDS Training Schedule and Registration page: <http://dhss.alaska.gov/dsds/Pages/ops/senior-disabilities-servicetraining.aspx>

²³ SDS Cost Survey page: <http://dhss.alaska.gov/dsds/Pages/info/costsurvey.aspx>

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. Notice may be attached to an email to dscertification@alaska.gov. 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 Conduent, 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.

You may use SDS Approved Form [Cert-44 Change of Status - Care Coordinator or Program Administrator](#)

What happens when a Care Coordinator wants to change CC Agencies?

The Care Coordinator must send notice to SDS with the new CC Agency Administrator signature. It is best to have this completed BEFORE leaving the current CC agency to prevent a break in certification. *Any breaks in certification will require new training certificates in Beg. Care Coordination and a new CC application to be processed.*

From the CC COPs:

C. Conflicts of interest.

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 or her as care coordinator or to initiate the process of transferring any recipient to the hiring agency for care coordination services or targeted case management; 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.

Can a Care Coordination agency be sold or transferred?

All information regarding recipients is confidential. An individual Care Coordination or Agency certification and enrollment themselves cannot be sold or transferred. If a Care Coordination agency (business) is to 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 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 is to contact DSDS Certification at least 6 months prior to starting the process of selling an Agency.

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](#)

[7AAC 105.400-490 Provider Sanctions and Remedies](#)

UNIT 3 -Regulations & Responsibilities

All Providers Required Standards

Six Assurances to CMS

Ethics and Boundaries

Understanding Guardianship

Responsibilities of a Care Coordinator

Case Notes for CC Services

REGULATORY ORDER OF CONSIDERATION

1. Federal Laws required of all People
2. CMS Regulation – Federal Code of Regulations (CFR)
3. Alaska’s application to operate HCB Waivers- found on the SDS webpage
4. Alaska Statutes for Medicaid Participation- 7 AAC 105....
5. Alaska Statues for Home and Community-Based Waiver Services- 7 AAC 130
6. Conditions of Participation- adopted in the 7 AAC 130....
7. SDS Policies

Federal Regulations all Providers Must Follow

Federal Medicaid regulations:

- [Civil Rights Act of 1964](#)²⁴
- [Section 504 of the Rehabilitation Act of 1973 \(Div. of Vocational Rehab.\)](#)²⁵
- [HIPAA \(Health Insurance Portability and Accountability Act of 1996\)](#)²⁶ P.L 104-191
- [HIPAA Title II Administrative Simplification and Compliance Act](#)²⁷ 45 C.F.R. Part 160
- [Age Discrimination Act of 1975](#)²⁸
- [Americans with Disabilities Act of 1990](#)²⁹
- [Olmstead Act, July 1999](#)³⁰

CMS Regulation – Federal Code of Regulations (CFR)

An official website of the United States government

Medicaid.gov
Keeping America Healthy

Search | Archive | Site Map | FAQs

Federal Policy Guidance | Resources for States | Medicaid | CHIP | Basic Health Program | State Overviews | About Us

Home > Medicaid > Home & Community Based Services > Guidance > HCBS Final Regulation

Guidance

HCBS Final Regulation

HCBS Settings

Electronic Visit Verification

Additional Resources

HCBS Health & Welfare

Home & Community Based Services Final Regulation

The final Home and Community-Based Services (HCBS) regulations set forth new requirements for several Medicaid authorities under which states may provide home and community-based long-term services and supports. The regulations enhance the quality of HCBS and provide additional protections to individuals that receive services under these Medicaid authorities.

Related Links

- [HCBS Technical Assistance for States](#)
- [HCBS Training Series](#)

- **Final Regulation:** [1915\(i\) State Plan HCBS, 5-Year Period for Waivers, Provider Payment Reassignment, Setting Requirements for Community First Choice, and 1915\(c\) HCBS Waivers - CMS-2249-F/CMS-2296-F](#)
 - **Informational Bulletin - Final regulations for HCBS provided under Medicaid's 1915(c), 1915(i) and 1915(k) authorities** (PDF 99.21 KB)
 - **Press Release - Final regulations for HCBS provided under Medicaid's 1915(c), 1915(i) and 1915(k) authorities**
 - **Fact Sheets Regarding Final Regulation CMS-2249-F/CMS-2296-F**
 - [Overview of Regulation](#) (PDF 105.39 KB)
 - [1915\(c\): Changes to HCBS Waiver Program](#) (PDF 118.56 KB)
 - [1915\(i\): Key Provisions for HCBS State Plan Option](#) (PDF 109.22 KB)
 - [Summary of Key Provisions of the HCBS Settings Final Rule](#) (PDF 120.41 KB)
 - HCBS Final Rule [Webinar Presentation Download](#) (PDF 405.51 KB)

²⁴ U.S. Social Security Administration's page on Civil Rights Act of 1964: https://www.ssa.gov/OP_Home/comp2/F088-352.html

²⁵ U.S. Department of Labor's page on Section 504: <https://www.dol.gov/oasam/regs/statutes/sec504.htm>

²⁶ U.S. Government Publishing Office on HIPAA: <https://www.govinfo.gov/app/details/PLAW-104publ191/summary>

²⁷ U.S. Department of Health and Human Services Office for Civil Rights – HIPAA Administrative Simplification:

<https://docs.google.com/viewer?url=https%3A%2F%2Fwww.hhs.gov%2Fsites%2Fdefault%2Ffiles%2Focr%2Fprivacy%2Fhipaa%2Fadministrative%2Fcombined%2Fhipaa-simplification-201303.pdf>

²⁸ U.S. Department of Health and Human Services Office for Civil Rights – Age Discrimination: <https://www.hhs.gov/civil-rights/for-individuals/age-discrimination/index.html>

²⁹ U.S. Department of Justice – Civil Rights Division - Americans with Disabilities Act page: <https://www.ada.gov/>

³⁰ Americans with Disabilities Act page: https://www.ada.gov/olmstead/olmstead_about.htm

Six Assurances to Centers for Medicare & Medicaid Federal Authority

For Home and Community Based Waivers (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 (Support Plan or PLAN):

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](#)³¹

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.

Senior and Disabilities Services (SDS) is part of the Department of Health and Social Services (DHSS), State of Alaska.

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.

Office of Rate Review (ORR) works with Medicaid Provider Rates of reimbursement.

³¹ AS 47.24.010: <http://www.akleg.gov/basis/statutes.asp#47.24.010>

Alaska’s application to operate HCB Waivers

The Olmstead Act, issued in July 1999, allows each state to create a system of Home & Community Based services to meet the needs of its specific population. Each state must apply to the Centers for Medicare & Medicaid (CMS) for the authority to ‘Waive’ the requirement for a Medicaid recipient to receive all their Nursing or Institutional level cares in the institution or hospital.

Anyone can review the application the State of Alaska has made on the [AK HCBS Waivers page](#) under the “Of Interest” section.³² Any drafts or amended- approved applications will be available there too.

The screenshot shows the website for the Alaska Department of Health and Social Services, Senior and Disabilities Services. The page title is "Approved HCBS Waivers". It features a navigation menu with links for Home, Divisions and Agencies, Services, News, and Contact Us. A search bar is located in the top right corner. The main content area is divided into two sections: "Approved HCBS Waivers" and "Proposed Waiver Amendments".

Approved HCBS Waivers

- > IDD approved amended waiver, AK.0260.R05.02, effective 7/18/18
- > ALI approved amended waiver, AK.0261.R05.02, effective 7/18/18
- > APDD approved amended waiver, AK.0262.R05.02, effective 7/18/18
- > CCMC approved amended waiver, AK.0263.R05.02, effective 7/18/18
- > ISW approved waiver, AK.1566.R00.00, effective 7/1/18

Proposed Waiver Amendments

- > Draft ALI waiver
- > Draft APDD waiver
- > Draft CCMC waiver
- > Draft IDD waiver
- > Draft ISW waiver

To expedite the review process, SDS has highlighted in yellow the waiver sections containing proposed amendments to all five waivers in appendices D.2 and G.2 and, for the CCMC waiver only, additional proposed amendments in appendix G.3

Senior and Disabilities Services

- Home
- Our Mission
- Contact Us
- Centralized Reporting
- Units**
- Adult Protective Services (APS)
- CAT Review Unit
- Central Intake
- Early Intervention/Infant Learning Program
- Grant Services
- Intake and Assessment Unit
- Intellectual & Developmental Disabilities (IDD) Unit
- Operations, Training, Transportation & Hearings
- Policy & Program Development
- Provider Certification & Compliance
- Quality Assurance (QA)
- Research & Analysis

³² SDS Webpage – AK HCBS Waivers: <http://dhss.alaska.gov/dsds/Pages/AK-HCBS-waivers.aspx>

Alaska Statutes for Medicaid 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. \(7 AAC 105.100 - 7 AAC 105.130\)](#)³³

This regulation set 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. \(7 AAC 105.200 - 7 AAC 105.290\)](#)³⁴

This regulation set 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. \(7 AAC 105.400 - 7 AAC 105.490\)](#)³⁵

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.

Alaska Statues for Home and Community-Based Waiver & other SDS Services

SDS has established standards to ensure that services are delivered by individuals with the requisite skills and competencies to meet the needs of recipients and to ensure that services are performed in a safe and effective manner. The SDS standards are specified in Alaska’s *Regulation* and in the [Provider Conditions of Participation](#) and each Service’s [Conditions of Participation \(COPs\)](#). *An excellent resource to access all of the regulatory sets and COPs is from the SDS Regulations and Related Materials page.*³⁶

³³ 7 AAC 105.100: <http://www.akleg.gov/basis/aac.asp#7.105>

³⁴ 7 AAC 105.200: <http://www.akleg.gov/basis/aac.asp#7.105.200>

³⁵ 7 AAC 105.400: <http://www.akleg.gov/basis/aac.asp#7.105.400>

³⁶ SDS Regulations and Related Materials page: <http://dhss.alaska.gov/dsds/Pages/regulations/default.aspx>



Alaska Department of Health and Social Services Senior and Disabilities Services



[Home](#) [Divisions and Agencies](#) [Services](#) [News](#) [Contact Us](#)

[Health and Social Services](#) > [Senior and Disabilities Services](#) > [SDS Regulations and Related Materials](#)

Current SDS Regulations and Related Materials

- › **Personal Care Services 7 AAC 125.010 - 125.199**
 - › **Personal Care Services and Community First Choice Personal Care Services Provider Conditions of Participation**
(effective October 1, 2018)
 - › **Personal Care Services Service Level Computation Chart**
- › **Community First Choice Services 7 AAC 127.010 – 127.990**
 - › **Personal Care Services and Community First Choice Personal Care Services Provider Conditions of Participation**
(effective October 1, 2018)
 - › **[Community First Choice Personal Care Services Service Level Computation Chart](#)**
- › **Long Term Services and Supports Targeted Case Management 7 AAC 128. 010**
 - › **Care Coordination Services and LTSS Targeted Case Management Conditions of Participation** *(effective October 1, 2018)*
- › **Home and Community-Based Waiver Services 7 AAC 130.200 - 130.319**
 - › **Waiver Conditions of Participation**
(effective November 5, 2017, updated October 1, 2018)
- › **General Relief Regulations 7 AAC 47.300-47.900**
(effective June 16, 2016)

Ethics & Boundaries: Some Basic Best Practices

A Care Coordinator relies on an ethical approach to their work. It is important to consider best practices for ethical responsibilities. People entering and receiving services are naturally vulnerable. They rely on the Care Coordinator to help them navigate a system of services they depend on. 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 their needs in front of all the work you do in planning and working with systems and providers.

Many Alaskan communities are small. This can lead to people having multiple roles in the community. In cases when there are dual roles to support a person, there must be a way for your client to understand they have a right to informed choices. 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 = a Dual Relationship. This is when we have more than one role in our interactions with the person. For example, as a Care Coordinator we should avoid offering other goods and services to our clients when we stand to gain financially from the sale or referral. It’s important to practice conflict of interest because person may have a difficult time saying “no” because of our influence as their Care Coordinator. It is also possible to 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.

Are you person centered? Or are you putting our own stories & ideas for solutions first: We may wish to help a person avoid going through a perceived hardship we envision when he or she voices their own solution. It may be easy to state that we know about the best solution to meet the persons’ needs. However, if we apply supports and solutions without listening to the person we are not helping them find meaningful solutions. Without their participation, the person may not engage with solutions created for them. They may find them intrusive- which is counterproductive to the purpose of supports. Waiver services should support as much independence as possible, especially when extensive supports are necessary.

*When someone shows you who they
are, believe them the first time.*

~Maya Angelou

Exploiting dependency: People rely on Care Coordinators for navigation to supports and services they depend on. It may become difficult to move towards independence when we think of people by their needs or deficits 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.

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. Every person communicates differently. Sometimes we have a bad or hectic day that results in being unintentionally rude or short with the person. Because of your position of authority, people may interpret this as being somehow their fault. The people we serve come first. Using person-first language and interacting with an attitude of warmth and genuineness helps achieve this. Each person has an individual story. Expect to interact with people who come from different cultures, economic levels, and philosophies of life in addition to their specific care needs. Take time learning more about how each person communicates in order to be able to put him or her at the center of their Support Plan. 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: It's ok to not know: Care Coordination requires significant skills in working with people and specific community resources beyond what is outlined in the certification process.. It is your ethical responsible to know your limitations and to ask for help when a situation requires additional expertise. It is ethically responsible to increase your knowledge base through professional development. 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.

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

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

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)

Understanding Guardianship

Guardianship takes away a person's rights so it is only done as a last resort. Guardianship is assigned by the court after determining that someone lacks the capacity to make decisions for themselves. 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: Makes few decisions and role as defined by the court order.
- Conservatorship: Decisions are strictly financial management.
- Supported Decision Making: A written agreement details the role of supporters in making specific types of decisions. Allows an individual to maintain their rights, but also have support system for decisions.

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 \$100.00 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 13.26.311](#).³⁷

Resource for this information: Disability Law Center <http://www.dlcak.org/>; Governor's Council on Disabilities & Special Education <http://dhss.alaska.gov/gcdse/Pages/projects/SDMA/default.aspx>

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](#)).³⁸ Power of Attorney (POA) can be tailored to meet the person's specific needs. 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](#)).³⁹ 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 13.26.630](#).⁴⁰

"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.⁴¹



³⁷ AS 13.26.316: <http://www.akleg.gov/basis/statutes.asp#13.26.316>

³⁸ AS 13.26: <http://www.akleg.gov/basis/statutes.asp#13.26>

³⁹ AS 13.52: <http://www.akleg.gov/basis/statutes.asp#13.52>

⁴⁰ AS 26.630: <http://www.akleg.gov/basis/statutes.asp#13.26.630>

⁴¹ AS 47.05.017: <http://www.akleg.gov/basis/statutes.asp#47.05.017>

Responsibilities of a Care Coordinator

Care Coordinators assist individuals who are recently eligible or already receive waiver services. They assist in gaining access to needed waiver and other state plan services. They also help with gaining 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 community or other 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. Conditions of Participation are adopted by the Alaska Statutes in the Alaska Administrative code, Title 7 and are therefore law.

You will initiate and maintain your education, training and certification requirements associated with the Care Coordination service you are providing. Certified Care Coordinators are responsible for correct Medicaid billing and record keeping practices. You are also responsible to 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.⁴² The Care Coordinator will informally assess the person's needs, and create a Support Plan 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 ISW and CFC are not subject to exception of the quarterly visit. ISW must have a face to face visit to the client as determined in the approved support plan and at least once per quarter. CFC must have a face to face visit plan in the approved person centered support plan. See Conditions of Participation for Care Coordination Services and Targeted Case Management (COP-02).**⁴³

The Care Coordinator defined under 7 AAC 130.240(b)(2)(A):⁴⁴

“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 waives 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 Support Plan; the annual Support Plan 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.

⁴² 7 AAC 130.240: <http://www.akleg.gov/basis/aac.asp#7.130.240>

⁴³ COP-02: http://dhss.alaska.gov/dsds/Documents/SDSforms/CC_TCM_COP.pdf

⁴⁴ 7 AAC 130.240: <http://www.akleg.gov/basis/aac.asp#7.130.240>

When we think of Care Coordination we often think of the activities of visiting the person and writing the Support Plan. 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 Support Plan 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 Support Plan 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 termination.

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.

On-going Care Coordination visits

- Be flexible: 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 Mon. - Fri. workday as some of your clients and/or their legal representatives will be working during those times.
- Be present and connect: A good length of time for a visit can be considered one hour. This allows for time to observe and interact with your client in the environment (whether it is at home or at a service provider). You may also need to interact with your clients’ informal (non-waiver) supports and other providers to understand the depth of the problem and make creative solutions. This could include medical providers, school officials, day care personnel, or any individual that has a personal or professional relationship with your client.
- Be an educator: Care Coordinators may need to help a person learn about their choices and be supported in decisions about their direct service staff. You may have to explain that regulations limit who may be a paid provider, to protect against conflict of interest.
- Be realistic: 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.
- Be compliant: 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. You may visit/contact the legal representative for the required “second contact”.

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. Your service is to ensure an individual is supported to live the life they choose. It takes time and trust to build a professional relationships that meaningfully achieves this objective.

Care Coordinators gather the planning team

The person to receive support is central in developing their support plan and choosing who is a part of their planning team. They are empowered to make choices and entitled to dignity throughout the process. The Care Coordinator receives feedback and practical information about services through the planning team meeting. Meetings may be conducted in person, by e-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 Support Plan.
 - this should be the same person who signs the Plan

Exceptions to the planning team are:

- the Specialized Medical Equipment provider
- the Environmental Modifications provider
- the Transportation provider

These providers do not have to be on the planning team however, they are required to sign the PLAN.

Person Centered Practice detailed in 7 AAC 130.218 clearly establishes the rights of waiver recipient in the planning process.⁴⁵ The plain language summary of these rights require:

- I (the recipient) choose who helps me develop a support plan.
- I have a right to change my goals and needs.
- I am entitled to timely responses.
- My time is valuable. Meetings must consider my schedule and be located conveniently.
- My culture is special and must be honored.
- I have a right to make informed decisions about services. Information must be shared in plain language.
- Planning my care is conflict free. Providers must collaborate with all members of my support team and have strategies for solving conflicts.
- My support team and I must prevent unnecessary or inappropriate services.
- The places where my services are rendered must support my community inclusion.

Report changes in recipient basic information

Use the UNI-11 [Recipient Change of Status form](#) to report changes.⁴⁶ Email addresses are located on the form for each SDS program unit. *Change of Status forms are not reports of harm or critical incidents.* These must be completed as separate reports.

Things that must be reported are:

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

In the [SDS](#) Harmony data system the CC only needs to make a Consumer record Note after the appropriate demographic fields have been updated.

⁴⁵ 7 AAC 130.218: <http://www.akleg.gov/basis/aac.asp#7.130.218>

⁴⁶ Recipient Change of Status form: <http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx>

Adult Protective Services Mandatory Reporters

To comply with [AS 47.24.010](#) of the Alaska Statutes, CCs 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.

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.⁴⁷ Vulnerable adults have a physical or mental impairment or condition that prevents them from protecting themselves or from seeking help from someone else.

Adult Protective Services helps to prevent or stop harm from occurring to vulnerable adults. The following are reportable:

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>

**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/>

⁴⁷ AS 47.24.900(21): <http://www.akleg.gov/basis/statutes.asp#47.24.900>

Protect against Conflict of Interest

Care Coordinators disclose business and familial relationships with other HCB providers. This will be disclosed in two ways to SDS & to the client.

First, a CC must submit a [Cert-20 form](#) during the certification process with Senior and Disabilities Services.⁴⁸

Second, a CC must explain any potential conflicts to their client the applicant/recipient. Evidence of this conversation must be documented on the Application for ALI/APDD/CCMC/CFC([UNI-04](#)).⁴⁹

“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 their choices between different providers. “Yes” means your client has been informed of the CC familial/business relationships with HCBW providers. “No” means your client 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.)

Use 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 (if the ROI is expired). 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. SDS uses a Department of Health & Social Services specified Release of Information form as part of the initial application. The form is prefilled to authorize any medical provider or medical billing provider to give medical documentation for program eligibility determination. The individual may choose an event based expiration or an actual date.

For ALI/APDD/CCMC/CFC applications:

<http://dhss.alaska.gov/dsds/Documents/SDSforms/UNI-16-ROI-Form.pdf>

For IDD/ISW applications & ICAP respondents:

<http://dhss.alaska.gov/dsds/Documents/SDSforms/DHSS-Authorization-Release-Information.pdf>

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 assist the person to revoke consent of private information sharing when it’s necessary.

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 is fully responsible for sharing necessary information with providers. The former Care Coordinator can then redirect subsequent inquiries to the new Care Coordinator.

⁴⁸ Cert-20 form - Care Coordinator Disclosure of Business and Familial Relationships:
<http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx#cert>

⁴⁹ Uni-04 form – Application for ALI/APDD/CCMC/CFC

Follow (HIPAA) Health Insurance Portability and Accountability Act 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. SDS requires all certified providers to use Direct Secure Messaging (DSM) provided through healthEconnect Alaska. They will register your agency admin and individual employees for an InprivahDirect email account.

All providers must register for a DSM account with healthEConnect Alaska. Please see <https://www.healthconnectak.org/>

Critical Incident Reports

In accordance with the Critical Incident Reporting and Management regulation 7 AAC 130.224, CC's make Critical Incident Reports in the Alaska Centralized Reporting System. All reports must be made within 24 hours of discovery. CCs **MUST** report each incident that effects their client regardless of other reports that may have been made.

Critical incidents are defined in 7 AAC 130.224 as:

- a missing recipient;
- recipient behavior that resulted in harm to the recipient or others;
- misuse of restrictive interventions; in this subparagraph, "restrictive intervention" has the meaning given in 7 AAC 130.229(g);
- a use of restrictive intervention that resulted in the need for evaluation by or consultation with medical personnel; in this subparagraph, "restrictive intervention" has the meaning given in 7 AAC 130.229(g);
- death of a recipient;
- an accident, an injury, or another unexpected event that affected the recipient's health, safety, or welfare to the extent evaluation by or consultation with medical personnel was needed;
- a medication error that resulted in the need for evaluation by or consultation with medical personnel; in this subparagraph, "medication error" has the meaning given in 7 AAC 130.227(j);
- an event that involved the recipient and a response from a peace officer;

Home and Community-Based Waiver Services Provider Conditions of Participation

3. Critical incident reporting training.

- a. The provider must have on file, for all staff, documentation of attendance and completion of, at least every two years, training on how to report critical incidents to SDS.
- b. The provider may
 - i. arrange for staff to attend SDS training; or
 - ii. appoint staff who have attended SDS training to train additional staff.
- c. At a minimum, the following agency employees must refresh, every two years, critical incident reporting training by attending and completing the course offered by SDS:
 - i. the program administrator; and
 - ii. the individuals who supervise each home and community-based service the agency is certified to offer.

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.

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.

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)

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
Prosecutions and Appeals
310 K Street, Suite 300
Anchorage, AK 99501
email: medfraud@alaska.gov

Medicaid Fraud Control Unit Hotline Office of Special
907-269-6279
fax 907-269-6202

Crimestoppers Hotline at 1-907-561-7867

Case Notes of Care Coordination Service

Maintain a written record (Case Note) of all applicant/recipient, service provider and informal support contacts. 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 Conduent (formerly known as 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 Support Plan.

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.

Tips for writing professional notes

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 bring strengths, gifts and talents to their story. Those strengths are valid and important to document. 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 Support Plan. 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)

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

Records Retention schedule for the Alaska Medicaid Long Term Services and Supports

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. The Agency must retain a copy of service records after the recipient is no longer serviced. For clients who were served and are now deceased you still need to retain records according to the regulation.

UNIT 4 - Eligibility

Medicaid Eligibility

Appointment for Care Coordination Services

Release of Information

Developmental Disabilities Eligibility

IDD Waiver Eligibility

Nursing Facility LOC

CCMC Waiver

Services through Grants

Did you know?

Every state makes a Plan for administering Medicaid funds. 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](#).

Medicaid Eligibility

Medicaid is a program created by the federal government, but administered by the state, to provide payment for medical services for low-income citizens. People qualify for Medicaid by meeting federal income and asset standards and by fitting into a specified eligibility. Under federal rules, DHSS has authority to limit services as long as the services provided are adequate in “amount, duration, and scope” to satisfy the person's medical needs.

Medicaid began as a program to pay for health care for people in need who were unable to work. It covered the aged, the blind, people with disabilities, and single-parent families. Over the years, Medicaid has expanded to cover more people. For instance, children and pregnant women may qualify under higher income limits and without asset limits. Families with unemployed parents may qualify, and families who lose regular Family Medicaid because a parent returns to work may continue to be covered for up to one year.

There have also been changes in the eligibility rules for people who need the level of care provided in an institution, such as a nursing home. Now, most Alaskans who need — but cannot afford — this expensive care may qualify for Medicaid. In addition, recent changes within the Alaska Medicaid program give some people who need an institutional level of care the opportunity to stay at home to receive that care.

To apply for Medicaid services please contact the [Division of Public Assistance](#). Applications, office locations, and useful information can be found on their web site.

Useful Links:

- [Local offices for getting help with Medicaid](#)
- [Eligibility Requirements: Current Medical Assistance Income Standards](#)
- [Denali KidCare - Health insurance for low-income pregnant women and children/teens](#)
- [Help and Resources Beyond Medicaid](#)
- [Medicaid State Plan](#)

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

The applicant needs to turn in complete financial/income information and medical documentation. In most cases DPA will do phone interviews with the applicant rather than asking them to come to the office.

If an 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 for that child. 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.

How do care coordinators help with regular Medicaid?

A care coordinator can help the person locate the correct DPA Application and help them fill out the application for Medicaid. For HCB Waiver Services the person will need to fill out the “MED4” or [Application for Adults and Children with Long Term Care Needs](#).

The complete application must include a signed Appointment of Care Coordination form and a [DPA- Release of Protected Health Information form \(GEN-150\)](#) signed by the individual. If you want to communicate with DPA about your clients Medicaid eligibility.

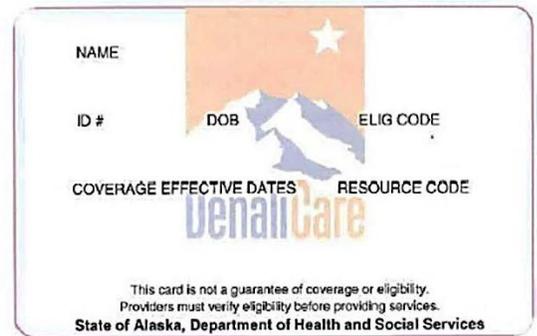
[DPAweb | DPA online resources](#)
dpaweb.hss.state.ak.us

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. They must meet LOC before Medicaid is authorized.
- ❖ **Please note the 300% eligibility category DOES NOT apply to applicants for Community First Choice only. The person can be eligible only for the Waivers through the 300% category.**

After the person turns in their application for Long Term Care Medicaid (form MED 4) DPA assigns the person a functional team and then they will do an interview. DPA determines all the form(s) of Medicaid the person will qualify for. If the person qualifies for Medicaid, they will receive a letter and a Medicaid Denali Care card.

- ❖ DPA must issue a “screening coupon” (WD 19) for individuals who are applying for LTC Medicaid and are likely to meet LOC for the waiver in order for the SDS Level of Care application to be accepted.
- ❖ The “screening coupon” allows the CC to assist the person to make their first application for the ALI or APDD waiver.
 - The coupon must be for the same month as the assessment. If the coupon expires, the CC must ask DPA for a new coupon or screening letter.



In some Alaskan communities there is no “DPA office”. There is often a “fee agent” which is simply an individual or 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.

Medicaid Ethics & Boundaries

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.

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. 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.

Applicant already on Medicaid?

A person may already have Medicaid and ask you to be their care coordinator. For current Medicaid recipients the Care coordinator needs to contact the DPA.LTC office through DSM once they begin pursuing the HCB Waiver. The e-mail must include an Appointment of Care Coordination form and a [DPA- Release of Protected Health Information form \(GEN-150\)](#) signed by the individual. A Med 4 is not needed for an ongoing Medicaid recipient. Med 4's are only required for new applicants. Please request that DPA issue a screening coupon for the individual to apply for Waiver consideration.

- ❖ An ACC & DPA- ROI will be needed to share any information and notices with the care coordinator.
- ❖ DPA must issue a "screening coupon" (DE 25 or WD 19) for individuals who are applying for LTC Medicaid and are likely to meet LOC for the waiver.

You must verify current Medicaid and the Eligibility code.

- This information is located on the persons Denali Care card. Having a card does not guarantee that Medicaid is active.
- Contact Provider Inquiry/Provider Services at Conduent to confirm client eligibility/payment status: (907) 644-6800 (option 1) or toll free (800) 770-5650 (option 1, 1)

Medicaid Re-Application

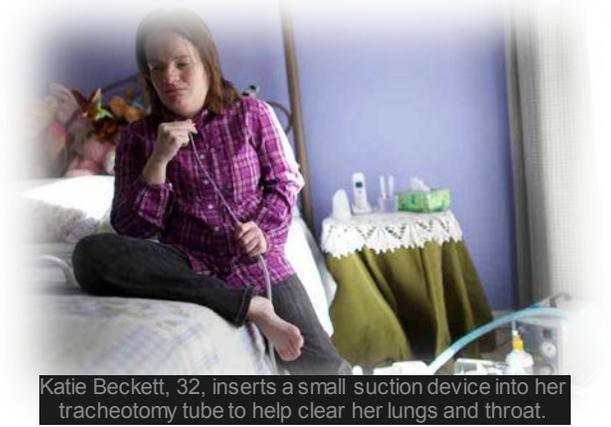
Your client will get a Medicaid application each year and you can help the person reapply for Medicaid. As long as there is an Appointment of Care Coordinator and a DPA-ROI (form GEN-150) on file at DPA you should also get notice of Medicaid renewal for each person on your caseload. You SHOULD remind the person or their legal representative to reapply. It is important to track because if your client's Medicaid expires, their services will not be reimbursed.

TEFRA/ Katie Beckett Waiver

Children who experience disability, and TEFRA/ Katie Beckett Waiver

Who was Katie Beckett?

She changed health care policy for children. Katie Beckett was an individual who experienced disabilities and was medically fragile. She lived in Iowa and died in 2012 at the age of 34. 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.



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

President Reagan authorized the Katie Beckett waiver in 1982 under the Tax Equity and Fiscal Responsibility Act (TEFRA). 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.

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.

Some Care Coordinators also offer TEFRA Coordination to assist families who have children with disabilities to apply to the Division of Public Assistance and find out if they can access Medicaid for their child through TEFRA.

SDS is contracted from DPA to do an assessment for children who experience Intellectual Developmental Disabilities- but this is not Waiver access. Qualis Health is contracted from DPA to do an assessment for children who experience Complex Medical Conditions- but this is not Waiver access. TEFRA is only a form of **Medicaid for children with long term care needs**. Waiver eligibility must still be applied for and granted based on the child’s current level of need.

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.**

Cost of Care (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.

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 its ending.

Care Coordinators can contact DPA with specific questions about the Cost of Care Co-Pay.

*Must have an Appt. of CC & a Release of Information document on file with DPA

Billing and Cost of Care Co-Pay

- 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. Generally the provider who delivers the most expensive services is a good choice.

Reductions to Cost of Care

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.

Developmental Disabilities Eligibility

Determining Level of Care

The Level of Care for an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID) is associated with the IDD Waiver and TEFRA determination. The person will need 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.

People of any age who experience Intellectual and/or Developmental Disability first need to apply for eligibility for services with SDS, by completing a [Developmental Disability Determination Application](#). 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 the State definition.

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

Completion of this form is often done by a **Short Term Assistance and Referral** counselor.

This activity is not part of Waiver-reimbursed Care Coordinator activities.

Short Term Assistance and Referral (STAR)

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/Documents/grant/services/PDFs/STAR_Roster.pdf.

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.

DEFINITION OF ELIGIBLE DIAGNOSES FOR DD SERVICES-

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 a 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

- is attributable to a mental or physical impairment or combination of mental and physical impairments;
- is manifested before the person attains age 22;
- is likely to continue indefinitely;
- 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
 - 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;

Completing an Eligibility Determination & Request for Services

The form is located on the SDS Webpage under the Approved Forms section

<http://dhss.alaska.gov/dsds/Documents/SDSforms/IDD-01-eligibility-application.pdf>

Appropriate documentation of disability and/or diagnosis includes:

- ✓ Documentation from a physician,
- ✓ Speech/Language Therapist;
- ✓ Infant Learning Program (ILP) reports
 - (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*.

Children under the age of 16 must show Functional Limitations at least three of the first five functional life areas (self-care, receptive and expressive language, learning, mobility, self-direction) to be determined eligible for DD services. After age 16, eligibility will consider their “capacity for independent living and economic self-sufficiency”. People of any age must experience substantial limitations in at least 3 of these 7 life areas in order to be determined eligible for DD services.

After submitting the completed *Eligibility Determination Application*, and diagnostic materials, SDS will evaluate 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 Alaska DD Registry.

Developmental Disability Registry

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*.

After the individual has been determined to experience a developmental disability, the next step is to complete the fillable [Developmental Disabilities Registration and Review \(DDRR\) form](#). Please review the [DDRR Standardized Criteria](#) for more information about how to complete the DDRR. This can be done with a STAR representative or the individual or their legal representative can submit the form on their own.

Once the individual has submitted his/her DDRR form, it will be scored and placed on the Developmental Disabilities Registry (also known as the “Wait List”). The DDRR score is calculated according to the responses provided. Highest scores are drawn from the Registry as funds become available. Individuals drawn from the Registry will be notified with a certified letter (the “Notice to Proceed” letter) sent to the most current mailing address SDS has on file.

IDD/ISW Waiver Eligibility: diagnosis

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

Cerebral Palsy

Seizure Disorder

Autism

Diagnosis by a licensed psychologist, child psychiatrist, or developmental pediatrician as specified in 7 AAC 140.600 (c) (3), (4), (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.

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 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.

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 already have a current ICAP assessment on file, because they were receiving TEFRA Medicaid.

The SDS Assessment tool for determining 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 than 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.

After interviews are completed with all three respondents, SDS sends a letter (by DSM to the CC) of eligibility (or ineligibility) for the DD Waiver services. If the person was found eligible for Waiver Services, the CC will create the INITIAL PLAN and submit it to SDS within 60 days. (Initials ONLY)

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.

Applying for the IDD/ISW Waiver

When an individual is drawn from the DD Registry (DDRR), a “Notice to Proceed” letter is sent. The individual is directed to select a care coordinator and notify the department of their choice by completing an **Appointment of Care Coordination form** and **Release of Information** and submitting them to Senior and Disabilities Services (SDS). *It’s possible they will ask you to submit the documents for them, that’s OK.* These documents must be submitted within 30 days of receipt of the “Notice to Proceed” letter.

Upon notice to SDS of care coordinator selection, an ICAP Packet request is generated. **Once the request has been sent, the care coordinator has 30 days to submit the complete ICAP packet.** The application packet contents will depend on the age of the applicant

Age of applicant	Birth to 36 months	36 months to 7years & 11 mon.	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?	At application & LOC renewal	At application & LOC renewal	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 it’s available.		

Use the [CHECK LIST OF FORMS AND DOCUMENTS FOR COMPLETE ICAP/INTERIM PACKET LOCATED ON THE SDS APPROVED FORMS PAGE IN THE IDD FORMS SECTION](#)

Uni - 05	Appointment For Care Coordination Services
DHSS 06-5870	Release of Information
Uni - 07	Recipient Rights and Responsibilities
IDD - 13	Qualifying Diagnosis Certification
	Medical documentation (see chart above)
IDD-03	ICAP Assessment Information and Consent Form
	-DHSS 06-5870 Release of Information for every respondent
	Legal Representative Documents

All of the following forms are located on the [SDS Approved Forms Webpage](#)

To apply for the IDD/ISW Waiver, the individual must submit (through their appointed Care Coordinator) the following:

Uni-05 Appointment for Care Coordination Services

<http://dhss.alaska.gov/dsds/Documents/SDSforms/UNI-05AppointmentOfCareCoordinator.pdf>

The Appt. for Care Coordination (ACC) is the primary form for the recipient to declare their chosen Care Coordinator. It must be accompanied by a Dept. of Health & Social Services, Senior & Disabilities Services Release of Information form. Both forms must be signed by the recipient or the legal guardian (must be the same person signing both forms.)

The form begins with this statement “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 (Choose the Waiver Type) Waiver Program.”

- You must choose the Waiver type from the drop down menu

It is expected the CC will review the information with the recipient line by line to verify or explain every item. This will help your new client to understand what they should expect from you.

Appointment and Transfer of Care Coordination

When a current waiver recipient decides to change Care Coordinators (transfer) this same form is used but now includes the previous CCs information too. When a new ACC is signed it needs to be sent (by DSM) to the previous CC with the new ROI and a request for the last 12 months case notes. The previous CC has 5 business days to provide a copy of the case notes to the new CC.

A new ACC needs to be sent (by DSM) to any current service providers so they are notified and know how to contact the new CC.

Release of Information

[DHSS 06-5870 Release of Information](#)

Every initial IDD or ISW application will require this ROI, signed by the applicant (or their Legal Representative). This ROI can be given to any Medical Professional who has provided treatment or services to the individual in order to authorize the CC and SDS to receive the applicant’s medical information.

Please complete the following

Name:	Client Name
Record #:	Medicaid ID
Date of Birth:	Client DOB
Person/ Organization Releasing Info:	CC Name/ CC Agency Name
Person/ Organization Receiving Info:	AK DHSS- Senior & Disabilities Services
Description of Information To Be Released:	Clinical, medical or functional records or information.
The purpose...:	To determine program eligibility
Authorization expires on the following date or event:	Either is acceptable, event based may be described as “When program eligibility ends.”
Signature	If a legal decision maker, then include authorization

There are instructions on the back of the form on how to complete it.

Uni-07 Recipient Rights & Responsibilities

<http://dhss.alaska.gov/dsds/Documents/SDSforms/Uni-07RecipientRightsResponsibilities.pdf>

Review this information with your client to inform them of their Rights in the waiver process and who's responsible for what. All four sections need to be acknowledged.

- I have the right...
- I have been informed that...
- I am responsible for...
- If receiving CDPCA services, I am also responsible for:
 - CDPCA = consumer directed PCA
 - Place N/A here if not receiving CDPCA
- Intentional Program Violations or Program Abuse statement of understanding
- MUST be signed by the recipient or legal guardian

IDD-13 QDC- Qualifying Diagnosis Certification 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 annual renewal applications. The individual's medical provider will fill out the form including the age of onset.

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. This is a requirement of CMS (Centers for Medicare and Medicaid Services) national Medical Coding Requirement.

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.

IDD-03 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 3 respondents, and providing alternate respondents. Only 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 respondents must know the applicant's functional abilities and daily need for care.

- Every potential Respondent must have a ROI completed to authorize them to discuss the client with the SDS Qualified Intellectual Developmental Disabilities Professional
- Use this form: [DHSS 06-5870 Release of Information](#) for all identified respondents including alternates

Refer to [Guidelines for the ICAP Process](#) on the approved forms page of the SDS website to assist families understanding of the process.

Required medical diagnostic documentation:

- Medical documents and evaluations are required by the division in order to support the qualifying diagnosis.
- All evaluations must be dated within 36 months of the date of submission of the ICAP packet.

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

A completed [Qualifying Diagnosis form](#) indicating a condition specified [in 7 AAC 140.600 \(c\) \(1\)](#), and signed by a:

- licensed psychologist,
- psychological associate,
- developmental pediatrician

AND

An evaluation based on the specific qualifying diagnosis as follows:

- When the qualifying diagnosis is **Intellectual Disability or Other Intellectual Disability** a comprehensive diagnostic evaluation is required. This evaluation must include IQ/Cognitive testing, and adaptive testing and must be completed by a licensed psychologist, neuropsychologist, or psychological associate.
- When **Autism** is the qualifying diagnosis, a comprehensive diagnostic evaluation is required. This evaluation must include IQ/Cognitive testing, and adaptive testing and must be completed by a clinical level psychologist, neuropsychologist, or developmental pediatrician.
- When the qualifying diagnosis is **Seizure Disorder or Cerebral Palsy**, documents to identify substantial functional limitations in three or more areas of major life activity. This can be done through ESER's, OT/SL/Physical therapy reports, assessments by their Primary Care Providers, etc.

- All supportive documentation must identify a substantial functional limitation in three or more of the following areas of major life activity:
 - 1) Self-Care
 - 2) Receptive or Expressive language
 - 3) Learning
 - 4) Mobility
 - 5) Self-Direction
 - 6) Economic Self-Sufficiency
 - 7) Capacity for Independent Living

Send completed applications for annual IDD LOC determinations, including all supporting documents to: [SDS.IDDAnchorageAK](#) (DSM address)

Once Care Coordinators are authorized to use the SDS Harmony Data System, you will submit all of these documents by attaching them to a Note in the Client's record.

Note Type: Consumer Application DD Sub-Type: Initial Application Waiver- Submitted

(Specific Note Types must be used in order to route the Application properly)

Interim year Assessment (the years between the ICAP cycles)

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. The Care coordinator completes the Interim form and submits it to SDS with the supportive documentation.

IDD-10 Interim ICF /IID Level of Care Information Form:

<http://dhss.alaska.gov/dsds/Documents/SDSforms/IDD-10InterimICF-IIDD%20Info.pdf>

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 assessments. 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 completed by the Care Coordinator which is added to the document set that is reviewed by SDS to determine continuing level of care for the IDD waiver.

All of the other Annual LOC documents are still required except the ICAP Info & Consent.

Nursing Facility LOC

Nursing Facility Level of Care, is associated with the **ALI, APDD, and CCMC waiver programs**. The individual with Nursing Facility Level of Care would need to reside in a Skilled 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.

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.

ADRC Person Centered Intake Requirement

Potential Applicants for ALI, APDD, CCMC and CFC MUST have completed a Person Centered Intake with the [Aging and Disability Resource Center \(ADRC\)](#) .

The ADRC specialist conducts a short interview to determine what information and options counseling the individual needs to assist in planning for immediate and future needs and to prevent institutionalization. The Intake process will indicate whether an individual is likely to meet both functional and financial eligibility requirements of various Alaska State Plan programs prior to spending time and effort to complete an application that may be denied.

People are referred to Care Coordinators if it appears they may be eligible for Waiver Services. A Copy of the Person Centered Intake summary is given to the individual to share with the CC. The CC works with the applicant to create a complete application for HCB Services including CFC-Services. A Copy of the Person Centered Intake summary must be included with the initial LOC Application for ALI, APDD And CCMC waivers, and Community First Choice-Only applications.

ALI/APDD/CCMC/CFC Application

Per 7 AAC 130.211 Screening (Application) for the ALI, APDD, CCMC Waiver, or CFC option can occur once every 365 days. If the applicant does not meet Nursing Facility Level of Care, he or she may not apply again for 365 days, unless a documented material change in condition occurs sooner.

- 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 the individual will need to receive care in a Nursing Facility if Waiver Services are not available.

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.

Follow the guidance in the ALI/APDD application checklist on the [SDS Approved Forms Page](#) in order to submit a COMPLETE Application.

Uni - 05	Appointment For Care Coordination Services
Uni -16	Release of Information
	ADRC Person Centered Intake Summary
Uni - 04	Application for ALI/APDD/CFC/CCMC
Uni - 07	Recipient Rights and Responsibilities
Uni - 09	Verification of Diagnosis
For APDD only	Proof of DD eligibility
	Medical and Functional Documentation
	Proof of Medicaid Eligibility (usually just Medicaid #)
	Legal Representative documents, if applicable

The application packet will be processed by the CAT Intake unit at SDS. It's important to have accurate and COMPLETE information such as correct physical address and contact information, if an Assessment visit is to be scheduled and completed. [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.

Uni-05 Appointment for Care Coordination Services

<http://dhss.alaska.gov/dsds/Documents/SDSforms/UNI-05AppointmentOfCareCoordinator.pdf>

The Appt. for Care Coordination (ACC) is the primary form for the recipient to declare their chosen Care Coordinator. It must be accompanied by a Dept. of Health & Social Services, Senior & Disabilities Services Release of Information form. Both forms must be signed by the recipient or the legal guardian (must be the same person signing both forms.)

The form begins with this statement "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 (Choose the Waiver Type) Waiver Program."

- You must choose the Waiver type from the drop down menu

It is expected the CC will review the information with the recipient line by line to verify or explain every item. This will help your new client to understand what they should expect from you.

Transfer of Care Coordination

When a current waiver recipient decides to change Care Coordinators (transfer) this same form is used but now includes the previous CCs information too. When a new ACC is signed it needs to be sent (by DSM) to the previous CC with the new ROI and a request for the last 12 months case notes. The previous CC has 5 business days to provide a copy of the case notes to the new CC.

A new ACC needs to be sent (by DSM) to any current service providers so they are notified and know how to contact the new CC.

Release of Information

[DHSS 06-5870 Release of Information](#)

Every initial IDD or ISW application will require this ROI, signed by the applicant (or their Legal Representative). This ROI can be given to any Medical Professional who has provided treatment or services to the individual in order to authorize the CC and SDS to receive the applicant’s medical information.

Please complete the following

Name:	Client Name
Record #:	Medicaid ID
Date of Birth:	Client DOB
Person/ Organization Releasing Info:	CC Name/ CC Agency Name
Person/ Organization Receiving Info:	AK DHSS- Senior & Disabilities Services
Description of Information To Be Released:	Clinical, medical or functional records or information.
The purpose...:	To determine program eligibility
Authorization expires on the following date or event:	Either is acceptable, event based may be described as “When program eligibility ends.”
Signature	If a legal decision maker, then include authorization

There are instructions on the back of the form on how to complete it.

The person’s completed Person Centered Intake summary – from the Aging and Disability Center

Uni-07 Recipient Rights & Responsibilities

<http://dhss.alaska.gov/dsds/Documents/SDSforms/Uni-07RecipientRightsResponsibilities.pdf>

Review this information with your client to inform them of their Rights in the waiver process and who's responsible for what. All four sections need to be acknowledged.

- I have the right...
- I have been informed that...
- I am responsible for...
- If receiving CDPCA services, I am also responsible for:
 - CDPCA = consumer directed PCA
 - Place N/A here if not receiving CDPCA
- Intentional Program Violations or Program Abuse statement of understanding
 - MUST be signed by the recipient or legal guardian

UNI 09 Verification of Diagnosis

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.

It is the applicant's responsibility to obtain the VOD from their medical providers. Care Coordinators can assist with this and requesting medical and functional information for the application.

**Remember to send your ROI and ACC with any requests you make to the providers.

Uni-04 Waiver Application

This Application is completed for multiple waiver types

- Indicate the waiver type and the CFC option on the cover page
- Must include all pages / sections
- Complete every line and every page; use "n/a" if the information does not apply
- Medicaid number must be present on the application
- Respond to each item in the Health Summary individually
 - use "n/a" if the information does not apply
- List the full name, contact information, reason and frequency of visits for each doctor or health professional listed
 - Must be a specific reason
 - Enter the # of times they saw the provider in the previous year
- Complete every block under current medications including reason prescribed
 - Unknown is not accepted, ask the person or contact the prescriber
- Must be dated and signed by Applicant
 - If there is a parent or legal representative, they must sign where designated (not on recipient line)

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

A person age 21 or over that experiences a physical disability and an intellectual/developmental disability, **will need to follow the process in the previous section to apply for DD eligibility**. The person must be listed on Alaska's DD registry. When this individual applies for the Adults with Physical and Developmental Disabilities waiver (APDD), they receive an assessment to determination of Nursing Facility Level of Care. If NFLOC is determined both the habilitative and non-habilitative services can be offered through the Home and Community Based Waiver.

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.

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

Send completed applications for annual NFLOC determinations, including all supporting documents to the correct DSM address:

ALI/APDD/CCMC/CFC Initial Applications: dsds.nfloc-initialapplication@hss.soa.directak.net

Renewal Applications: dsds.nfloc-renewalapplication@hss.soa.directak.net

Once the received application is determined complete, an SDS Assessor schedules within 30 days (within 10 days for a valid expedited assessment) to visit the person in his or her residence, to determine needs for support. The Assessor 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.

Determining (NFLOC) Nursing Facility Level of Care

It's important to understand that NFLOC consists of some *skilled nursing care* **AND** some *intermediate care*.

Skilled care means the person doing the care has received licensed medical training usually they are a nurse, doctor, or other licensed specialist.

Intermediate care means some tasks require professional licensed training and some do not.

The HCBW offers services mostly done by UNSKILLED (unlicensed) staff. Although there are some professional medical services offered in the Waiver, they are mostly considered the INTERMEDIATE level of NFLOC.

- People are not given waiver benefits simply because their medical conditions are disabling. People with disabling conditions do not automatically qualify for waiver. Rather, people are given waiver benefits if they have functional or nursing care needs that are so significant that they would otherwise be institutionalized.
- Medicaid Waiver benefits are services offered to recipients who would otherwise be institutionalized, and these benefits must be reviewed annually and are based on specific eligibility requirements. Not all people with disabilities require nursing care or supervision of the type that would be offered at a hospital or nursing care facility.

Skilled nursing services are ordered by and under the direction of a physician that are provided directly by or under supervision of qualified technical or professional personnel who are authorized by state law to provide that service and who are on the premises at the time service is rendered; technical or professional personnel include a registered nurse, a licensed practical nurse, a licensed physical therapist, a licensed physical therapy assistant, a licensed occupational therapist, a certified occupational therapy assistant, a licensed speech-language pathologist, a registered speech-language pathologist assistant, and an audiologist.

- Skilled nursing services are the observation, assessment, and treatment of a recipient's unstable condition requiring the care of licensed nursing personnel to identify and evaluate the recipient's need for possible modification of treatment, the initiation of ordered medical procedures, or both, until the recipient's condition stabilizes.

Intermediate nursing service are ordered by and under the direction of a physician to an individual who does not need skilled nursing services.

- Intermediate nursing services are the observation, assessment, and treatment of a recipient with long-term illness or disability whose condition is relatively stable and where the emphasis is on maintenance rather than rehabilitation, or care for a recipient nearing recovery and discharge whose condition is relatively stable but who continues to require professional medical or nursing supervision.

To understand more about the Nursing Facility Level of Care please review the table on the following pages for cares your client need. The table suggests the appropriate type of care provider to meet that care need.

Table of Nursing Facility Level of Care, skilled services & 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 NFLOC?	Provided by Licensed Medical only?	Can a nurse delegate to waiver staff or others?	"Intermediate" NFLOC? Can this be done by HCBS (Waiver), by unskilled staff?	Do HCBS Waiver (unskilled staff) provide this service?	What Waiver service 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
Medication that requires IV, NG, frequent injections, and/or clinical judgement call	Y	Y	N	-	N	SPDN	N
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
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

Transferring or supervision of transferring	Y if Nurse needed	Y	Yes, is allowed in Waiver	Y	Y transferring	Transferring- all waiver svcs except CC, chore. Meals, EMOD	Y transferring
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, delegatable tasks	N	Y, Treatment needed daily at home only, delegatable 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, eta, 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 elim and skin	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 delegatable tasks	SPDN/NOCM Needed daily only, with delegation all waiver svcs except CC, chore, transportation, meals, EMOD. Usually not IAT	Y, prescribed only
Skin care- decubitus, not infected or extensive Minor skin tears, abrasion, conditions that need daily observation/intervention by nurse	Y if Nurse needed	Y	Y, some pieces of these tasks may require delegation but usually not	Y with delegation	YES with delegation	SPDN/NOCM Needed daily only, with delegation all waiver svcs except CC, chore, transportation, meals, EMOD. Usually not IAT	Y, not decision making daily observation Y CDPCA

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 all waiver svcs 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
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	N	N		N	Y- as approved in PLAN	RSL, Res Hab, Adult Day, Day Hab, In Home hab supports, Supp Emp Also- not solely for WAIVER, but Personal Care Services also 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 Support Plan.
- 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.
- CFC requires that the person meet a facility level of care – NFLOC, ICF/IID, or IMD (Institution for Mental Disease)

RESOURCES used:

Alaska nursing regulation and statute

<https://www.commerce.alaska.gov/web/Portals/5/pub/NursingStatutes.pdf>

definition of long term care in the home and community

http://www.cdc.gov/nchs/data/nsltcp/long_term_care_services_2013.pdf

CFR, nursing facility level of care

<http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol2/pdf/CFR-2010-title42-vol2-sec409-33.pdf>

Alaska Administrative Code: HCBS Waiver regulations

[7 AAC 130 Home and Community Based Waiver Services, NFLCO and ICF/IID Level of Care](#)

PCS Regulations

[7 AAC 125.010-199 Personal Care Services](#)

CAT (Consumer 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 Assessor wants to know what the person can do for him/herself and what kinds of hands on help has been needed within the last 7 days. Responses and observations are entered in each section of the CAT which creates a numerical score for the different areas of functional skill. *There is a separate CAT for children, which is used for the CCMC waiver.*

The Assessor uses the Consumer Assessment Tool (CAT) to determine LOC based on the numerical values. Every CAT is reviewed by an SDS assessment supervisor prior to LOC determination. A Care Coordinator can attend the assessment appointment at the request of the applicant and/or legal representative. CC's are not required but are helpful when present.

In order for a person to be considered as having Nursing Facility LOC they must 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 areas 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 a person for the waiver program.

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

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/Pages/provider/pr-skillednursing.aspx>

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 care to remain in their home or community if it is safe to do so.

Preparing for the Assessment

- Tell your recipient what to expect—they will need to demonstrate their abilities or inabilities
- Encourage the family to limit attendance and not interrupt
- Let the assessor know if you expect to have comments after the interview is concluded
- Makes notes during the assessment to discuss with the assessor after they are done DON'T INTERRUPT
- Hold your comments during the assessment, unless a question is directed to you

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. A notice of [Adverse Action & Fair Hearing Rights](#) is included.

Assessments in a Nursing Facility or Long Term Care Hospital

A person residing in a nursing facility or long term care hospital will have a team comprised of medical professionals, a discharge planner and usually a medical social worker helping to discharge that person from the nursing facility into their choice of community living situation. The person most likely will need some type of help with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). A person leaving a nursing/hospital facility has choices.

- He or she can choose to apply for Personal Care Services (PCS). This is an appropriate choice for someone discharging to their home, if they need hands on help with ADLs and/or IADLs.
- They may need other services in their own home, such as chore services (for example if the person is physically unable to cook/clean and has no other supports to help.)
- The person may need to discharge to an assisted living home.

When a person is discharging from the nursing/hospital facility and wants to apply for either PCS or the waiver, the person will need an assessment from SDS staff.

You will likely be part of the “discharge planning team” if you are helping someone transition from a nursing facility or hospital to their home or an assisted living home. Discharge planners and medical social workers at the facility or hospital will ask you to be part of the team (as long as the person has chosen you to be their care coordinator).

If the person wants to apply or reapply for the ALI or APDD waiver, they will need to start with [ADRC options counseling](#). ADRC staff may be available to visit the person face to face or they can document needs over the phone. The person will need to choose you as their care coordinator by asking them to fill out a Release of Information and an appointment of Care Coordination form.

- The person must have a discharge plan from the current facility (since they are applying for care outside of the facility they should have one). A discharge plan is written by the medical team and discharge planner at the facility.
- The discharge plan needs to include specific information. If it does not, SDS will send the care coordinator a form to be **filled out by the discharge staff to request the information**.
- The care coordinator needs to include the discharge plan and all other medical documentation related to the person’s medical conditions which create the need for long term care with the application for the waiver.

CAT Intake and Assessment Unit Discharge Plan Summary

SDS needs to review this information for applicants discharging from hospitals and or nursing homes, which is required prior to an assessment. This information is needed in addition to the complete waiver or PCS application, if the person currently resides in a facility, and the assessment will be conducted in the facility.

Instructions: The following should be answered by the **discharge planner (SW/RN)** and medical documentation in support of the responses provided is required.

1. Patient information, Name, DOB, Medicaid #.
 2. Anticipated discharge date and a summary of situation:
 3. Admission and discharge diagnoses:
 4. Discharge Disposition: (home, ALH, NF with family, friend, POA, adult children, etc)
 5. Discharge Medications:
 6. Skilled Nursing Needs: (wounds, tubes, etc) (Notes/Orders required)
 7. Therapy Needs: Senior Disabilities Services (SDS) requires all Physical Therapy/Speech Therapy/Occupational Therapy notes/visits/encounters of the client's stay in the hospital or long term care facility. By not providing these notes/visits/encounters will only slow & delay the process of getting the assessment done. Additional: indicate the PT/OT/ST needs after discharge as well.
 8. Dietary:
 9. Assistive Devices:
 10. Detailed description of the level of need for ADL's (bed mobility, transfers, locomotion, dressing, eating, toileting, personal hygiene and bathing):
IADL's (cooking, cleaning, shopping, etc):
 11. Cognition Summary: (makes own decisions? Legal Rep?) Medications. Neuropsych eval? Notes required.
 12. Behavioral Summary: Medications
 13. Additional Information for SDS to consider:
 14. List all attachments
- If the above is followed, people can get an assessment while they reside in the facility.
 - If the person resides in the facility, the facility name and address is their residence at the time of application. The facility is the person's physical address on the application.
 - The care coordinator can [request an expedite](#) for the assessment if the conditions for requesting an expedite are met.

UNIT 5 – HCB Services

Requesting Services during temporary absence

Residential Services

Waiver Transportation Services

Duplications with (PCS) Personal Care Services

Duplications with CFC Services

Environmental Modifications (E-Mods)

Specialized Medical Equipment

Nursing Oversight and Care Management

Supported Employment

Acuity Rate for Out of Home Residential Services

Community First Choice Services

Community First Choice service (CFC) are available for Medicaid recipients who meet Nursing Facility Level of Care, ICF/IID Level of Care, or Institution for Mental Disease–Behavioral Health (IMD) Level of Care. For IMD level of care only, the recipient must be under 21 or over 65 years of age.

The available services in CFC are:

- **Care Coordination (Targeted Case Management):** Application, Annual Plan and ongoing Monthly case management. (for a CFC-only client)
- **Personal Care Services** – PCS, when delivered in a CFC plan is called “CFC-PCS”.
 - Hands on help with Activities of Daily living
 - Hands on help with Instrumental Activities of Daily Living
- **Supervision and Cueing:** Additional PCS service time in which the PCA is in proximity to the recipient and only supervises and cues the recipient to perform an ADL or IADL. (Not hands on help time.)
- **Skills Building:** Help given by trained PCA worker to guide the recipient be more independent with an ADL/IADL that the person chooses. (Not hands on help time.) PCS agency representatives are attending required SDS training to be able to train their staff to do it.
- **Personal Emergency Response system (PERS):** Communication system installed by PERS provider for the person to be able to summon help at home.
- **Optional Training Resources to Manage Their Own Staff:** Available as a download from the SDS website

Applying for CFC on behalf of someone who may meet IMD (Institution for Mental Disease) Level of Care

Care Coordinators apply for CFC services on the person’s behalf using the UNI-04 Application. Senior and Disabilities Services Assessment unit will schedule an assessment at the applicant’s residence. An assessment is done using the Consumer Assessment Tool (CAT) AND **SDS will refer the applicant to Qualis** for an assessment to determine IMD level of care. If the person is found to meet IMD level of care, the CFC-PCS services can start.

The applicant must:

- Be between age 6 and 21
- Or over age 65
- Have active Medicaid
- Have a PCI intake form completed with the ADRC
- Have a diagnosis from a psychiatrist or mental health professional
- Show some of the indicators of IMD level of care

Regulation: [7 AAC 127.025 Eligibility and enrollment for Community First Choice services; level of care determination](#)

The applicant, if approved for CFC through IMD level of care, will have a “CFC only” plan. (Not a waiver or a combination of waiver and CFC, because **IMD Level of Care does not apply to waivers.**)

Waiver 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, then review the Conditions of Participation for the specific service.** All services requested in a Support Plan 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.

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. <u>Ongoing Monthly service for the Waivers, to include provider and recipient visits, service monitoring and documentation, and amendments.</u>	7 AAC 130.240 Care coordination services	CC cannot provide any other reimbursed Home & Community Based services or PCS	-Monthly Please note for CFC and Waiver Combo recipients, the care coordinator provides care coordination and targeted case management at the "Waiver" level.
Targeted Case Management	<u>Initial Applications for All Waivers and CFC.</u> <u>Annual person centered support plan for all Waiver and CFC.</u> For CFC only clients – who do not also have a waiver - all activities of care coordination are targeted case management.	7 AAC 128.010 Long Term Services and Supports Targeted Case Management	CC cannot provide any other reimbursed Home & Community Based services or PCS	1 initial application 1 Annual Plan For CFC- only – without a waiver – includes the monthly unit as it is written in the approved plan of care.
Adult Day Services	Meaningful daily activities provided in a protective setting outside the home.	7 AAC 130.250 Adult day services	No PCA during Adult Day Service time	1 st unit= 1-4 hours, then 15 min units up to 6 hrs after. 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, or home delivered meals. Waiver does not pay room and board. (rent)	Daily unit

<p>Transportation</p>	<p>A ride to community services and resources</p> <p>Vehicle must be owned/leased by transportation provider</p>	<p>7 AAC 130.290. Transportation services</p>	<p>Not medical transportation or Transport to medical appointments. Driver of vehicle is not the “escort”. See escort.</p> <p>Not approved for recipients of Habilitation homes (Group Home or Family Hab.)</p>	<p>One way trip segments. Intermittent stops are NOT additional trips.</p> <p>Not for errands when participant is not in vehicle. Allowance for distance >20 mi.</p>
<p>Escort</p>	<p>An individual who accompanies and assists the recipient during transportation to ensure health and safety.</p>	<p>7 AAC 130.290. Transportation services</p>	<p>Escort is not employee of transportation co.</p>	<p>During trip segments if necessary to help with mobility needs.</p> <p>*Reimbursement is paid to the Transport provider for the 2nd person</p>
<p>Home Delivered Meal</p>	<p>Meal delivered to a recipient at their home.</p>	<p>7 AAC 130.295. Meals services</p>	<p>Not available during 24 hour out of home residential services: RSL, group home, family hab.</p>	<p>One meal</p> <p>Not to exceed 2 meals per day.</p>
<p>Congregate Meal</p>	<p>Meal provided in a setting with a gathering of people such as an adult day center which is also a meals provider.</p>	<p>7 AAC 130.295. Meals services</p>	<p>Must have a socialization component</p>	<p>One meal</p> <p>Not to exceed 2 meals per day</p>
<p>Chore</p>	<p>Regular cleaning of the residence in areas used by the person.</p> <p>Shopping and light meal prep.</p> <p>Heavy household chores.</p> <p>Snow removal for safe access and egress to residence.</p> <p>Chopping wood and hauling water, disposing of human waste.</p>	<p>7 AAC 130.245. Chore services</p>	<p>Not available with PCA IADLs. Can't replace what unpaid caregiver (Spouse or Parent) can do to assist, or what is done by landlord/property management.</p> <p>If more than one person with Chore in same residence, requests are reviewed for duplication.</p> <p>May limit Chore hrs authorized.</p> <p>Paid provider of chore cannot live in the same residence as the recipient.</p>	<p>15 min. Unit</p> <p>10 hr week limit/5 hr for APDD, CCMC or IDD unless documented respiratory issues</p>
<p>Hourly respite</p>	<p>Another caregiver to give the primary unpaid caregiver a break.</p> <p>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.</p>	<p>7 AAC 130.280. Respite care services</p>	<p>Available for family habilitation.</p> <p>Family habilitation may not provide paid care for another individual at the same time as respite.</p> <p>Not to allow an unpaid provider to work.</p>	<p>15 minutes</p> <p>520 hours per PLAN year</p> <p>Chore, Transportation, Meal services continue</p>

Out of home daily respite	24 hour respite in a licensed assisted living home.		Not available with Residential supported living or group home.	Daily: 1 day 14 full days per year (12+ hours)
In-Home daily respite	24 hour respite in the person's own home		Not available with RSL 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.	Daily: 1 day 14 full days per year (12+ hours)
Family Directed Respite	Family selected caregiver to give the primary unpaid caregiver a break. Family refers staff to certified agency who is the employer of record. Family directs staff.	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. Must be specific care for an individual. Requires direct hands-on skilled nursing and is 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. Reimbursed by regular Medicaid service for those under 21. Regular Medicaid will not cover SPDN after age 21. If CCMC recipient needs SPDN through the waiver after 21 st birthday, plan to apply for ALL or APDD BEFORE age 21!	15 minutes
Nursing Oversight and Care Management	Evaluation and monitoring 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	Available to CCMC and IDD- must meet health requirements of CCMC. Local and Non-local categories	15 minutes
Environmental Modifications	Physical adaptations to a person's home per the Support Plan. Done by an enrolled builder/contractor. Rental homes with permission.	7 AAC 130.300. Environmental modification services	Not available in assisted living homes providing RSL and group home. Available for family habilitation homes unless owned by an HCBS Certified Agency.	\$18,500 total every 36 months

Specialized Medical Equipment "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.	7 AAC 130.305. Specialized medical equipment and supplies	Allowable Items are found on the SME list Cannot duplicate durable medical equipment or other items available through regular Medicaid. Need must be documented in writing by a professional per regulation.	As approved, from SME schedule Limited repairs to pre-existing items. Some shipping costs are included.
CFC- Personal Emergency Response System -	Is an "SME" as above Offered exclusively through the Community First Choice option NOT a waiver service after Oct 1 2018 Call button for person to summon help when needed (local emergency services)	7 AAC 127.010 – 7 AAC 127.990	Not allowed with out of home residential Not approved when person has other supports and does not live independently	One annual install
CFC-Skill Building	Definition Training to build skill of self care to be more independent.	7 AAC 127.010 – 7 AAC 127.990	Is not habilitation Cannot duplicate or be duplicated by habilitation Time limited – 3 continuous months per lifetime Outcome/result oriented Skills to accomplish ADLs, IADLs, or health related tasks, such as taking medicine more independently. Person chooses what of these to build skill	15 minutes
CFC Supervision & Cueing	Definition Help for a recipient who is partially accomplishing ADLs and IADLs. Reminders, demonstration, set-up, redirection and cueing from a support worker who remains in physical proximity to the recipient during the service.	7 AAC 127.010 – 7 AAC 127.990	Not habilitation. Cannot duplicate or be duplicated by habilitation. Does not teach skills. Not offered or available during other activities such as community engagement, social activities, or during any activities except ADLs and IADLs.	15 min
CFC Training for Managing Staff	Definition Optional training materials for recipient to review and use at own discretion. Helpful for those who are or would like to direct their own staff.	7 AAC 127.010 – 7 AAC 127.990	Offer the person Your PCA and You book and review. Optional for the person. PCS Provider may also share this info.	
CFC Personal Care Services	Hands on help at home with activities of daily living and instrumental activities of daily living	7 AAC 127.010 – 7 AAC 127.990	Not received with out of home residential services. Cannot be duplicated by help that others give such as family and friends	

Service Habilitative	Definition	Regulation	Service-related Exclusion(s)	Unit size Max. Allowed
Day Habilitation	<p>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.***</p> <p>Includes transportation time to and from activity if noted in the plan.</p> <p>Must include measurable goals, objectives and interventions for service duration.</p>	<p>7 AAC 130.260. Day habilitation services</p> <p>***May be provided in a residential setting upon approval of SDS- for rural/remote areas without other types of community gathering spaces</p>	<p>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.</p> <p>Transportation not billed separately & will not be approved.</p> <p><i>Transportation choice must be documented in the Plan.</i></p>	<p>15 minutes</p> <p>624 hours per Plan year</p> <p>Available in 2 forms: GROUP - 2 or more served as a group. INDIVIDUAL: 1:1 support.</p>
Supported Living (18 & over)	<p>Supporting a person who lives in his/her own home with goals and objectives related to activities of daily living. Must be provided 1:1</p>	<p>7 AAC 130.265. Residential habilitation services</p>	<p>18 yrs and older.</p> <p>Requested Chore, home delivered meals, PCA and transportation must not duplicate.</p>	<p>15 minutes 1:1 service</p> <p>Limited to 18 hrs per day, from all providers combined.</p>
In Home Supports (under 18)	<p>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</p>	<p>7 AAC 130.265. Residential habilitation services</p>	<p>Individuals under 18 yrs PCA, Chore, Transportation, Meals or services provided by another resident of the home are not allowed.</p>	<p>15 minutes 1:1 service</p> <p>Limited to 18 hrs per day, from all providers combined, subject to approval of SDS.</p>
Group Home (licensed ALH)	<p>24 hour year round residential service in a licensed assisted living home. Accompanied with goals and objectives for residential service. Includes social & community interaction opportunities.</p>	<p>7 AAC 130.265. Residential habilitation services</p>	<p>PCA not allowed. Transportation, chore, respite, home delivered meals.</p> <p>Services provided by another group home resident not reimbursed. PERS not allowed. Other SME may be allowed.</p>	<p>1 day</p>

<p>Family Habilitation (licensed ALH that has oversight from an SDS Certified Agency)</p>	<p>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</p> <p><i>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.</i></p>	<p>7 AAC 130.265. Residential habilitation services</p>	<p>Chore, PCA, home delivered Meals, transportation not allowed on family hab. home days.</p> <p>Services done by another resident of the family hab home are not reimbursable.</p> <p>EMOD are allowed in a family habilitation home.</p> <p>PCA upon approval allowed for child with OCS placement.</p> <p>Family hab. home must be an enrolled certified family hab. provider.</p> <p>The CC must report to SDS when the recipient moves or primary provider changes.</p>	<p>1 day unit.</p> <p>Possible to request family hab days needed- does not have to be requested as a full year of care.</p> <p>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.</p>
<p>Acuity Rate</p>	<p>24 hour, 1:1 full time support for a resident due to health & safety concerns. For group home or residential supported living home only.</p>	<p>7 AAC 130.267</p>	<p>Please see regulation for requirements</p>	<p>1 day</p>
<p>Intensive Active Treatment</p>	<p>Professional provision or supervision of a time-limited intervention or service that addresses a personal, social, behavioral, mental or substance abuse disorder.</p> <p>Treatment or therapy plan created by a licensed professional: AS 08.</p> <p>Professional develops and implements intervention plan.</p>	<p>7 AAC 130.275. Intensive active treatment services</p>	<p>Not for routine or ongoing behavioral challenges or solely for training staff.</p> <p>Local and non-local categories.</p> <p>For adults with IDD or APDD Waiver- IAT upon approval.</p>	<p>15 minutes</p>
<p>PRE-EMPLOYMENT</p>	<p>Building skills toward employment, for</p>	<p>7 AAC 130.270. Supported-employment services</p>	<p>ONE 3 month time period total during the whole time the individual has the waiver.</p>	<p>15 minutes</p>

<p>Supported Employment</p>	<p>Long term support to a person at a worksite by providing assistance on the job in order to maintain employment. Accompanied with measurable goals and objectives for the service.</p> <p>Employment must be in a setting that also employs people who do not experience disability.</p> <p>Can support a person to be self-employed.</p>	<p>7 AAC 130.270. Supported-employment services</p>	<p>Not to supplant or replace services 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 a workplace accommodation routinely provided to employees by the employer, or routine supervision of an employee.</p>	<p>15 minutes</p> <p>These services may be provided as a group: 2 recipients or more are served as a group. Or as 1:1 Supported Employment.</p>
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Requesting Safeguard Funding for the ISW Waiver

According to 7 AAC 130.206(h),

During any three-year period, a recipient of individualized supports waiver services may request, by an amendment to the recipient's support plan, up to an additional \$5,000 for services and supports to address needs related to

- (1) a time-limited change in the recipient's health, behavior, or functional capacity; or
- (2) the unavailability of the recipient's primary unpaid caregiver for a reason stated in [7 AAC 130.209\(a\)\(3\) - \(5\)](#).
 - (3) an unplanned absence of a primary unpaid caregiver due to a medical or family emergency or hospitalization;
 - (4) the declining health of a primary unpaid caregiver that makes the caregiver unable to continue to provide care for the applicant;
 - (5) the death of a primary unpaid caregiver 30 or fewer days before the date of the application;

ISW Safeguard funding requests are available only up to a total of 5,000.00 every three years, starting the date of the approved support plan.

ONLY Request this finding only within a renewal ISW plan or through an amendment. (Safeguard funding is not available as part of an initial support plan.) **Request only additional services that are available in the ISW.**

Services through Grants

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 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.

These services are 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. Funding for these programs comes from the U.S. Administration on Aging, the Alaska Mental Health Trust Authority, and state general funds.

Senior Grants for Home & Community Based 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. [Adult Day Provider List](#)

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. [SIH Provider List](#)

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. [NFCSP Provider List](#)

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. www.alzaska.org

ADRD Mini-Grants:

Grants available on a statewide bases 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. Information and applications are available at www.alzaska.org or by calling 561-3313 or 1-800-478-1080.

- Eligibility and Access to Services
- Program Specific Links for Consumers or Providers

Other Resources For Individuals with Developmental Disabilities

Centers for Independent Living:

Centers for Independent Living provide 5 core services to anyone of any age with any disability.

1. Information and Referral,
2. Independent Living Skills training,
3. Advocacy,
4. Peer Support,
5. Transition Services

<https://www.alaskasilc.org/Independent%20Living>

Traumatic or Acquired Brain Injury (TABI)

The TABI program provides Case Management and Mini-grants to individuals who have experienced a Traumatic Brain Injury. The Alaska Brain Injury Network manages and distributes TABI min-grant funds.

<http://dhss.alaska.gov/dsds/Pages/tabi/default.aspx>

DD Mini-Grants

The Alaska Mental Health Trust authority funds mini-grants to beneficiary groups of up to \$2500. Beneficiary groups include: Behavioral Health Mini grants, ADRD Mini grants, and DD Mini grants

<https://alaskamentalhealthtrust.org/alaska-mental-health-trust-authority/grants/mini-grants/>

Self-Employment Grants

Grant funds are available for qualifying people with disability and their families. Monies may be used for costs associated with starting a new business, expanding a current business or acquiring an existing business. Qualified individuals can request anywhere from \$500 - \$10,000 (\$10,000 lifetime limit).

Allowable costs include but are not limited to: business license, insurance, permits, inventory, raw materials to make a product, equipment, supplies, rent or lease for space to offer a service or product, utilities, furnishings, marketing activities, transportation costs not related to vehicle purchases, accounting services and training/support services.

<http://dhss.alaska.gov/gcdse/Pages/microenterprise.aspx>

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 individual with a disability transition from a nursing facility back into the community.

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.

This grant 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.

HCBS Settings Compliance

The Centers for Medicare and Medicaid (CMS) issued a new (March 2014) regulation ([42 CFR §441.301\(c\)\(6\)](#)) that requires that all Medicaid-funded services be provided in settings that exhibit home and community-based characteristics and do not isolate recipients.



This includes opportunities to

- seek employment, work in competitive and integrated settings,
- engage in community life,
- control personal resources,
- have full access to benefits of community living,
- receive services in the community to the same degree as people who do not receive home and community based services.

Services that must be Settings Compliant

Any of these HCB Medicaid Services delivered in settings that are owned, rented, leased, and/or contracted by the provider:

- Supported Employment
- Residential Habilitation: Group Home Habilitation
- Residential Habilitation: Family Home Habilitation
- Residential Habilitation: Supported Living
- Congregate Meal Service
- Adult Day Services
- Day Habilitation
- Residential Supported Living

Visit the [SDS Home & Community Based Settings](#) webpage to understand more about how CMS settings rules guide the services you can offer to your clients.



Freedom and support to **access food** at any time of the day.

Freedom and protection to **have a lock** on your bedroom door.



Freedom to choose your compatible **roommate**.

Freedom to **have visitors** of your choice at any time.



Freedom to a **flexible curfew**.

What does this mean to a Care Coordinator?

You are not a settings based service provider however...

- You arrange for appropriate waiver services for the person you serve so a CC has some responsibility to present the settings compliant choices to the person.
- The CC must also demonstrate or show in the Support Plan what providers were reviewed and selected.
- For each modification a CC must include in the Support Plan a description of the modification and why it's necessary. Including:
 - The specific individual assessed need
 - Positive interventions & supports used prior to any modification
 - Less intrusive methods of meeting the need that were tried and did not work
 - Condition that lead to the specific assessed need
 - How data will be recorded & reviewed to measure ongoing effectiveness of modification
 - How often will it be reviewed to determine to continue or end the modification
 - Informed consent of the recipient
 - Statement of Assurance – “No Harm to the Recipient will result from the modification”

According to settings rules, residents in an out of home service (group home, family habilitation home, residential supported living in the assisted living home must have a legally enforceable rental agreement. Rental agreements require a 30 day notice of tenants intent to move. Currently residents do not have to give notice. How is that going to change with the new settings requirements?

The 2014 Final Rule brings under scrutiny the presence of eviction protections and the prevention of unreasonable tenant responsibilities (i.e. residents are required to clean the agency's facilities, etc.). Not all settings need to align to a standard landlord/tenant lease. The rule is not that the setting must use a standard tenancy lease used by all Alaska landlords but rather that the occupancy of the dwelling by the recipient affords the same protections from eviction that would be found for anyone under AK landlord/tenant law and affords the same responsibilities. Specifically the Final Rule ensures that a setting provides a specific physical place (ex: unit) that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law. RL provides guidance in their licensing documents regarding the protections for eviction so, if your home reflects these protections already in place on the service/residential contract/agreement, you meet the final rule regarding the aspects under scrutiny.

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 Support Plan or Amended plan.

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

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 must be necessary to maintain the recipient's current level of functioning and prevent placing the person at risk of institutionalization. The providers must continue to oversee the provision of the services while the person is temporarily absent from the state of Alaska.

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>

The Care Coordinator convenes a team including the individual and the involved providers, to create a written plan for how the individuals' needs will be met during the temporary absence. All requests must state the reason for the request with supporting documentation. This request is submitted to SDS no later than 30 days prior to travel, in the Support Plan or in an Amended Plan. SDS may approve up to 30 days of service, after receiving a request which follows the policy. Any extension past 30 days must be specifically requested approved by SDS.

Medicaid funding does not pay for services outside the United States

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.

Out of Home 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 to 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?
5. Think about the needs of your client and what you learn about the home’s capacity to serve.
6. 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. Only some tasks can be delegated 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, the tasks carry minimal risk to the person and can be done by a person who does not have nursing skills training.

Waiver Transportation Services

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.

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. But if they do, you will need to justify the request in the Support Plan by describing the client's need of Escort to help meet the client's mobility needs.

The transportation provider may use vehicles the agency owns or leases 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.

The following guidance is offered to assist care coordinators include and support these trip units in a recipient Support Plan. 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 Support Plan under Section IV-A "Summary of Non Habilitative Services" as a separate service
2. Include a written description that includes the purpose for the trips requested, including the reason the recipient's needs cannot be met in any other way.
 - a. No other caregivers
 - b. Why can't they access the public bus system?
3. 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 not 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 per transportation provider.

If a person needs transportation to medical appointments, they need "non-emergency medical transportation", or NEMT. The transportation can be paid by Medicaid if the request for the ride is made by the referring or receiving medical provider. The person's Alaska Medicaid coverage must include (medical) transportation. The appointment must be for a covered service. The appointment must be medically necessary. The person must not have access to public transportation. The person must have no other mode of transportation available to him/her. **The Care Coordinator does NOT make this request.** The medical provider does this.

http://manuals.medicaidalaska.com/docs/dnld/Update_Submit_TransAuth_AK04.pdf

Duplications with Personal Care Services (PCS) or CFC-PCS Services

To receive Medicaid PCS, 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. Review the Alaska Regulations for delivery of Personal Care Services to Medicaid recipients [7 AAC 125.010](#).

A person who needs 'hands on help at home' will need to contact a PCS agency in their community to inquire about services. The PCS Agency will help them apply. They must provide a Verification of Diagnosis, from his/her medical provider and additional supporting documentation of physical limitations. The individual will receive an Assessment from Senior and Disabilities Services to determine the number of authorized PCS hours.

Sometimes the person already has a Care Coordinator (if he/she has a HCB Waiver), the Care Coordinator may assist their client to inquire to PCS agencies about services. The person needs to choose which PCS company will deliver services, if found eligible for PCS. A current assessment –on file will be used to determine Authorized PCS hours.

The Care Coordinator must be aware of regulatory limits under non- duplication of services.

- The waiver service of Chore, can include cleaning in the home, shopping and food preparations.
- Personal Care Services - Instrumental Activities of Daily Living (IADLs) - also include possible tasks of cleaning in the home, shopping and food preparations.

**The individual or his/her legal representative must choose which Service they want to do the tasks.
Which one will 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 PCS for children:

When PCS is requested for a child who also receives waiver services, the care supports performed by a PCS 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 PCS 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.

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. 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.

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,
- ✓ include feature or material upgrades that exceed what would be considered routine construction grade materials,
- ✓ include the installation of privately purchased equipment or materials
- ✓ duplicate existing modifications regardless of funding
- ✓ 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.

Please note that EMOD process policies are shared among three regulatory components:

7 AAC 130.300, EMOD COP and Care Coordination COP (section-V)

How to begin an E-Mod Request:

You must **First** 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 these inquiries with the E-mod request.

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 within 36 months **ONLY** 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***

Take digital pictures of the areas of the home that require access modifications. You must also include photos of similar areas in your request to SDS to show that accessibility is not possible in any other area of the home.

Prepare a Project Cost Estimate using the forms available on the [SDS Approved Forms Page](#). The certified EMod contractor needs to return the project estimate using the SDS sponsored estimate documents. The contractor should 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 project estimates must be collected and held private (do not communicate project estimates among multiple E-mod providers).

Email the project estimate request to ALL certified EMOD providers to request cost estimates for the EMod. *Please note that excluding any currently enrolled EMod provider for any reason will result in a denial of service.*

You can search currently certified EMOD providers through the Alaska Access Point - Provider Search Tool <https://akaccesspoint.com/SitePages/Home.aspx>

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;
 - Photographs of the area to be modified with sufficient detail for provider review
4. 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.

Collect all responses and documents you receive by the end of the 14 day period. Attach them to a Support Plan or Amended Plan. 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 guide your EMOD request. (Also available on the SDS approved forms page)

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** Was a digital photograph provided as part of the E-Mod project request? *(An SDS E-alert dated 12.1.09 noticed that a picture of the area to be modified is now required to help ensure the scope of work proposed is appropriate and consistent with regulatory guidelines & best practices.)*
2. **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)*
3. **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.)*

4. **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?
5. **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.)
6. **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.)
7. **Yes No** Does the proposed E-Mod project include any work or improvement to outbuildings, yards, driveways, or fences?
8. **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?
9. **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.)
10. **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.)
11. **Yes No** Does the proposed E-Mod project include installation of privately purchased equipment or materials?
12. **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.)
13. **Yes No** Does the proposed E-Mod project include installation or repair of prohibited items such as elevators, hot tubs, saunas, or hydrotherapy devices?
14. **Yes No** Is the proposed E-Mod project intended for a waiver recipient whose residence is licensed as an assisted living home?
15. **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.) Examples of all SDS project estimate forms can be found online: <http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx>)
16. **Yes No** Is Provider with the lowest estimate (that is being awarded the project) completed fully? (Example: All project estimate forms should be completed entirely or stated as N/A where appropriate. This includes a full list of proposed materials, labor, permits, and special fees where applicable).

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. If you need further assistance regarding an unusual circumstance, contact the appropriate case-responsible waiver unit or Health Program Manager

Helpful Hints for EMODS:**Care Coordinators and EMOD provider information needed to review EMOD Cost Estimates**

Use **only** the **current** Approved SDS Forms for Environmental Modification requests

<http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx>

Care Coordinators are required:

- to insure EMOD providers give you all information/lists
- to explain to the EMOD provider the scope of the project, include exactly what the client **needs**
 - all EMOD providers should be bidding on the same EMOD walk-in shower scope of work should not differ between contractors
- to send cost estimate request to all active EMOD providers
- to review the EMOD cost estimates for completion before forwarding for review
- to explain to clients and EMOD providers that maintenance and repairs of structure/home is not covered
- to send back to contractors cost estimates for corrections if incomplete or missing itemized list, associated costs, descriptions, sketches or images (if applicable)

The form itself states: "COST ESTIMATE SUMMARY: Please attach an itemized list containing a breakdown for each of the following cost estimate categories."

- Demolition Cost
- Materials and Equipment (i.e. folding grab bar, L-shape grab bar, standard grab bar; provide size (example non-covered items - shower curtains without itemized list it is unknown if this was included within the estimate or not; also why the cost charged is important)
- Labor (i.e. Demo/remove existing tub, shower, toilet, sink and vanity, etc.; install ADA walk-in shower, toilet, sink etc.)
 - Example: specific grab bars when looking at finished photos you see grab bars; however, reviewer doesn't know if there should be an "L-shaped" bar or all straight, how many etc.

- Specify Fees
 - Reminder Fees and permits: *“Regarding building permits the EMOD Cost Estimate Summary must indicate either the cost, “N/A”, “None” or “\$0.00”. If permit is required the request for the final payment must include a copy of the approved inspection report to include ongoing and final pictures.”*
- List Permits Required

Example of Itemized Materials List; in description include Model i.e. Prism P300, etc.

II. Construction Cost Breakdown	Average
Building Permit Fees	\$3,107
Impact Fee	\$2,850
Water and Sewer Inspection	\$2,952
Excavation, Foundation, and Backfill	\$17,034
Steel	\$1,012
Framing and Trusses	\$24,904
Sheathing	\$2,142
Windows	\$6,148
Exterior Doors	\$2,150
Interior Doors and Hardware	\$2,883
Stairs	\$1,052
Roof Shingles	\$5,256
Siding	\$8,739
Gutters and Downspouts	\$870
Plumbing	\$10,990
Electrical Wiring	\$8,034
Lighting Fixtures	\$2,193
HVAC	\$8,760
Insulation	\$3,399
Drywall	\$8,125
Painting	\$6,005
Cabinets and Countertops	\$10,395
Appliances	\$3,619
Floors and Carpet	\$8,363
Trim Material	\$3,736
Landscaping and Sodding	\$6,491
Wood Deck or Patio	\$1,918
Asphalt Driveway	\$2,729

Photographs:

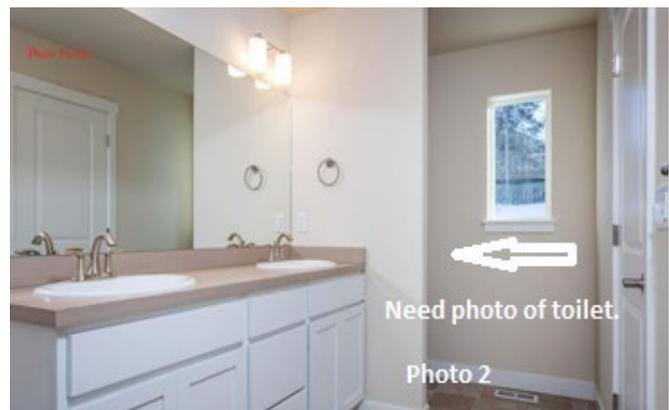
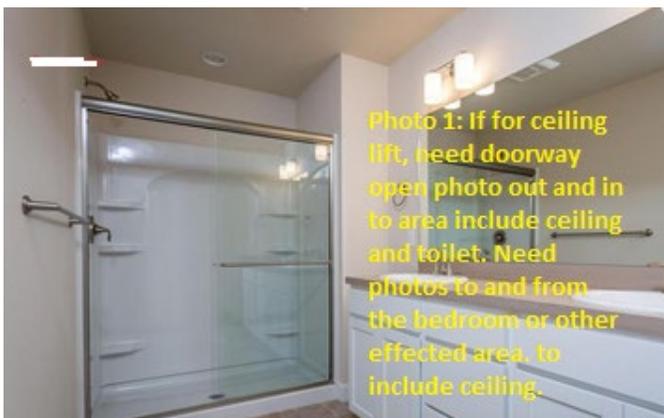
Photos should NOT be just a close up of the toilet, shower, front porch etc.

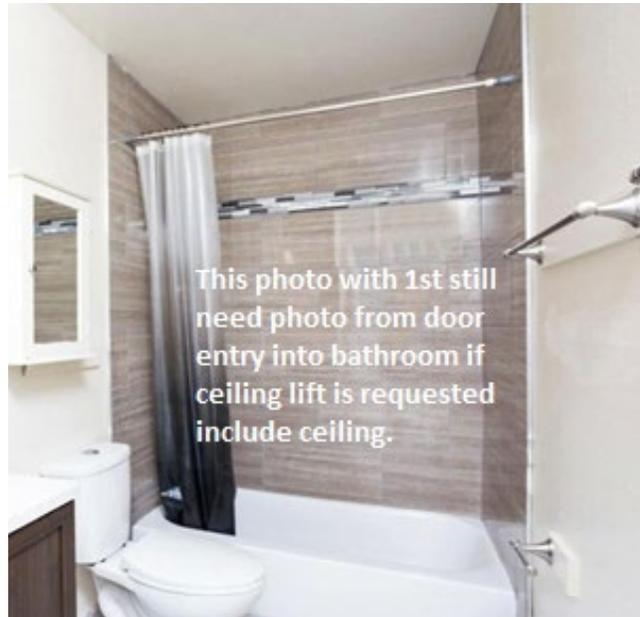
Photos should NOT be just the front door but all entries to include garage entry

Photos should show: from the bedroom to the bathroom to include ceiling (if applicable), bathroom floors, tub area, shower area, toilet area, a full photo of the entire bathroom, a wide enough angle of the entries to show how the entry is accessed, obstacles if any to ramp placement, etc.

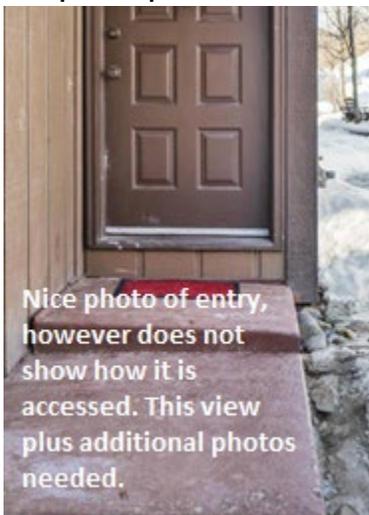
Examples of photos, images, and sketches to include but, not limited to, the following:

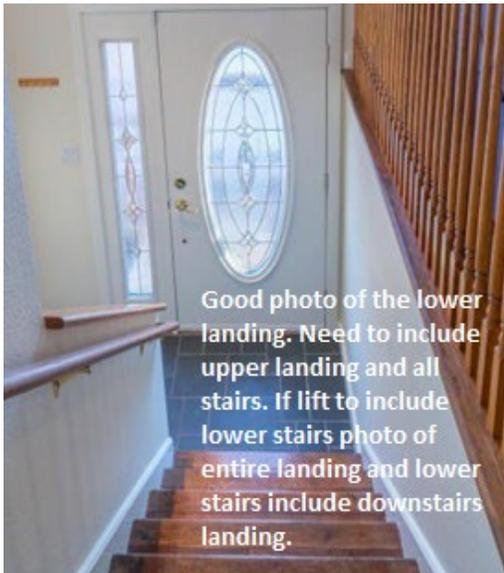
SDS requires photos of ALL bathrooms in the home.



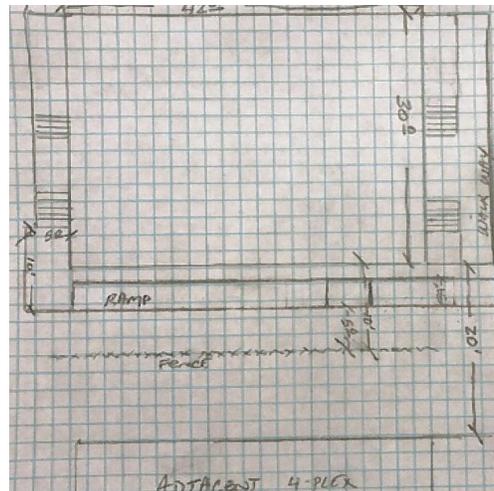
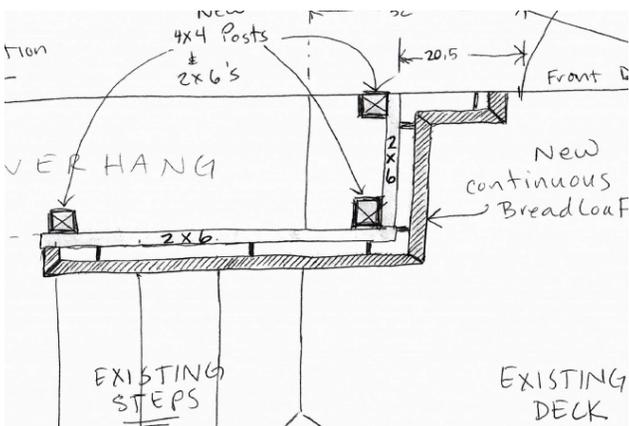
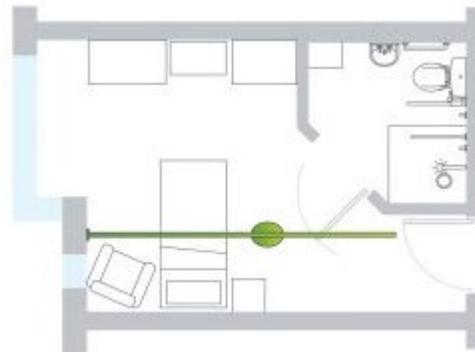
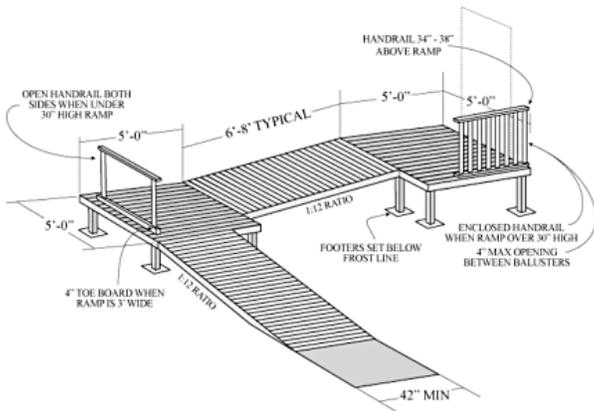


Require photos of ALL entrances to the home.





Simple sketch of bathroom, ramp or other EMOD



Product images:



Refer to the Care Coordinators COPS: **V. Environmental modification projects, A. Environmental modification evaluation, B. Request for cost estimates, C. Selection of the project provider.**

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.

Include written supportive documentation from the medical provider 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 Support Plan, and necessary to avoid placing the recipient at risk of institutionalization.

Specialized Medical Equipment is subject to approval and listed on the current SME Fee Schedule <http://dhss.alaska.gov/dsds/Documents/pdfs/SMESchedule1-1-2014.pdf>

Verify the item you are requesting is included on the authorized list. It's expected that when SME items are approved and delivered to the recipient their needs for hands on supports will be reduced.

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 (Conduent (formerly known as 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 Support Plan. 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 Support Plan 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 Support Plan- 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 anytime)
- 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 Support Plan.

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 <https://www.commerce.alaska.gov/web/portals/5/pub/NursingStatutes.pdf>

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)

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
- Negative attitudes of employers and co-workers
- Fear of loss of benefits and the ability to supplant loss of benefits with income
- On a policy level, lack of work-first option or requirement

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!

Acuity Rate 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 130.267](#) Acuity 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 6 - Writing a Person Directed Plan for Supports

Person Centered Approach

Writing Narrative in the Support Plan

Developing Goals & Objectives for Habilitative Services

Writing in Plain Language

Support Plan Questionnaire

People get the support they need from many resources...

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 Support Plan 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.



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.

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?
- What do they expect or need from their services?

People who need Medicaid Long Term Support Services (LTSS) to live in their chosen community should be encouraged and empowered to define 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. The Support Plan 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.

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

Person Centered planning can be part of a formal process, but it does not exist only within a formal process. 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.

Consider the following ideas/definitions.

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?

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

Each Support 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 Support Plan.

No two plans should be the same!

When plans are customized to the person, we are helping to increase the chances 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 / Person Directed plan.



Make time for listening and observing, then you will 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 (CMS) requires Support Plans to be person-centered. SDS is working with stakeholder groups to find out more about how to make person centered plans and services in Alaska.

CMS issued updated CFRs in March of 2014 that includes changes to the requirements regarding person-centered service plans for HCBS waivers under 1915(c) as follows:

The person-centered Support 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 a 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 will reflect-

- 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
- Opportunities to seek employment and work in competitive integrated settings
- The individual's strengths and preferences
- Their clinical and support needs
- Includes personal goals and desired outcomes
- Providers of services/supports, including unpaid supports provided voluntarily in lieu of waiver or state plan HCBS
- Settings chosen by the individual that are integrated in, and support full access to the greater community
- 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 be understandable to the individual and support providers
- Informed consent of the individual in writing
- Signatures of all individuals and providers responsible for services
- Distribution to the individual and others involved in plan
- Purchase/control of self-directed services
- Exclusion of unnecessary or inappropriate services and supports
- The review and revision upon reassessment of functional need as required every 12 months, or when the individual's circumstances or needs change significantly, and at the request of the individual.

Personal Goals in the Support Plan

All Support Plans need to include the recipient's personal goal. Plans which include the Habilitative services must have measurable goals and objectives for those services, which is different.

A personal goal is just that- something that is meaningful and relevant to the person. It doesn't need to be supported by Waiver services but could be. An individual's personal goal(s) is defined by themselves, there is not right or wrong kind. A Care Coordinator may discover what to include simply by listening to the person.



When working with elders, and adults who experience physical disability, many times you are serving people who have accomplished a lot in their lives. 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, if you listen like a detective you can find their goals. When you are developing or updating Support Plans listen for goals -- direct quotes from the person are encouraged.

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 PLAN 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>

Explore the Governor’s Council on Disabilities and Special Education webpage:

<http://dhss.alaska.gov/gcdse/Pages/default.aspx>

Developmental Disabilities Shared Vision

Alaskans share a vision of a flexible system in which each person directs their own supports, based on their strengths and abilities, toward a meaningful life in their home, their job and their community. Our vision includes supported families, professional staff and services available throughout the state now and into the future.



Writing Narrative in the Support Plan

A Support Plan is not written based solely on a diagnosis. A Support Plan 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* - an outmoded term, 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.

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, and 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 your 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 Support Plan 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 Support Plan 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.

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 Support Plan. 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.

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Refer to the assessment and other documents

A Support Plan 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

Collect ongoing supporting information when you visit

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.

All sections of the Support plan must be reviewed and updated/confirmed with each renewal plan. SDS reviewers often see plan narrative that hasn't been reviewed in many years. This is NOT a person centered approach! SDS will not accept Plans that have not been updated!

When requesting 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 Support Plan must indicate how services are not duplicative.



What Are Habilitation Services?

According to 7 AAC 130.319 Definitions, (6) "habilitation services" means services that (A) help a recipient to acquire, retain, or improve skills related to activities of daily living as described in [7 AAC 125.030\(b\)](#) and the self-help, social, and adaptive skills necessary to enable the recipient to reside in a non-institutional setting; and (B) are provided in a recipient's private residence, an assisted living home licensed under [AS 47.32](#), or a foster home licensed under [AS 47.32](#); In other words, habilitation services teach the person to develop or maintain skills in the setting in which the service is provided.

Habilitation services differ from rehabilitation services. Rehabilitation relates to re-gaining skills previously acquired, which one has lost or diminished due to an injury or illness.

Habilitation services help people to learn and maintain skills for everyday life in the home and or community, as needed due to an intellectual or developmental disability. These services help a person work towards a goal that the person identifies. The person gets support to take steps (objectives) to meet their goal. The person may have other supports in his or her life that help them to work on the same goal.

You will work with the person you are serving to learn what their goals are, and what steps the person could take to get there. The agency that the person chooses to provide the habilitation service will also help to identify what the staff will do to help the person work on the objectives. Direct support staff efforts are called the "interventions" in the plan.

Habilitation services, like all waiver services, are provided in a "unit" size. Hourly habilitation services are offered in 15 minute units. If a person receives one hour of a habilitation service, there are 4 units in that hour. The written plan (which reflects the person's goal) should show how the habilitation service will actively support the person to work on his/her objectives, for each 15 minute unit.

Group home and family habilitation are residential habilitation services. They are provided in a licensed assisted living home. These services are provided in a "24 hour unit". This means the person resides in the home and the home staff provide assistance for the person to gain or maintain skills in everyday living that they do at home. The 24 hour unit takes into account that in addition to working on skills (to include socialization) at home, the

person will have some type of “down time” during the day such as time when they are asleep.

When working with people to discover their goals and what they would like to achieve in life, it’s important to listen. Listen for the person’s wishes desires and needs. Listen for ways the person can be supported with help they already have in their life. Listen for ways a waiver service could help. Listen for strengths the person has to be able to indicate choice, and their communication style. The waiver services can help people achieve their goals and dreams. Waiver services in and of themselves are not the goal and dream. They can help the person get closer to these. For the person, it’s not about getting services. *It’s about getting a life.*

Some background on habilitation services:

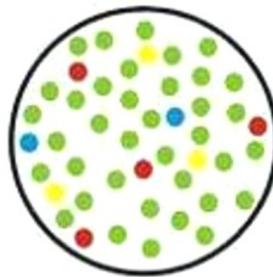
Habilitation services are not for only doing the definition of the service!

For example – day hab “to get someone out into the community.”

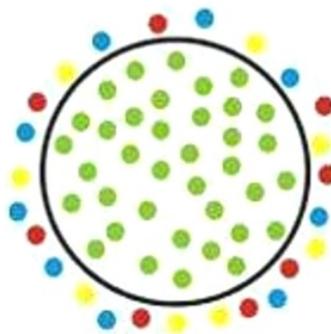
- ***Exclusion is not inclusion***
- ***Exposure is not inclusion***
- ***Integration is not inclusion***

Full participation is inclusion

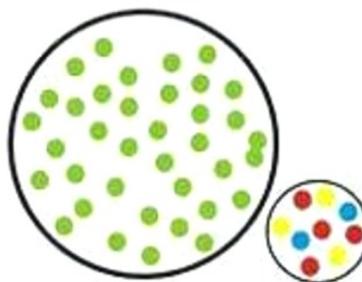
Full participation: at home, at school, at work, in my community



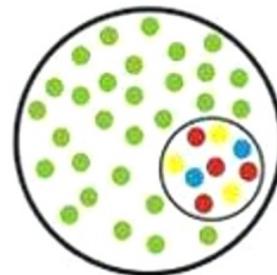
Inclusion



Exclusion



Segregation

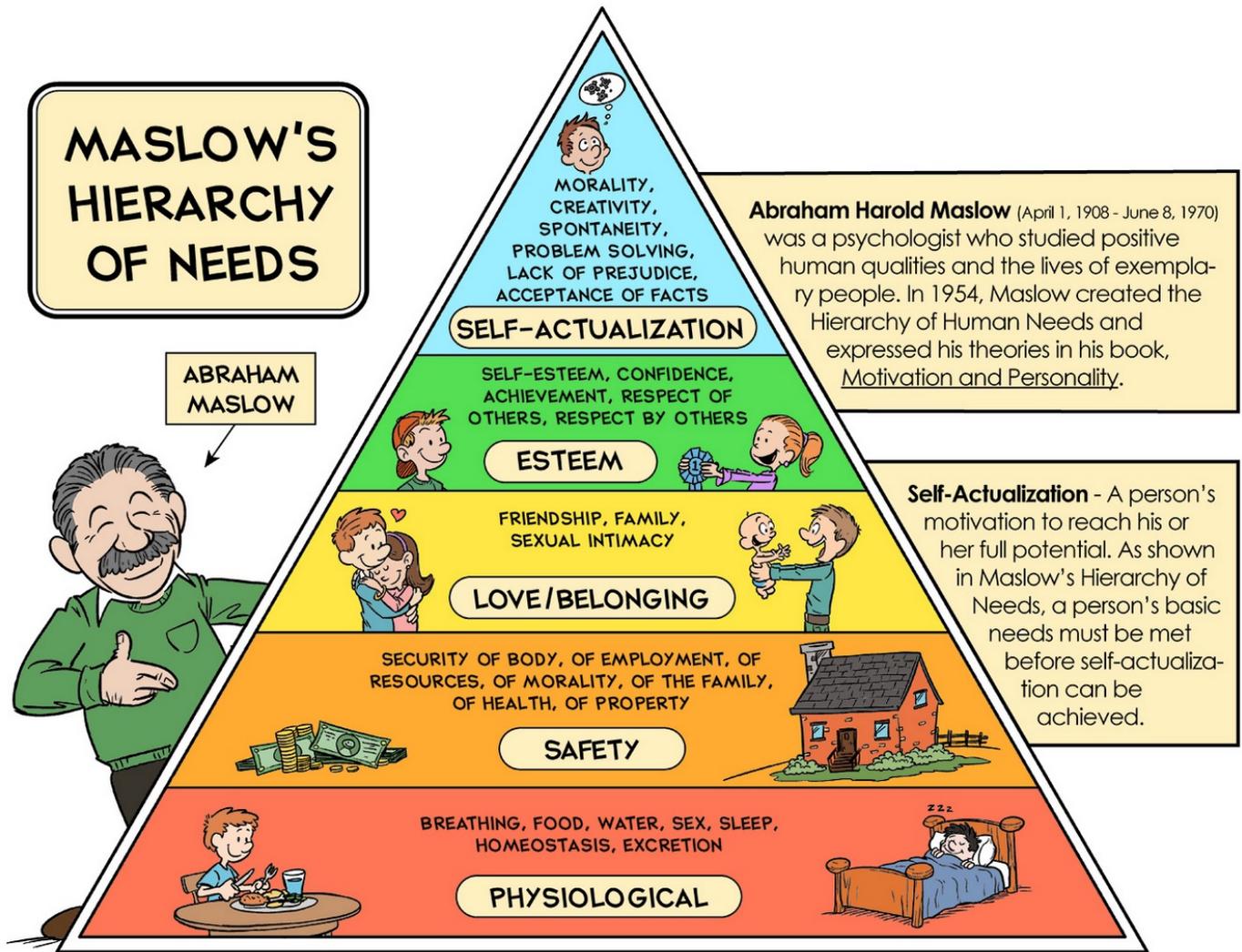


Integration

Full participation usually happens in stages.

Stages = where the person is in life – child? adult? Who is around the person? Who is their champion? What challenge does the person face to full inclusion? What could he

or she learn to do that would help them get closer to inclusion? Independence? Indicate their choice? What is best to start with **NOW** – according to the person’s desires and strengths?



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Habilitation services provide help for the person to do something, learn something

Habilitation services fit the needs of the person, not the needs of others.

Habilitation services are far more than shopping and weight loss!

Service planning can take into consideration all the help available to the person.

Habilitation service providers are certified and enrolled. And, they are providing habilitation services because they BELIEVE in the person's abilities, without judgement.

Habilitation service providers are able to listen, observe, and adapt their teaching to the person's needs. Direct service staff are trained to listen, observe and adapt.

Habilitation service providers believe in full inclusion on behalf of those they serve. All service efforts help the person get closer to that – **without judgement.**

- ***No matter how small the steps are.***
- ***No matter how many times it takes to try.***
- ***No matter how many different strategies are tried***
- ***No matter how long it takes to see progress.***

Developing Goals & Objectives for Habilitation Services

Personal goal

Please note that all support plans require a “**personal goal**”. This is the person’s goal, which they indicate to the care coordinator. The personal goal may or may not be supported by waiver services, and may or may not have service-supported goals and objectives related to it. It is simply something the person holds important and has set for a goal for themselves. For example a **personal goal** may be

“John wants to live in his own house someday.”

Habilitation Services Goals

(The following information is about habilitation goals and objectives – for which waiver services are requested.)

For habilitation services, there is no prescribed or set number or limit on goals, objectives and interventions, or format. There is no formula for how many objectives are necessary related to the hours of service requested. The plan must articulate the person’s goal and objectives that will support that person to pursue their goal, within the request for habilitation services. Habilitation service staff providing the support to work the objectives must document their services according to what is written in the service plan.

The person will work with the care coordinator and the team to develop goal statements and measurable objectives for all habilitation services requested in the Support Plan. Here are some basic guidelines to creating

measurable goals and objectives. (The examples given are for educational/training purposes.)

- Each goal and objective developed will come from the person and his or her supportive team.
- Goals & objectives are person centered and relevant to the individual vs. the caregivers or paid supports.
- Goals, objectives and interventions should evolve based on the person's achievement or success toward reaching the goals.
- Portray how the person has met markers of independence or need for change in support.
- Give an accurate description of a person's abilities and strengths.
- How does the person make choices?
 - What does she do for herself?
 - Avoid the conceptual answer "nothing".

People of all abilities can make choices and communicate them. The person you are serving needs you to be observant of strengths and needs for support. You need to be able to train direct service staff to provide the skill based supports and make this expectation clear to staff.

How to organize your thoughts about a person's need for and how he or she can benefit from a habilitation service.

- Describe the supports he or she needs to accomplish activities in an average day.
- What help is needed to engage with the home environment? School? Work?
- Activities in the community?
- Describe what others do to help the person in the different phases of their average day.
- Describe what others do to help the person in the different phases of their average sick day.
- How will the service help the person get closer to a leading a life of his or her choosing?

Assessing risks for habilitation services

When proposing or helping to propose goals and objectives for a habilitation service, you and the team may start with assessing basic risks around the goal and objectives offered.

For example:

If the person wants to learn to shower or bathe more independently, what are the inherent risks to that person specifically?

1. Consider where the person will be learning, in this case the bathroom, tub/shower.
2. Can he/she feel water temperature to tell if it is too hot or cold?
3. Can he or she physically maneuver into or out of the tub/shower?
4. Does he/she have any health conditions that staff need to support or know about (seizures?)
5. What is the plan for safety to address these risks?
6. What will staff do to help?
7. What will staff do to teach?

Providing support for habilitation goals

Your person may be supported to pursue steps to his or her goal. People often need to start at the basics and work towards the goal. Person centered services can help the person make gains in the “zone” of their goal.

The care coordinator and habilitation provider must communicate with the person and his/her legal representative if applicable to be specific about what is important. What is most meaningful to the person? When you can answer the questions, the care coordinator can articulate the answers in the request for the service in the plan. The habilitation provider can articulate intervention statements – to describe the helping actions of staff – for the service plan and for documentation of the service.

Habilitation service provider reflection: “Once we worked with a young man who wanted to be a police officer. This was all he talked about when we talked about getting a job. We all knew that wouldn’t literally be possible for him. We did not tell him “no” as this was his dream. However when we had a person centered plan for him, we discovered that what he really wanted was a job where he could wear a uniform. It didn’t matter what kind of uniform. This opened up so many possibilities for him. He still has his job where he wears a uniform – basic coveralls with his name on the front.”

Goals for habilitation services

A goal is the end result that the person wants to achieve with the supports of the habilitation service. The goal for the habilitation service is measurable. Consult the person and his or her supportive team to find out what the person would like to achieve. Goals need to be meaningful to the person, based on assessed level of need and relevant to the service. The person will be making progress towards more independence or maintaining a level of current independence.

Support Plans may include more than one goal. Consider the person’s functional strengths and abilities when developing goals so that they are realistic and achievable through the support of the habilitation service. In this way goals and objectives can stay meaningful and relevant to the person’s life and progress or assistance to maintain skills. It is possible to change goals and objectives during a support plan duration based on the person’s progress toward achievement, or personal choice.

A goal is the person’s overall theme.

Example goal statements:

John wants to live in his own apartment.

Cathy wants to learn how to cook.

Peter wants to keep his collections orderly and neat.

Jamal wants to meet at least one friend who is interested in video games.

Lana wants to work in a retail store.

Helen wants to establish and develop her microbusiness.

Joe wants to take his girlfriend out on a date.

Gina wants to host a barbecue party at her house.

What is an objective?

An objective is one step that needs to be taken to move towards the goal. The purpose of objectives is to teach in steps and to assess progress. The individual, the care coordinator and the supportive team can break down steps that are as small or large as needed. Each objective should contribute to the overall goal. There may be more than one objective under each goal. The individual and the team will need to decide what objectives are best for working towards the goal. Sometimes a goal can be more broad, however in that case there should be specific objectives to really break down how that goal will be achieved.

Direct support staff will be helping the person achieve the goal through each objective. Objectives are tailored to the specific learning needs and physical abilities of each person. 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.

Verbs that describe the actions the person will take should be OBSERVABLE. Verbs such as learn, think about, consider, regulate are not observable. Use specific observable action verbs in the objective.

Observable action verbs:

This example objective could be related to the example goal described above, “John wants to live in his own house someday” and the measurable habilitation goal “John wants to shop for groceries once a week”. State relevant objectives, portraying measurability:

John needs to **review** food in the pantry **twice a week**.

John **prepares** a grocery list **once a week**.

John goes **shopping** for necessary groceries **once a week**.

In this example we would have met with John and his supportive team to figure out what kinds of activities John is motivated for and needs to 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.

What does “measurable” mean?

To measure means to do something – to perform an action to measure an amount.

When you are thinking about writing measurable objectives, ask yourself “what would I or others do or see if the individual has accomplished this goal through this objective?”

Habilitation objectives must be measurable.

When you are developing measurable habilitation objectives, analyze them to see if they meet this criteria:

Characteristics of a measurable objective:

1. *Reveals what to do to measure the objective*
2. *Yields the same conclusion if measured by several people*
3. *Allows a calculation of how much progress it represents*
4. *Can be measured without additional information*

(From Writing Measurable IEP Goals and Objectives; Bateman, Herr; Attainment Company Inc, 2010)

About Criterion, also known as quantitative data:

Criterion portrays the type of performance to be determined successful within the objective.

Criteria addresses how much or how little of an action will be the dividing line for progress or maintenance of a goal. Example criteria:

Completing something:

- in 3 out of 5 trials
- Once a day
- Once a week
- In 2 consecutive hours
- Taking less than 2 hours a week, etc

About qualitative data:

Quantitative data is not required for all objectives. In some cases the narrative may portray how completion or progress is measured.

About percentages:

Percentage criteria should be applied only to very specific observable goals. For example: “*Kara completes sorting her bedding laundry into lights/darks with 80% accuracy*”. This might be possible to accomplish if we know about how much laundry is sorted. It is reasonable to know and could fit with everyday life.

However “*Kara indicates her preference for music using her eye gaze 60% of the time*” cannot be measured. It’s not possible to place a percentage on subjective choice or many other everyday living skills. It may be more useful to propose an objective based on being offered the criteria above.

Here is another example of a non-measurable objective: “Chandra will learn to act appropriately in public.”

- It’s not possible to know what acting appropriately looks like here.
- It’s not possible to tell how or when she learned it.
- It’s likely that people would disagree on whether this was achieved or partially achieved.
- Because it is not specific.

To make it measurable, be specific:

Example objective statement: While waiting in line at the grocery store, Chandra makes no verbal comments to other customers and stays in the line in 2 out of 3 trials.

You can easily measure if Chandra completes or makes progress for this. Others could also understand and likely agree on the progress. Direct support staff can offer this opportunity to learn to Chandra. Staff can follow their interventions for support to her so she can learn.

Measurable means the person and his/her supportive team will be able to see progress or maintenance of the skills that are described in the objectives, usually through the documentation done by the direct support staff. The Care Coordinator will be able to report on progress, or maintenance, including relevance of the objectives to the person, through this documentation. This information will help with planning for habilitation services in the renewal Support Plan.

You can write a measurable objective with a condition (a “given”) if needed.

Example objective statement: Given a visual recipe and measuring cup set, Joe measures dry ingredients correctly in 2 out of 3 trials.

You can write a measurable objective without the condition (the “given”). In this example, it is ok to assume the person will use a phone to call. (You wouldn’t have to write “given a phone…”).

Josephine calls her mother once a week and talk with her for at least 30 minutes.

Please note that narrative progress is required in addition to any quantitative data. The care coordinator needs this info when planning services or renewal.

Habilitation services to help decrease behavior

At times you may serve someone who wants habilitation services to help them decrease behavior. You can write a goal to help a person decrease behavior.

- Before you do that, you need to meet with the person and the team to establish:
 - Are there clear and imminent health and safety risks because of this behavior?

- Has the person had any trauma in their past that might be informing this behavior now?
 - Has the behavior happened before and what was done to help before?
 - What worked? What did not work?
 - What does the behavior that needs to decrease mean to the person?
 - What does the behavior that needs to decrease mean to the people/person who spends the most time with the individual?
 - Does the behavior need to decrease because of needs of the individual?
 - Or the needs of others? (not a reason to propose the habilitation service/goal)
 - What happens from the person's point of view when they do it?
 - Does she get to leave a situation because of the behavior?
 - Does he get something he likes?
 - Does she get away from something she doesn't like?
- What is another way the person can get what he/she needs without using that behavior?
 - What can the team do to help the person get what he/she needs without using that behavior?
 - Does the person and the team think that reducing the behavior now is important to the person's health, safety and quality of life?
 - If so:
 - How will the team ensure that the person has no restrictions placed on them during help to decrease the behavior?
 - How will the team reduce risks to health and safety during help to decrease the behavior?
 - How will the team measure the reduction of the behavior?
 - How will the team measure increase in functional behavior?
 - How will the team discontinue help to decrease behavior when it is no longer necessary?

When you, the person, their legal rep if necessary, and your team can answer all the questions, you could propose objectives to decrease nonfunctional behavior. You should document your meetings, answers to the questions and decision to offer objectives to help the person decrease the behavior.

Example goal statement: *Kara shouts less than 5 minutes per week.*

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. What markers will the person achieve to show progress? In what time frame will these be reviewed? (Quarterly meeting?)

What are the "interventions"?

Interventions describe 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) will be offered?

Here is an example of interventions that relate to John's objectives above:

"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."

What if goals change during the current Support Plan?

If a person wishes to change his/her goals or objectives during the current Support Plan, 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 Support Plan, or an amended plan as applicable.

Renewal planning for goals and objectives?

The planning team reviews documentation about the progress of the habilitation services during the previous Support Plan year. It is possible to use observation of progress to determine if services need to change or stay the same. Goals and their accompanying objectives and interventions are either “continued” or “discontinued”.

Objectives for Goals that are continued should be reviewed and the interventions evaluated for effectiveness. New Goals can be identified in the renewal Support Plan but should be balanced with existing goals to promote success. The Support Plan will need to address progress and/or maintenance in the Personal Profile section “Progress towards previous goals” regarding habilitative services.

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

~Confucius

What is SDS looking for?

Goals and the accompanying objectives must be:

- Person centered- What do they want to do?
- Measurable- How will they know it's being achieved?
- Based on information provided in Personal Profile and Assessments-
- 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 (every, always...)
3. Subjective goals (good choice, enough, bad things...)
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 or an intervention for something larger?

Documenting Habilitation Services

Attribute	Habilitation Note
The case note is based on facts not opinion	X
Includes the provider's signature and credentials	X
Includes the date and time of the note writing	X
Is written as soon as possible after the event/service occurs	X
If late entry, is noted as a late entry (within 24 hours)	X
Is typed/digital or if handwritten is blue or black pen	X
If handwritten errors are crossed out with one line and corrections written next to the error	X
Free of whiteout or blackout/coloring in to cover errors	X
The note addresses a personal and/or habilitation goal.	X
The Habilitation service has measurable goals and objectives.	X
The Habilitation service note references the goal, and the objectives applied during the service.	X
The Non Habilitation service note references the outcome.	X
Has the person's name on it.	X
An identifier such as Date of birth, Medicaid Number, SDS Number, Harmony Number	X
Documents one service at a time.	X
Each note occupies one individual page or digital document/section.	X
States type of service	X
Includes date of service	X
Service start and end times	X
How many hours if applicable	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	X
Justifies the duration of the service	X
States where the service was done	X
Describes what the provider did to help the person reach the goal/outcome	X
Describes the person's response	X
Describes any progress made	X
Documents unusual occurrences	X
States if the person declines the service	X
Indicates any change in performance or needs for support	X
Does not include stand by time or other time that is not the approved service	X

Writing in Plain Language

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

You don't write because you want to say something, you write because you have something to say.
~F. Scott Fitzgerald

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:

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

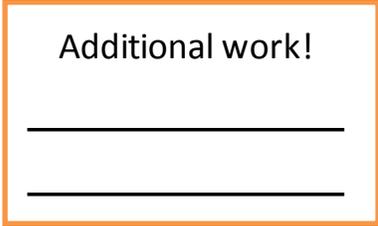
Additionally Plain Language:

- 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



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.

“Clear writing from your government is a civil right.”

~Former Vice President Al Gore, 1998

Identify your audience

- Think of why the user needs to read your document
- Keep in mind the average user's level of technical expertise
- Write to everyone who is interested, not just to experts
 - (focus on the readers in the middle of the spectrum)
- Even an expert will prefer a clearly written document

Apply plain language to your writing?

Use Short paragraphs with short sentences

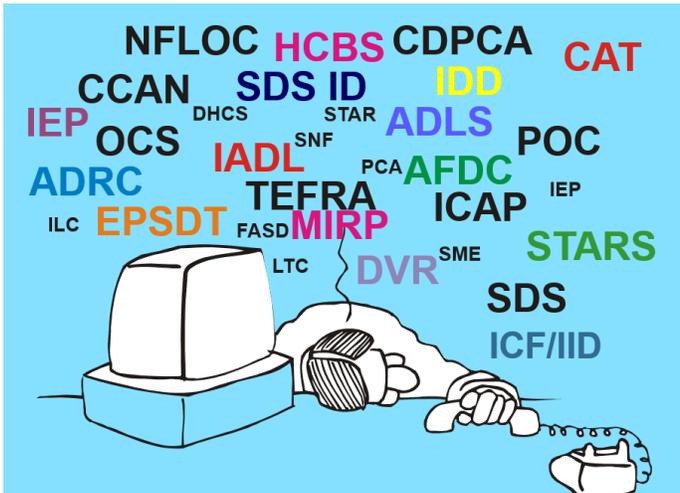
- ❖ Limit a paragraph to one subject or step
- ❖ Smaller “bites” of info are easier to digest
- ❖ Aim for no more than 7 lines
 - Treat only one subject in each sentence
 - Avoid complexity and confusion
 - Aim for 20 words per sentence or fewer

Don't sound so clinical-

The PLAN is about the person not their diagnosis. Talk about the person as a person not a diagnosis or list of needs

- Limit jargon and acronyms
- Contractions aren't (are not) bad
- Use everyday words
- Don't write like the government!!!





Eliminate

- Excess Words
- Excess content
- Repetitiveness
- Give small bites of information

Use Everyday Words:

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

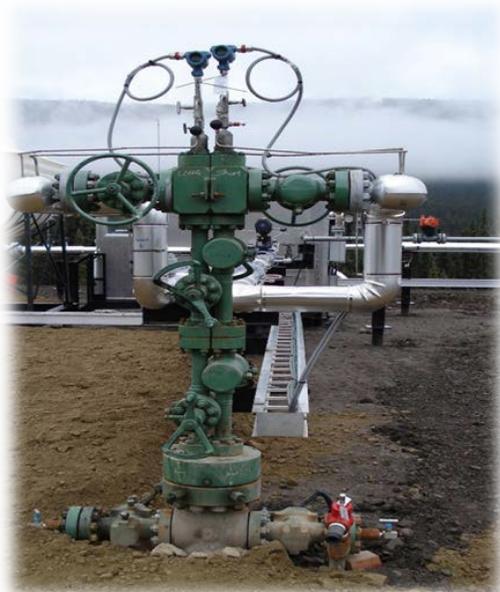
- In the event that _____
- Submit _____
- Terminate _____

What are some other words you think are confusing?

Use Consistent terms = Common language in all you do

...be consistent in your narrative, throughout your Plan and in Applications

What is commonly called this?



Use an Active, not passive voice

Active writing is

- More clear, concise and direct
- Makes it clear who does what: “The Director wrote the memo yesterday.”
- Is concise
- Is natural

Passive writing is

- A characteristic of bureaucratese “Mistakes were made.”
- Can disguise who does what: “The memo was written yesterday.”
- Is wordy
- Is awkward

An Example:

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)

Avoid hidden verbs

-verbs disguised as nouns

Conduct an analysis

Analyze

Present a report

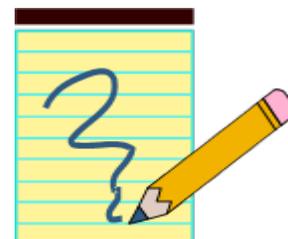
Do an assessment

Provide assistance

Came to the conclusion of

Use lists (But not too long of lists)

- ❖ Make it easy for the reader to identify all items or steps in a process,
- ❖ Add blank space for easy reading
- ❖ Help the reader see the structure of your document.



–avoid “shall”

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

Avoid using “shall” it could mean something different then you intended

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.

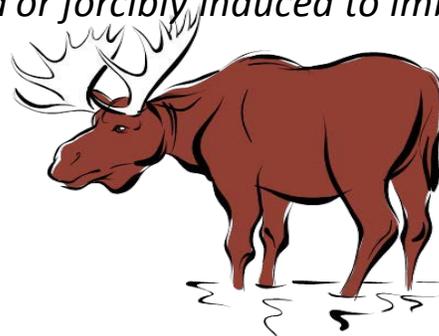
Consider these words, what do they mean?

Client
Established
Potential
Objectives

Develop
Provider
Implement
Capacity

Simpler is Better

"An Alces Alces unguate may be propelled toward a body of aqueous fluid, but such unguate 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."



Always Consider:

Who are you talking about?

What are all the uses for the Support Plan?

Who will sign agreement to the Support Plan?

Is it important that multiple readers understand the Support 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)*

Resources for writing

- [NIH plain language training](#) - Additional training on the web
- [Plainlanguage.gov](#) - Federal plain language guidelines
- [Center for Plain Language](#)
- [Plain Language: Writing for Readability](#)
- Online training course- Plain train <http://www.lisibilite.net/PlainTrain/>

Support Plan Questionnaire

Every Plan of Care must include a Person Centered Plan Questionnaire (Uni-15). It is intended to show federal oversight agencies that recipients of HCB Waiver services in Alaska are experiencing some level of person-centered interactions with their Plan development.

The [Uni-15 PCP Questionnaire](#) must be completed prior to submitting an initial or renewal Support Plan. Discuss the topics with the person you are serving and his/her representative (if applicable), and record the recipient's response. You will need to provide an explanation if the recipient answers "No" to any of the questions. Be sure to ask the participant for clarification on any no answers and quote their response.

Encourage your clients to be open and truthful when answering the PCP Questionnaire. We will accept this document completely handwritten by the client (or representative), as long as it's legible and signed.

The questions are:

For Renewal Plans of Care Only:

1. During the last year, did you receive the services identified in your current Plan of Care?
2. Did the waiver services you received during your current Plan of Care year help you work towards your goals?

For All Plans:

3. Did you get to choose who should be present at your planning meeting for your current Plan of Care?
4. Did you get to choose where and when your planning meeting for your current Plan of Care took place?
5. Did you have the choice to lead your own planning meeting for your current Plan of Care?

As with all SDS forms you can find the blank form in PDF format on the [SDS Approved Forms](#) Webpage

Because this document must capture the signature of the person receiving services or the legal representative and SDS uses the information collected on the form to evaluate program changes and report to CMS federal oversight, the answers must be entered into the Harmony data system. Then the actual form is scanned as a supporting document to the Support Plan.

Unit 7 - Renewing CFC and Waiver Services

LOC Reapplication

SDS requires the Care Coordinator to submit a complete renewal application **90 days before the current Level of Care expires**, if the individual wishes to continue Waiver Services **7 AAC 130.213. Assessment and reassessment**. This allows the State of Alaska assessor time to re-establish Level of Care before the current LOC expires. Care Coordinators need to assist the recipient 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 and CFC must complete the Waiver Application form UNI-04, which includes CFC
- A new Recipient Rights and Responsibilities form
- An updated Qualifying Diagnosis or Verification of Diagnosis

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

Re-Assessment for ALI, APDD, CCMC, and CFC 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. It is again very important for the assessor to see precisely what the person can and cannot do for themselves.

The IDD Waiver LOC Reapplication will include depending on the applicants age & length of program eligibility:

- [IDD-03 ICAP Assessment Information and Consent](#) or [IDD-10 Interim ICF IDD Level of Care](#)
- [Uni-07 Recipient Rights & Responsibilities](#)
- Current [IDD-13 Qualifying Diagnosis Certification Form](#)
- Updated Legal, Medical and Diagnostic Information if available

Submit the Renewal Application (in one message) by DSM to: SDS.IDDAnchorageAK

or FAX to: 907-269-3639

The ALI, APDD & CCMC Waiver LOC Reapplication will include:

- Uni-04 Annual Application for ALI/APDD/Reapplication CCMC Waivers
- [Uni-07 Recipient Rights & Responsibilities](#)
- Current [Uni-09 Verification of Diagnosis](#)
- Updated Legal, Medical and Diagnostic Information from the previous 12 months

Submit the Renewal Application (in one message) by DSM to: [DSDS.NFLOC-Reapplication](#)

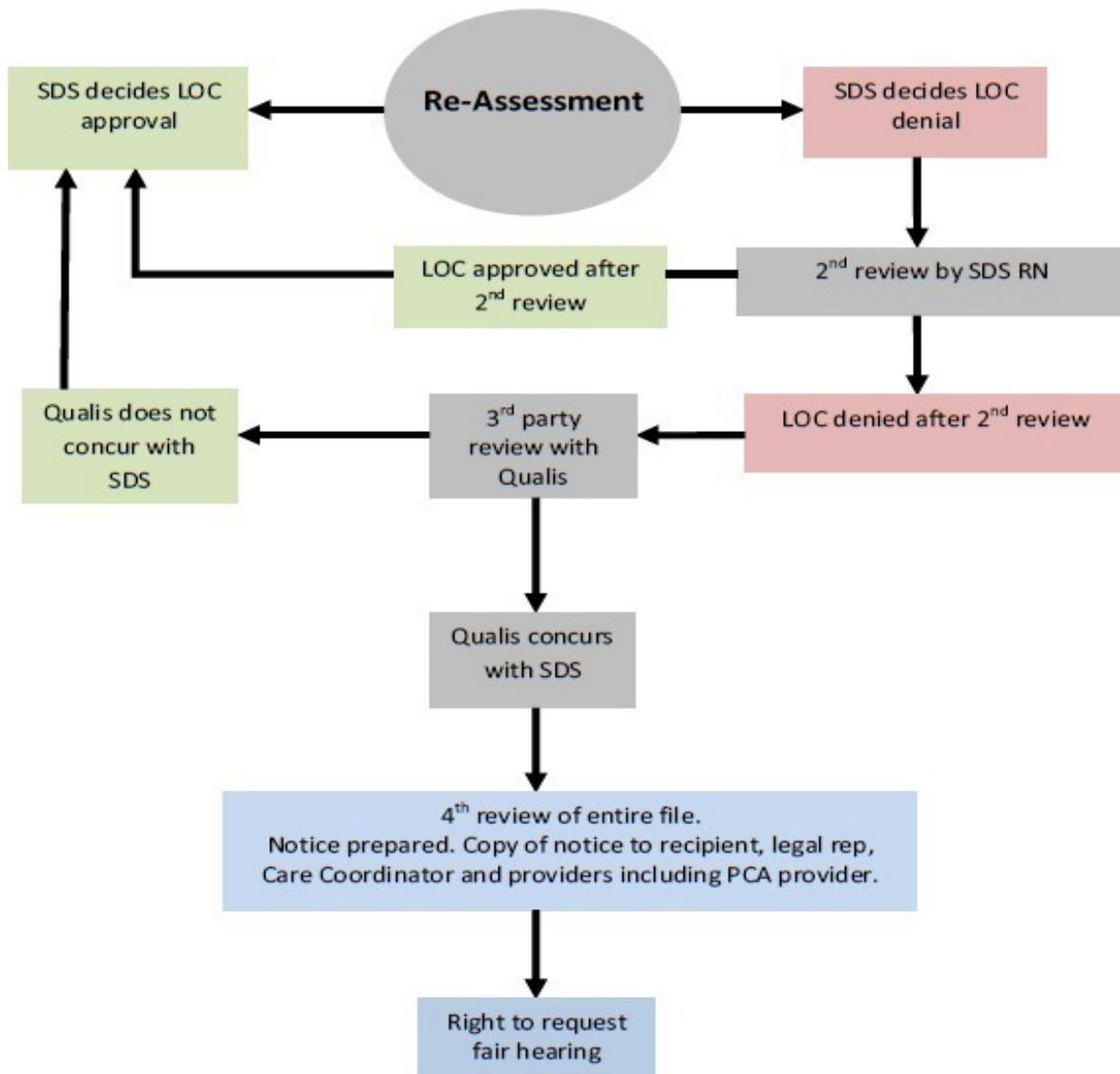
or FAX to: 907-269-6246

Material Improvement Review Process (MIRP)

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. (Currently Qualis) Please note: Prior authorizations (meaning that providers are prior authorized to provide the approved service to the person) are continued throughout the process.

Fair Hearing & Hearing Process Rights

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

When an individual disagrees with a decision made by the Senior and Disabilities Services, they can request a fair hearing. The fair hearing process has two steps, mediation and hearing.

Mediation -1st Step

The mediation step, which is step one, is a critical piece in the two step process. It allows for both the recipient/applicant and SDS to be educated on the specific situation. The case details are reviewed for accuracy based on the information on file. Any new information can be presented and can be considered against the regulations that govern the programs.

The mediation step has been very successful for recipients/applicants in resolving any concerns they have and allows SDS to amend decisions based on new information presented. At this first step, the recipient/applicant is given an opportunity to express to SDS and the mediator (a neutral party) why they disagree with the decision. They can present documentation, usually medical records, to support their statements and provide greater insight into their situation so SDS can review and consider.

Once all the information has been presented and SDS has had the opportunity to review, it will be determined if any changes to the original decision can be made and if so, what those changes are. Once changes, if any, are presented, the recipient/applicant reviews and determines if they agree with the change.

- If the recipient/applicant agrees with the change, the second step, the hearing, is cancelled.
- If the recipient/applicant disagrees with the change, they can request to move to the second step, the hearing.
 - If an individual chooses to move forward to the second step, any offers and/or information presented and discussed at the mediation step cannot be discussed or presented to the judge at the hearing step.
 - The hearing is a clean slate and an opportunity for both sides to present their case based on the information SDS had when it made its decision.

As a Care Coordinator when you are assisting an applicant/recipient through the application or renewal process, it is very important to assist them in submitting supporting documentation to include behavior and care calendars, current medical records from all their providers as well as a plan of care that outlines the individual's current needs and situation. It will be this information that is used by SDS to make determinations and will be the basis during any talks in mediation.

If it is believed information given to SDS at the time of application or renewal was not clear or failed to be presented, it's important for the CC to assist their client to identify the missing information and submit it. Include an outline of what determinations they disagree with and why prior to the actual mediation date and time to allow SDS to review. Presenting information prior to the mediation streamlines the process and ensures the information is received timely for a review to be conducted.

Fair Hearing – 2nd Step

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

Transfer of Care Coordination

At times a client will choose a different Care Coordinator. You should receive a new Appointment and Transfer of Care Coordination form and a new Release of Information form. As the now previous CC you need to sign the Appt. of CC form and return it to the new CC with the last 12 months of Case Notes for the individual. You need to complete this action within 5 business days. Utilize Direct Secure Messaging to complete this.

According to the Appt. and Transfer of 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 (at least 30 days).
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.
4. Give your client names & contact info of care coordinators in the area who work with that waiver type.
5. 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, the **agency** must still give the client options to choose a Care Coordinator. Follow the guidelines found in the [Anti-Solicitation letter](#), issued by SDS, June 2, 2015.

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.

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 the steps in the Care Coordinator Harmony User Guide

FOR ANY WAIVER CLOSURE OTHER THAN DEATH:

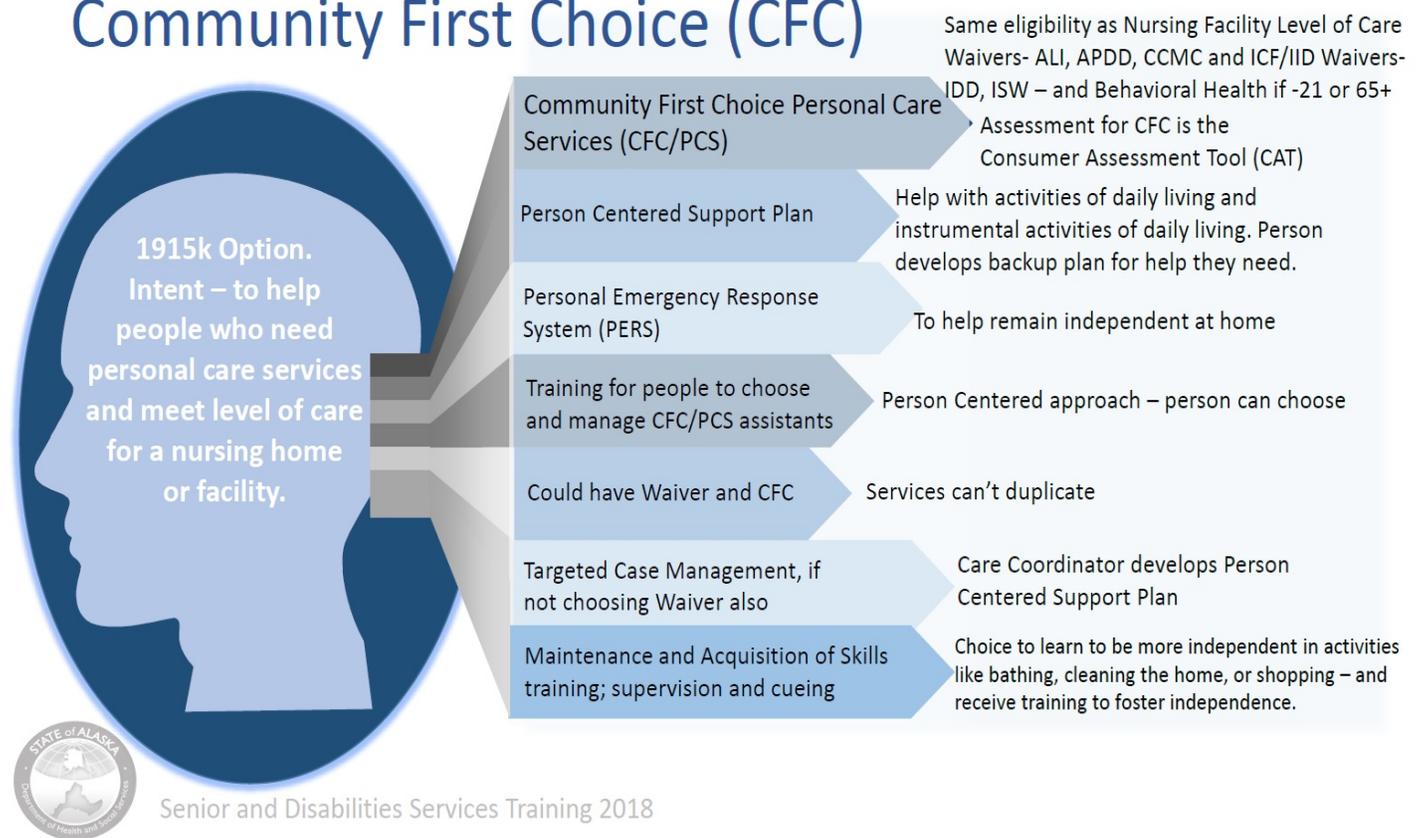
1. Give the person a letter stating that you are terminating Care Coordination services to them
2. Follow the standard for this notice as seen in the Appt. for Care Coordination Services (30 days' notice).
3. Update the Waiver Services Overview form indicating the last known dates of service(s)
4. Submit the information to SDS via SDS Harmony data system
5. Convey the closure information to DPA by DSM.
6. 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.

Community First Choice (CFC) is a Medicaid option but it is not a home and community based Waiver.

Community First Choice (CFC)



Care Coordinator Basic FAQs – Community First Choice, Prior to Care Coordinators using Harmony Data System November 29, 2018

Please note that questions and answers may change over time.

When Care Coordinators work within Harmony, processes and expectations will be different. More training and information available soon.

1. Does the “Plan of Care” have a different name now?

Yes – the Plan of Care is now called the Person Centered Support Plan, or Support Plan for short.

2. What’s different now about how Care Coordination services are reimbursed?

As of October 1, 2018:

- Initial application for all Waiver types and CFC is reimbursed under Targeted Case Management, a regular Medicaid service and code. (This includes application for ISW and IDD: the “application” for these waivers is the set of documents to request an ICAP assessment for the recipient.)
- Annual Support Plan development is also now reimbursed under Targeted Case Management, a regular Medicaid service.
- Ongoing care coordination (Monthly) for ALI, APDD, CCMC, ISW and IDD is reimbursed as a monthly unit under Waiver Medicaid. ISW Monthly has a different code modifier.
- Ongoing care coordination (Monthly) for CFC is reimbursed under Targeted Case Management (TCM), a regular Medicaid service.

3. Why this change?

- To respond to the legislative requirement to save Alaska Medicaid money by realigning services
- To comply with federal regulations to implement Community First Choice

4. Where can I see the current rates of reimbursement?

On the webpage: <http://dhss.alaska.gov/dsds/Pages/info/costsurvey.aspx>

5. What is a “CFC only” plan?

Community First Choice (CFC) is available for Medicaid recipients who meet Nursing Facility Level of Care, ICF/IID Level of Care, or Institution for Mental Disease – Behavioral Health (IMD) Level of Care. For IMD level of care only, the recipient must be under 21 or over 65 years of age.

The available services in CFC are:

- **Care Coordination (Targeted Case Management):** Application, Annual Plan and ongoing Monthly case management.
- **Personal Care Services** – PCS, when delivered in a CFC plan is called “CFC-PCS”.
Hands on help with Activities of Daily living
Hands on help with Instrumental Activities of Daily Living
- **Skills Building** – through CFC-PCS: help given by trained PCA worker to help the recipient be more independent with an ADL/IADL that the person chooses. PCS agency representatives are attending required SDS training to be able to train their staff to do it.
- **Supervision and Cueing:** CFC-PCS service in which the PCA is in proximity to the recipient and only supervises and cues the recipient to perform an ADL or IADL. (Not hands on help time.)
- **Personal Emergency Response system (PERS):** Communication system installed by PERS provider for the person to be able to summon help at home.
- **Optional Training resources to manage own staff**

6. Is the recipient required to have ALL the CFC services?

No. The person can choose which ones to request.

7. **NEW - My client has a Waiver and had PCS too and was auto-enrolled in CFC. He doesn't want any of the other CFC services, except the PCS. Shouldn't he just opt out and keep just PCS?**

Auto-enrollment and its' opt out period has ended.

If a recipient with CFC and waiver wants to opt out of CFC, the recipient is choosing to discontinue CFC. The care coordinator submits the CFC-01 (CFC Amendment form) to remove CFC, which also removes the CFC-PCS services that are in CFC.

The recipient will need to reapply for PCS only, by applying through a PCS agency. The recipient should be aware that they may need a new assessment and services may be awarded at different levels than previously, based on the new assessment.

8. What is Care Coordination for a “CFC only” Support Plan?

- A “CFC only” plan means the recipient has some or all of the CFC services listed above. AND the recipient does not have any additional HCB waiver services in to the CFC services.

Care Coordination for a “CFC only” client is called “Targeted Case Management”.

The Care Coordinator:

- Performs and requests reimbursement for ongoing monthly care coordination at the TCM monthly rate
- Portrays the frequency of face to face visits in the Support Plan, subject to review and approval
- Creates the application, the annual plan, CFC amendments and travel requests
- Performs all activities of care coordination found in the regulations and Conditions of Participation (COPs)
- Follows the approved Support Plan for the face to face visit schedule requested by the CFC only client

9. Can a Care Coordinator request the Visit Exception for a CFC Only Client?

No. The schedule of face to face visits to the recipient are proposed in the Support Plan, subject to approval.

(Also see [CC TCM Conditions of Participation](#))

10. Are Personal Care Services going away?

No. A Medicaid recipient who does not meet a facility Level of Care can still receive Personal Care Services. Recipients who do meet a facility level of care can still choose to receive only Personal Care Services and authorized Waiver services.

11. Can a person have both CFC and a Waiver?

Yes. The person must meet level of care for the Waiver they are enrolled in.

Most people who had Waiver and Personal Care Services were automatically enrolled in CFC as of October 1, 2018, (unless they opted out). Recipients were sent a letter in April 2018 about how to opt out. The majority of current recipients with both Waiver and PCS did not opt out and now have waiver and CFC-PCS.

- Please note –if a person wants to have a PERS, the recipient must be in the CFC program. PERS is only offered as a CFC service as of Oct 1, 2018. If your client had a PERS and wants to keep it, or add one, they must participate in the CFC program.)

A current or future Waiver recipient can apply to add CFC services. The person can receive any of the CFC services, and Waiver services. The services cannot duplicate each other.

12. If a recipient has both CFC and a waiver, does the care coordinator get reimbursed for 2 applications, 2 Support Plans, etc.?

No. Care Coordination “defaults” to the Waiver care coordination in responsibilities and reimbursement.

However the Care Coordinator must follow certain requirements to help the recipient with CFC-PCS services.

13. How does a Care Coordinator apply on behalf of a new applicant for CFC and the ALI, APDD or CCMC waivers?

For ALI, APDD, CCMC and CFC only, the applicant will start by contacting the ADRC for an options counseling.

Once completed the applicant will provide the options counseling form to the care coordinator.

The care coordinator then completes and assembles the application packet.

The applicant will have a CAT assessment scheduled, to determine Nursing Facility Level of Care (NFLOC). SDS notifies the applicant and care coordinator by letter of the assessment determination. If the person needs the same care as that provided to people living in a nursing facility, if the Service Level Authorization (SLA) for CFC-PCS is created shortly after the CAT assessment. The SLA authorizes the amount CFC-PCS services that can begin prior to the Support Plan approval. The care coordinator will develop and submit the Person Centered Support Plan within 60 days.

14. What’s a “SLA”?

Service Level Authorization. This is the chart that the SDS assessor completes after the CAT (Consumer Assessment Tool) assessment to show what type of CFC-PCS supports are authorized how much of each.

15. Does the recipient need to wait for approval of the Support Plan to receive the CFC-PCS Services?

No. The CFC-PCS services can start the date of the Service Level Authorization (SLA).

16. Does the SLA include “Skills Building” and the PERS?

No. CFC Skills Building and PERS are requested on the Support Plan, subject to review and approval.

17. NEW - How is “IMD” level of care determined?

Through a partnership with Qualis Behavioral Health. SDS is working on the partnership with Qualis for this assessment. The person will have a level of care assessment through Qualis.

18. NEW - Can a Care Coordinator apply for CFC for someone who may meet the IMD level of care?

Yes. The applicant must:

- Be between age 6 and 21
- Or over age 65
- Have active Medicaid
- Have a PCI intake form completed with the ADRC
- Have a diagnosis from a psychiatrist or mental health professional
- Show some of the indicators of IMD level of care

Indicators of IMD Level of Care, from 7 AAC 127.025:

The applicant must (1) require a level of care in an institution providing psychiatric services for individuals under 21 years of age or an institution for mental diseases for individuals 65 years of age and over; (2) have a mental illness or severe emotional disturbance that (A) has been diagnosed by a psychiatrist or mental health professional; (B) is likely to cause serious harm to self and others or is gravely disabled; and (C) has persisted six months and is expected to persist for a total of 12 months or longer; and (3) absent appropriate intervention in the home and community, requires psychiatric hospitalization as documented by a mental health professional.

From AS 47.30.915 (definitions):

- **Gravely disabled** means a condition in which a person as a result of mental illness
 - (A) is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken; or
 - (B) will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of the person’s previous ability to function independently;
- **Likely to cause serious harm** means a person who
 - (A) poses a substantial risk of bodily harm to that person’s self, as manifested by recent behavior causing, attempting, or threatening that harm;
 - (B) poses a substantial risk of harm to others as manifested by recent behavior causing, attempting, or threatening harm, and is likely in the near future to cause physical injury, physical abuse, or substantial property damage to another person; or
 - (C) manifests a current intent to carry out plans of serious harm to that person’s self or another;
 - **Mental illness** means an organic, mental, or emotional impairment that has substantial adverse effects on an individual’s ability to exercise conscious control of the individual’s actions or ability to perceive reality or to reason or understand; intellectual disability, developmental disability, or both, epilepsy, drug addiction, and alcoholism do not per se constitute mental illness, although persons suffering from these conditions may also be suffering from mental illness

19. NEW – What does CFC do for a person with IMD level of care?

- a. The person will have a “CFC only” plan
- b. The person would not also have a waiver because IMD level of care does not apply to waivers

- c. The person will have a CAT assessment to determine the CFC-PCS service level authorization
- d. The person may have some of the CFC-PCS services, a PERS, and or skills building
- e. Like all CFC, the person will have a care coordinator providing targeted case management

20. NEW - My Waiver client received a document that says he is eligible for CFC services, but he lives in an assisted living home. If the recipient lives in an assisted living home, a group home or family habilitation home, can the recipient get CFC services?

No. CFC services duplicate Waiver out of home residential service. The recipient received a document confirming possible eligibility for Alaska Medicaid long term services and supports (such as the Person Centered Intake form). The document does not authorize CFC services.

21. How does a Care Coordinator apply for CFC on behalf of a recipient who currently has only the ISW or IDD waiver?

For IDD and ISW only, the applicant will have a CAT assessment scheduled. The Service Level Authorization (SLA) for CFC will be created shortly after the CAT assessment. The SLA tells the authorized CFC-PCS services. The recipient and care coordinator will receive a copy of the SLA from SDS.

The care coordinator completes and assembles the application packet to have a CAT assessment completed and PCS Service Levels determined.

NEW - The ADRC Person centered intake form is not required if the person already has a Waiver.

- Uni 04 Application (since the applicant will be requesting CFC-PCS the Care Coordinator should enter the name of the chosen CFC-PCS agency on the first page)
- Uni 07 Recipient Rights and Responsibilities
- Uni 09 Verification of Diagnosis
- Uni 12 Request for Expedited Consideration (if applicable circumstances)
- Medical documentation that supports need for CFC or waiver
- Proof of legal representative (if applicable)
- Proof of Medicaid eligibility: current Denali Card, Medicaid number, DPA printout or Enterprise printout
 - The care coordinator submits the above to SDS via Direct Secure Messaging (DSM) to dsds.nfloc-initialapplication@hss.soa.directak.net

22. How does a Care Coordinator apply for CFC on behalf of a recipient who currently has only the ALI, APDD, or CCMC waiver?

NEW - The ADRC Person centered intake form is not required if the person already has a Waiver.

- Uni 04 Application (since the applicant will be requesting CFC-PCS the Care Coordinator should enter the name of the chosen CFC-PCS agency on the first page)
- Uni 07 Recipient Rights and Responsibilities
- Uni 09 Verification of Diagnosis
- Uni 12 Request for Expedited Consideration (if applicable circumstances)
- Medical documentation that supports need for CFC or waiver
- Proof of legal representative (if applicable)
- Proof of Medicaid eligibility: current Denali Card, Medicaid number, DPA printout or Enterprise printout
 - The care coordinator submits the above to SDS via Direct Secure Messaging (DSM) to dsds.nfloc-initialapplication@hss.soa.directak.net

23. My client has had an ICAP assessment and meets level of care for the waiver. Would my client also need to have a CAT assessment for CFC?

Yes. The CAT determines the CFC-PCS services the person could receive, which is shown in the Service Level Authorization (SLA). The SLA shows type, frequency, scope and duration of CFC-PCS services.

24. Does the recipient who has a waiver and CFC need to wait for approval of the Support Plan to receive the CFC-PCS Services?

No. The CFC-PCS services can start on the date of the Service Level Authorization chart.

25. Does that include PERS and Skills Building?

No. The care coordinator requests PERS and Skills Building on the Support Plan or Amendment. The Support Plan or Amendment is subject to review and approval of SDS. PERS and Skills Building can be delivered when the Support Plan is approved.

26. Can a recipient be eligible for CFC under the 300% above FPL Medicaid category?

No. A Medicaid recipient can apply for the Waiver program that fits the needs. The recipient could apply for CFC after approved for Waiver. However the recipient cannot be eligible for only CFC under the 300% category.

27. Does the PCS agency sign PCS amendments?

Yes, the newest [CFC-01 Amendment](#) form includes a signature line area. But if you've used an old version just ask them to sign below your signature.

28. Does the care coordinator send the amendment to the NFLOC e-mail as if it's a regular amendment or do we send it to the PCA e-mail?

Yes, send any CFC amendment requests through the dsds.nflocwaiver@hss.soa.directak.net DSM.

29. How will current Waiver Support Plans and CFC SLA dates align? Recipients that were auto-enrolled into CFC now have Service Level Authorizations ending before the current Support Plan. How is this handled?

Current and future Waiver (all types) recipients enrolled in CFC:

The CFC - PCS services are authorized until the end date of the Support Plan. This way they will automatically align going forward.

CFC only (no Waiver):

The start date of the CFC plan is the date of the Service Level Authorization (SLA) Chart

Current IDD/ISW Waiver recipients with CFC:

The CFC plan end date is adjusted by SDS to match the Waiver POC end date. This way they will automatically align going forward.

Current CFC recipients invited to apply for IDD/ISW:

When an individual is drawn from the registry, the CFC plan end date will be automatically adjusted accordingly to align with the IDD/ISW plan dates. This way they will align moving forward.

30. It sounds like requesting CFC services is now similar to requesting waiver services from "vendors" in waiver Support Plans. Is that true?

Yes. The care coordinator requests, renews and requests changes in CFC services on the recipient's behalf, much like waiver vendors in the waiver Support Plan.

31. Who provides CFC services?

An agency which is currently certified by SDS to provide CFC-PCS services and which is currently enrolled in Alaska Medicaid.

32. How can a care coordinator know what a CFC-PCS recipient's Service Level Authorization contains?

SDS will send a copy of the CFC-PCS recipients Service Level Authorization (SLA) to the care coordinator via DSM. When care coordinators are working in Harmony Data System, the SLA can be viewed there.

33. What can Care Coordinators ask the PCS agencies to submit through the SDS Harmony Data system?

The CC is ultimately responsible for submitting all requests to SDS. However the CC and the PCS agency can work together to submit these specific CFC documents through the PCS Agency in the SDS Harmony data system:

- [CFC-01 Amendment to Service Plan](#)

- [CFC-02 Request for CFC-PCS Services When Traveling](#)
- [CFC-03/PCS-16 Notification of Transfer Form](#)

All Applications and Support Plans must be submitted directly by the CC through DSM until SDS Harmony access is granted.

Care Coordinator Processes & Forms for CFC clients

1. *No action is required until Re-Application for recipients that were auto-enrolled in CFC unless there is a need to:*

Amend the current Waiver Support Plan to add Supervision & Cueing or increase CFC-PCS authorized hours

Complete and Submit:

- CFC-01 Amendment to Service Plan
 - Include a description of the changes requested to currently authorized CFC-PCS services
 - Submit with supporting documentation

Amend the current Waiver Support Plan to add PERS, Skills Training

Complete and Submit:

- PERS Prescription or documentation and cost evidence per 7 AAC 127.085
- UNI-14B CFC overview Cost Sheet (Auto Calculates the time authorized for Skills Training)

2. **Apply for ALI, APDD or CCMC waiver with CFC services (initially and at renewal):**

The care coordinator completes and assembles the application packet:

For CFC, ALI and APDD, the applicant will start by contacting the ADRC for an options counseling. Once completed the recipient will provide the options counseling form to the care coordinator.

The care coordinator then completes and assembles the application packet:

- ADRC Person centered intake form (for ALI, APDD and CFC only) ****Initial Only***
- Uni-04 Application -enter the name of the chosen CFC-PCS agency on the first page
- Uni-05 Appointment for Care Coordination Services ****Initial Only***
- Uni-07 Recipient Rights and Responsibilities
- Uni-09 Verification of Diagnosis
- Uni-12 Request for Expedited Consideration (if applicable circumstances)
- Uni-16 Release of Information ****check on Renewal***
- Medical documentation that supports need for CFC or waiver services
- Proof of legal representative (if applicable)
- Proof of Medicaid eligibility: current Denali Card, Medicaid number, DPA printout or Enterprise printout
- For APDD only – copy of DD Eligibility Determination letter from SDS

The care coordinator submits the above to SDS via Direct Secure Messaging (DSM) to

dsds.nfloc-initialapplication@hss.soa.directak.net

3. **Apply for IDD or ISW waiver with CFC services (initially and at renewal):**

The care coordinator then completes and assembles the application packet:

For CFC, ALI and APDD, the applicant will start by contacting the ADRC for an options counseling. Once completed the recipient will provide the options counseling form to the care coordinator.

- ADRC Person centered intake form ****Initial Only***
- Uni-04 Application -enter the name of the chosen CFC-PCS agency on the first page
- IDD-03 ICAP Consent OR IDD-10 Interim ICF/IIID level of care -per recipient age/ICAP cycle
- Uni-05 Appointment for Care Coordination Services ****Initial Only***
- Uni-07 Recipient Rights and Responsibilities
- Uni-09 VOD- Verification of Diagnosis
- IDD-13 QDC-Qualifying Diagnosis Certification
- IDD-15 request for day habilitation in residence exception if applicable
- Uni-12 Request for Expedited Consideration (if applicable circumstances)
- Uni-16 Release of Information ****check on Renewal***
- Medical documentation that supports need for CFC or waiver services
- Proof of legal representative (if applicable)
- Proof of Medicaid eligibility: current Denali Card, Medicaid number, DPA printout or Enterprise printout

- For APDD only – copy of DD Eligibility Determination letter from SDS

The care coordinator submits the above to SDS via Direct Secure Messaging (DSM) to IDD Unit DSM address pre region.

4. **Support Plan for a CFC only client:**

Complete and submit:

- Uni-02 Support Plan for All Waivers and CFC
 - Summarize CFC-PCS services authorized for the recipient on the SLA in the plan document
 - Request CFC Skills Building per recipient request on the support plan; no more than 3% of CFC-PCS total time authorized (auto calculates on the 14B CFC Overview)
 - Uni-14B CFC Services Overview and Cost sheet (if requesting PERS or Skills training)
- If PERS requested, attach prescription or documentation and cost evidence per 7 AAC 127.085
- Uni-15 Person Centered Plan Questionnaire
- Legal rep/guardianship documents if changed

5. **Support Plan for ALI, APDD or CCMC waiver with CFC services:**

Complete and submit:

- Uni-02 Support Plan for All Waivers and CFC
 - Summarize CFC-PCS services authorized for the recipient on the SLA in the plan document
 - Request CFC Skills Building per recipient request on the support plan; no more than 3% of CFC-PCS total time authorized (auto calculates on the 14B CFC Overview)
- Uni-14 Services Overview and Cost sheet
 - AND, Uni-14B CFC Services Overview and Cost sheet (if requesting PERS or Skills training)
- If PERS requested, attach prescription or documentation and cost evidence per 7 AAC 127.085
- If SME requested prescription or documentation and cost evidence per 7 AAC 103.305
- If EMOD requested documentation and process per CC COPS and 7 AAC 130.300
- Uni-15 Person Centered Plan Questionnaire
- Uni-10 Care Coordinator request for visit exception (if applicable)
- Legal rep/guardianship documents (if changed)

6. **Support Plan for IDD or ISW waiver with CFC services:**

Complete and submit:

- Uni-02 Support Plan for All Waivers and CFC
 - Summarize CFC-PCS services authorized for the recipient on the SLA in the plan document
 - Request CFC Skills Building per recipient request on the Support Plan; no more than 3% of CFC-PCS total time authorized (auto calculates on the 14B CFC Overview)
- Uni-14 Services Overview and Cost sheet (IDD) or Uni-14A ISW Services Overview and Cost sheet
 - AND, Uni-14B CFC Services Overview and Cost sheet (if requesting PERS or Skills training)
- If PERS requested, attach prescription or documentation and cost evidence per 7 AAC 127.085
- If SME requested prescription or documentation and cost evidence per 7 AAC 103.305
- If EMOD requested documentation and process per CC COPS and 7 AAC 130.300
- Uni-15 Person Centered Plan Questionnaire
- Uni-10 Care Coordinator request for visit exception (for IDD only, if applicable)
- Legal rep/guardianship documents (if changed)

7. **Request CFC while traveling**

Complete and submit:

- CFC-02 Request CFC-PCS Services While Traveling

8. **Request transfer of CFC-PCS Agency or Change the service model (AB or CD)**

Complete and submit:

- CFC-03/PCS-16 Notification of Transfer Form

9. Request Passive Range of Motion (PROM) during CFC-PCS services:

Have recipient’s prescriber complete and CC submit:

- [PCA-02 Request for Passive Range of Motion](#) filled out by prescriber of PROM
- Copy of prescriber’s written plan of care with detailed guidance for the movement of extremities for the PCA to follow
- Medical documentation that supports the prescriber’s recommendation

10. Add or renew request for supervision of eating during CFC-PCS services:

Have completed by licensed medical professional and CC submit:

- Swallow study conducted not earlier than one year prior to application or reapplication indicating the need for supervision of eating during CFC-PCS services
- CFC-01 amendment for Service Plan if added during current plan year

11. Information & Resources for the recipient about how to select and manage staff for CFC-PCS

Using training resource “Your PCA and You” from SDS Training unit, offer materials to the recipient and review with them if possible.

See updated forms on the SDS Approved Program Forms page:

<http://dhss.alaska.gov/dsds/Pages/info/approvedforms.aspx>

12. NEW – When filling out the CFC-01 (CFC Amendment) to add a Personal emergency Response System (PERS):

Use the Description of change(s) text box to request the PERS as seen below:

Description of change(s)
 Date(s) of the change(s): 10/25/2018 Describe the change(s) in the text box below:

Waiver Consumer would like to Add Personal Emergency Response System through CFC and have the most recent assessment reviewed for PCS Services.

*please include the CFC Cost sheet along with this amendment with signatures. The PERS provider signature is a requirement.
 (Depending on the situation this may require a New assessment to be conducted)

Requested adjustments to the Service Level Authorization for Personal Care Services or other CFC

Do Not use the PCS services area of the form.

ALASKA MEDICAID LONG TERM Services and Supports <i>Eligibility and Application Process</i>	PCS	CFC	ALI	APDD	CCMC	ISW	IDD
Person applies for and receives Alaska Medicaid	X	X	X	X	X	X	X
Alaska Medicaid 300% eligible If met NFLOC			X				
ADRC Options Counseling Required		X	X	X	X		

Apply at PCS agency	X					
STAR Coordinator help to apply to DD registry			X	X if DD	X	X
Wait list, get drawn from DD registry (letter of approval from SDS)					X wait list draws ongoing	X wait list draws limited to 50/year
Choose Care Coordinator	X	X	X	X	X	X
Care Coordinator applies annually	X UNI-04	X UNI-04	X UNI-04	X UNI-04	X (ICAP process)	X (ICAP process)

PCS only Application Packet submitted through Harmony

	to SDS	Keep on file at agency
Apply at PCS agency (NOT care coordinator)	X	X
PCA-08 PCS application	X	X
UNI-09 VOD	X	X
UNI -16 Release of Info	X	X
UNI-07 Recipient Rights and Responsibilities		X
Legal Rep documentation If applicable	X	X
Medical Documentation To support need for hands on help With ADLs and IADLs	X	X

Application Packet Completed by Care Coordinator Care Coordinator submits to SDS	CFC	ALI	APDD	CCMC	ISW	IDD
UNI-04 Application	X	X	X	X		
ADRC Options Counseling Form For initial application	X	X	X	X		
UNI-05 Appointment for CC/TCM						
UNI-09 Verification of Diagnosis	X	X	X	X		
UNI-16 Release of Information	X	X	X	X		
UNI-07 Recipient Rights and Responsibilities	X	X	X	X		
SDS DD Determination Approval Letter			X	X		
IDD-QDC Qualifying Diagnosis form					X	X
DHSS 06-5870 Release of Information					X	X
IDD-03 ICAP Assessment Info and Consent					X	X
Medical documentation To support need for facility Level of care	X	X	X	X	X	X
Documentation of required diagnosis for waiver: Autism, Seizure Disorder, Cerebral Palsy, Intellectual/Developmental Disability, Other dx which causes developmental delay: all prior to age 22					X	X
Legal rep documentation if applicable	X	X	X	X	X	X
Proof of current Medicaid eligibility (Denali card, Medicaid number, DPA or Enterprise printout)	X	X	X	X		
CFC-04/PCS-07 Consumer/Legal Representative Agreement Keep on file with CC and CFC-PCS Agency	X					

Other Resources

As stated previously, the Support Plan 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>

Medicaid (PCS) Personal Care Services Eligibility

Personal Care Services (PCS) is a Medicaid State plan option **but it is not a Home & Community Based waiver.**

To receive PCS, the person must have an assessment. The person must demonstrate that he or she needs hands on help at home with Activities of Daily Living and/or Instrumental Activities of Daily Living. The person does NOT need to meet Nursing Facility Level of Care.

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

- 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 PCS Agency direct/oversee the PCA about the how the services are rendered (Agency Based).

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/>

Health Insurance Portability and Accountability Act

For more information: <http://manuals.medicaidalaska.com/docs/hipaanews.htm>

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 – Ready.gov

Disaster Preparedness For Families with children who experience Intellectual Disability:

<http://dhss.alaska.gov/dph/wcfh/Documents/PDF/Prepared4HealthCare.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://dhss.alaska.gov/dhcs/Documents/PDF/Recipient-Handbook.pdf>

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, Conduent 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@Conduent.com

Alaska Legal Services Corporation

<https://www.alsc-law.org/>

907-272-9431

888-478-2572 (outside of Anchorage)

Many offices Statewide

Disability Law Center of Alaska: <http://www.dlcak.org/>

800-478-1234

3330 Arctic Boulevard, Suite 103,

Anchorage, AK 99503

Current SDS Contacts

How to send information and documents to SDS

BY SNAIL MAIL: If documents are:

All ALI, APDD eligibility, and CCMC documents	Senior and Disabilities Services Anchorage Office ATTN: CAT Intake unit 550 W 8th Ave, Anchorage, AK, 99501
All DD Eligibility, TEFRA, and IDD Recipient LOC documents , and all DD Recipient PLAN/Amended plan documents for recipients located <u>in</u> the Anchorage/Valley Area	Senior and Disabilities Services Anchorage Office ATTN: IDD Unit 550 W 8th Ave, Anchorage, AK, 99501
IDD Recipient PLAN/Amended plan 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	907 269-6246
ALI, APDD & CCMC renewal waivers and amended plans	907 269-5913
Verification of Diagnosis/Assessment	907 269-6246
Prior authorization	907 269-3688
All IDD documents	907 269-3639

<i>Mailing Address</i>	<i>Fax</i>	<i>Impriva DSM Email</i>
Senior & Disabilities Services <i>Attn: IDD Waiver Unit</i> <i>Attn: IDD Waiver Unit</i> 550 W. 8 th Ave Anchorage, AK 99501	(907) 269 - 3639	(Municipality of Anchorage & Matsu) sds.iddAnchorage@hss.soa.directak.net (All other areas) sds.iddfairbanks@hss.soa.directak.net

In addition to the general inboxes listed above, you may also reach SDS IDD Unit staff directly at the following Impriva DSM addresses:

Nursing Facility Level of Care (NFLOC) Support Plan and Personal Care Services

Contact Person	Phone Number	New DSM email
NFLOC Initial Applications Kimberlina Lopez	Ph: (907) 269-3463	dsds.nfloc-initialapplication@hss.soa.directak.net
NFLOC Renewal Applications Shannon Stallard	Ph: (907) 269-3464	dsds.nfloc-renewalapplication@hss.soa.directak.net
ALI, APDD, CCMC, CFC- Plans, Plan Amendments, Changes Leifiloa Felise	Ph: (907) 269-3087	dsds.nflocwaiver@hss.soa.directak.net
MIRP Documentation Shanon Stallard	Ph: (907) 269-3464	dsds.mirp@hss.soa.directak.net
PCS Initial Applications Jessica Pitchford	Ph: (907) 269-3612	dsds.mapplication@hss.soa.directak.net
Questions regarding PCS Renewal Applications, Re-Assessments, Transfers, COSS Lilian Schreiber & Sarah Bumpus	Sarah Ph: (907) 754-3500 Lilian Ph: (907) 269-3661	dsds.pcamailbox@hss.soa.directak.net

Intellectual and Developmental Disabilities (IDD) Unit in Anchorage

Mailing Address	Fax	Impriva DSM Email
Senior & Disabilities Services Attn: <i>IDD Waiver Unit</i> 550 W. 8 th Ave Anchorage, AK 99501	Attn: <i>IDD Waiver Unit</i> (907) 269 - 3639	(Municipality of Anchorage & Matsu) sds.iddAnchorage@hss.soa.directak.net (All other areas & MSSCA) sds.iddfairbanks@hss.soa.directak.net

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IDD Assessor	alison.seymour@hss.soa.directak.net amy.pheley@hss.soa.directak.net brooke.allen@hss.soa.directak.net jenna.farrally@hss.soa.directak.net joanna.croxton@hss.soa.directak.net julie.albert@hss.soa.directak.net katarzyna.lapinskas@hss.soa.directak.net liza.mccafferty@hss.soa.directak.net maria.delrosario@hss.soa.direct.net rachel.faranmingo@hss.soa.directak.net
IDD Admin	<i>Fairbanks- Jennifer Brinkman</i> sds.iddfairbanks@hss.soa.directak.net <i>Anchorage- Jeremy Meade</i> sds.iddAnchorage@hss.soa.directak.net

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